Trust Board in Public

Thursday 5 November 2026, 09:30 - 13:00

G.09 Kspa

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 (26/27.123)

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 (26/27.124)

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 (26/27.125)

Decision *Chair*

- *To **approve** the minutes of the 3 September Trust Board in Public*

03_DRAFT Mins of Public Board 03.09.26 v2_LN daedit(Final edit).pdf (43 pages)

09:35 - 09:38 (3 min)

4. Action log and matters arising (26/27.126)

Decision *Chair*

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

04_Action Log.pdf (1 pages)

09:38 - 09:53 (15 min)

5. Board Story (26/27.127)

Discussion *Acting Chief Nursing Officer*

- ***Receive** and **note** the Board Story on Organ Donation*

09:53 - 10:03 (10 min)

6. Chair's Report (26/27.128)

Decision *Chair*

- ***Receive** the Chair's report.*
- ***Approve** the following membership changes to Committee:*
  - *Niamh Lamond, from 16 November 2026, as a member of the Audit and Risk Assurance Committee (as Chair), Finance and Performance Committee, Charitable Funds Committee and People and Culture Committee.*
  - *Rae Hall, Associate Non-Executive Director, as a member of the People and Culture Committee and Quality Assurance Committee.*

Neave,Lynsey
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06_Chair's Report November 2026 V2 (Chair approved).pdf (8 pages)

10:03 - 10:18

7. Chief Executive's report (26/27.129)

15 min

Discussion *Chief Executive*

- *The Board is asked to **receive and note** the report, recognising the achievements described and the continuing operational, financial, workforce and infrastructure challenges requiring sustained executive focus and Board oversight.*

07_November CEO report public KOK.pdf (16 pages)

Section A: Matters for Discussion and Decision

10:18 - 10:28
10 min

8. Data Breach Investigation (26/27.130)

Discussion *Acting Chief Nursing Officer*

- ***Receive** for assurance the patient safety incident investigation report and action plan*
- ***Endorse** the proposed recommendations and approach for improvements outlined in the report and action plan.*

08.1_Staff Data Breech Public Board Report Final.pdf (7 pages)
08.2_PSII 255478 Data Breach Investigation Report RCHT.pdf (91 pages)
08.3_Appendix 2 FOI Staff Data Breech Action Plan.pdf (2 pages)

10:28 - 10:38
10 min

9. Urgent and Emergency Care (UEC) Performance (26/27.131)

Discussion *Chief Operating Officer*

- ***Discuss for assurance** we are not meeting the current UEC recovery trajectories and additional actions being taken to bring us back to the improvement trajectories*
- ***Note** progress to date on the GIRFT 11 Point Recovery Plan (Appendix A)*
- ***Note** the Chief Operating Officer's escalation of No Criteria to Reside and **support** continued action with system partners to reduce delays and deliver agreed trajectory; and*
- ***Take assurance** from the marked reduction in ward area corridor care since 29 September 2026, recognising that Emergency Department corridor care has not been fully eliminated, and the improvement is not yet proven to be sustained.*

09.1_UEC Performance and Corridor Care -November Board in Public and Private Final v3.pdf (8 pages)
09.2_GIRFT 11 POINT ACTION PLAN RCHT (20260930).pdf (2 pages)

10:38 - 10:48
10 min

10. Trust Bi-Annual Strategy Report (26/27.132)

Discussion *Chief Strategy Officer*

- ***Note** the progress in delivery of the Trust Strategy Year 1 milestones and ongoing strategic development across all areas of clinical focus.*

10_Bi-annual strategy implementation report Aug26 Board.pdf (13 pages)

10:48 - 10:58
10 min

11. Guardian of Safe Working Hours (26/27.133)

Discussion *Guardian of Safe Working Hours*

- ***Receive** and **note** the Quarter 2 report (2026/27) report from the Guardian of Safe Working Hours.*

11_GOSWH March 2026 (1).pdf (8 pages)

10:58 - 11:08
10 min

12. Freedom to Speak Up Guardian Bi-Annual Report (26/27.134)

Neve.Lynsey
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Discussion *Freedom to Speak Up Guardian*

- ***Receive and discuss for assurance** the key issues identified in the half year report.*
- ***Discuss for assurance**, the increase in concerns raised through the FTSU service, including anonymous concerns.*

12_November FTSU Report_ Trust Board Final (005).pdf (13 pages)

Section B: Reports and Matters from Committee

11:08 - 11:23
15 min

13. Quality Assurance Committee Assurance Report and Matters Escalated from Committee (26/27.135)

Discussion *Committee Chair*

- *Receive and note the Quality Assurance Committee assurance report from the September and October 2026 meeting.*

13.0_Assurance report from Quality Assurance Committee Sept_Oct2026v2_Approved.pdf (12 pages)

13.1. Perinatal Safety Report (26/27.136)

Discussion *Acting Chief Nursing Officer*

- ***Receive for assurance*** *the Perinatal Report which was endorsed by the Quality Assurance Committee 27th October with no matters for escalation to the Trust Board.*
- ***Receive for assurance*** *the PMRT Quarter 2 report which was endorsed by the Quality Assurance Committee 27th October 2026.*

13.1.1_Perinatal Safety Report October 2026 Trust Board Report.pdf (33 pages)
13.1.2_Appendix 2. Q2 PMRT Report.pdf (21 pages)
13.1.3_Appendix 3. Bereavement MIS Grid 2026.pdf (4 pages)
13.1.4_Appendix 4. MIS Year 8 Assurance Paper v3.pdf (11 pages)

13.2. Learning from Deaths Q1 Report (26/27.137)

Discussion *Chief Medical Officer*

- ***discuss for assurance*** *Discuss for assurance the Q1 Learning from Deaths assurance report*

13.2_Learning from Deaths Q1 26_27 Final V9.pdf (28 pages)

13.3. Volunteer Strategy (26/27.138)

Decision *Acting Chief Nursing Officer*

- ***Approve*** *the Voluntary Services Strategy 2026-2029 for implementation across the Trust.*

13.3.1_Volunteer Strategy Cover Sheet 2026 Final Trust Board.pdf (5 pages)
13.3.2_RCHT Volunteer Strategy 2026 Appendix One- Final.pdf (22 pages)

13.4. Thirlwall Inquiry (26/27.139)

Decision *Acting Chief Nursing Officer*

- ***Discuss and reflect*** *on the Thirlwall Inquiry report findings and recommendations.*
- ***Approve*** *the Trust gap analysis and action plan, noting the immediate or urgent actions taken in relation to:*
  - *Safe Storage of Insulin – essential actions include the installation of CCTV into the drug treatment room on the Neonatal Unit and Delivery Suite by 30 November 2026.*
  - *Sudden Unexpected Death in Infancy and Childhood (SUDIC) process communications to Board members and neonatal staff.*
- ***Take assurance*** *that safeguarding arrangements across RCHT and CFT are robust and substantially aligned with the safeguarding themes arising from the Thirlwall Inquiry.*
- ***Endorse the*** *delivery of the identified safeguarding improvement actions and receive progress updates through existing safeguarding assurance reporting arrangements.*

13.4.1_Thirlwall Inquiry Report to Trust Board - 2026-11 v2.pdf (8 pages)
13.4.2_20261020_Thirlwall Letter.pdf (2 pages)

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11:23 - 11:41
18 min

14. Finance and Performance Committee Assurance Report and Matters Escalated from Committee (26/27.140)

Discussion *Committee Chair*

- *Receive and note the Finance and Performance Committee assurance report from the September and October 2026 meeting.*

14.0_FPC Assurance Report Sept and Oct26_approved.pdf (9 pages)

14.1. Month 6 Revenue Financial Report (26/27.141)

Discussion *Chief Finance Officer*

- ***Note*** *the September (month 6) financial position which represents the halfway point of the 26/27 financial year position.*

14.1_Trust Board Public - M6 Revenue Position vFinal.pdf (4 pages)

14.2. Month 6 Capital Report (26/27.142)

Decision *Chief Finance Officer*

- ***Note*** *the financial position for the capital programme for the period to 30 September 2026 (Month 6) including the update on planned and actual mitigations.*
- ***Approve*** *following FPC support, the proposed reprioritisation of £1.258m of 2026/27 capital funding identified in section 7, reducing the remaining mitigation requirement to £1.406m before any capitalisation of revenue spend.*
- ***Approve*** *following FPC support, the receipt of £0.999m and £0.150m of Public Dividend Capital for the EEMAC and Truro UEC schemes.*
- ***Approve*** *following FPC support, the acceptance of £1.042m of additional Public Dividend Capital (PDC) for Ambient Voice Technology via the Frontline Productivity Programme.*
- ***Note*** *that the capital planning for 2027/28 has now started with a significant gap between the request for investment and available funding. The Finance and Performance Committee will receive a capital planning report in November 2026.*

14.2_Trust Board - Capital Programme report - Month 6 vFinal.pdf (14 pages)

14.3. Bi-Annual Green Plan Report (26/27.143)

Discussion *Chief Strategy Officer*

- ***Note*** *the progress against the Trust's Green Plan with ongoing management by the new Sustainability Manager.*
- ***Discuss and note*** *the risks associated with the delivery of the Trust Green Plan have been added to the corporate risk register owing to the broad and far-reaching impacts of failure to making progress against the green agenda.*

14.3_Green Plan Update Nov 26 Board.pdf (11 pages)

11:41 - 11:56
15 min

Break

11:56 - 12:11
15 min

15. People and Culture Committee Assurance Report and Matters Escalated from Committee (26/27.144)

Discussion *Committee Chair*

- *Receive and note the People and Culture Committee assurance report from the September and October 2026 meeting.*

15.0_People and Culture Committee Assurance Report_Sept26rk_approved.pdf (7 pages)

15.1. People Plan (26/27.145)

Decision *Dual Chief People Officer*

Neave,Lynsey
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- ***Note*** *that feedback was received from Executive Leadership Team, Staff Side representatives, Staff Network Chairs and inclusion leads and included within the paper presented today (a summary of consolidated feedback is in appendix 2);*
- ***Note*** *that the feedback was supportive of the overall direction and priorities of the People Plan and did not require significant restructuring;*
- ***Approve*** *the RCHT People Plan 2026–2030;*
- ***Support*** *continued co-production of the annual delivery plan with Staff Side, Staff Networks and relevant colleagues*

with lived experience to execute the plan; and

- ***Endorse** the proposed governance and assurance arrangements, including annual delivery planning and a quarterly People Plan assurance dashboard to be reported through the People and Culture Committee.*

15.1.1_Cover paper People Plan V9.pdf (7 pages)
15.1.2_RCHT_People_Plan_updated v9.pdf (34 pages)
15.1.3_RCHT_People_Plan_Consolidated_Feedback_Log.pdf (2 pages)

12:11 - 12:24
13 min

16. Audit and Risk Assurance Committee Assurance Report and Matters Escalated from Committee (26/27.146)

Discussion *Committee Chair*

- *Receive and note the Audit and Risk Assurance Committee assurance report from the October 2026 meeting.*

16.0_Audit and Risk Assurance Committee_Oct26_Chair approved.pdf (4 pages)

16.1. Board Assurance Framework (26/27.147)

Discussion *Company Secretary*

- ***receive and discuss** the refreshed element of the Board Assurance Framework;*
- ***confirm** that the revised principal risks appropriately reflect the Trust Strategy and the agreed risk appetite statements;*
- ***endorse** the more strategic and high-level presentation of the BAF*
- ***approve** the risk scores, tolerable ranges, target dates, action ownership and status*

16.1_BAF Cover report.pdf (10 pages)
16.2_BAF 1_Safe High Quality Care_new.pdf (5 pages)
16.3_BAF 2-Workforce_New.pdf (5 pages)
16.4_BAF 3_Integrated health services_New.pdf (5 pages)
16.5_BAF 4_Finance_New.pdf (4 pages)
16.6_BAF 5_Digital Infrastructure Strategic_New3.pdf (5 pages)
16.7_BAF 6_Physical Infrastructure and Supply Chain_New.pdf (5 pages)

16.2. Emergency Preparedness, Resilience and Response Annual Assurance Process (26/27.148)

Decision *Chief Operating Officer*

- ***Note** substantial compliance against the EPRR Core Standards Assurance Process*
- ***Endorse** EPRR Committee and Audit and Risk Assurance Committee maintain oversight of actions to ensure movement to full compliance of all standards.*

16_2_Trust Board 5.11.26 - EPRR Core Standards Assurance Process 2026.pdf (8 pages)

12:24 - 12:25
1 min

17. Remuneration and Appointments Committee Assurance Report to Board (26/27.149)

Discussion *Committee Chair*

- *Receive and note the Remuneration and Appointments Committee assurance report from the October 2026 meeting.*

17_Assurance Report from Rem Com to the Trust Board_Oct26_Approved.pdf (2 pages)

12:25 - 12:35
10 min

18. Integrated Performance Report (26/27.150)

Neave,Lynsey
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Discussion *Chief Operating Officer*

- ***Discuss for assurance** the Trust Board section of the report*
- ***Discuss for assurance** the feedback from the Finance and Performance committee and Quality Assurance Committee*

18.1_IPR cover sheet November 2026 (September data) - Trust Board.pdf (3 pages)
18.2_October 2026 Excel IPR_ National KPIS - Final.pdf (71 pages)

Corporate Trustee

12:35 - 12:40
5 min

19. Charitable Funds Committee Assurance Report (26/27.151)

Discussion *Committee Chair*

- ***Receive and note*** *a verbal report from November Committee meeting*

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

20. Corporate Risk Register (26/27.152)

Information *Acting Chief Nursing Officer*

- ***Receive for assurance*** *the new entries to the Corporate Risk Register*
- ***Receive for assurance*** *the changes in scores and the impact on the Trust's strategic priorities which have been endorsed by the Audit and Risk Assurance Committee*

20.1_CRR for ARAC Sep 26 Trust Board Final.pdf (11 pages)
20.2_CRR dashboard Tracker for ARAC Appendix 1.pdf (1 pages)

12:40 - 12:40
0 min

21. Trust Seal Annual Report (26/27.153)

Information *Company Secretary*

- ***Receive*** *and* ***note*** *the use of the Trust Seal Bi Annual Report for 1 April 2026 to 30 September 2026.*

21_Starred Item_Use of Trust Seal Bi Annual Report.pdf (5 pages)

12:40 - 12:40
0 min

22. Petition Policy (26/27.154)

Decision *Company Secretary*

- ***Approve*** *the proposed amendments to the Receiving and Management of Petitions Policy as a matter reserved for Board*

22.1_Petition Policy Cover Report_ARAC.pdf (5 pages)
22.2_Receipt and Management of Petitions Policy V2_Final.pdf (15 pages)

Section D: Other Matters

12:40 - 12:42
2 min

23. Summary consideration of risk and celebration (26/27.156)

Discussion *Company Secretary and Executive Director owners of risks*

12:42 - 12:57
15 min

24. Questions from the Public (26/27.157)

Discussion *Chair*

24_Protocol for Questions from Members of the Public.pdf (2 pages)

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12:57 - 13:00
3 min

25. Meeting effectiveness evaluation (26/27.158)

Discussion *Chair*

- *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

26. Date of next meeting and move to Board in Private (26/27.159)

Information *Chair*

Date of next Board in Public: 7 January 2027

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*

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Minutes of the **Trust Board Meeting in Public** of the **Royal Cornwall Hospitals NHS Trust** held on **Thursday 3 September 2026 from 09.30 to 13.10** in Room G.09 Knowledge Spa and via **MS Teams**

Voting Directors Present:

David Allen (DA), Chair

Kim O'Keeffe (KOK), Acting Chief Executive

Richard Kramer (RK), Non-Executive Director

Bernadette George (BG), Acting Chief Nursing Officer

Meridith Kane (MK), Chief Medical Officer

Ian Dean (IDe), Chief Finance Officer

Adrian Davis (AD), Non-Executive Director

Adam Broome (AB), Non-Executive Director

Uzma Bozai (UB), Non-Executive Director

Rebecca Hopkins (RH), Non-Executive Director

Robin Jones (RJ), Chief Operating Officer

In Attendance:

Ella Stracey (ES), Chief Strategy Officer

Jonathan Foster (JF), NExT Director

Kelvyn Hipperson (KH), Chief Information Officer

Alison Thorne-Henderson (ATH), Dual Chief People Officer

Niamh Lamond (NL), Associate Non-Executive Director

Aled Jones (AJ), Associate Non-Executive Director

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Rae Hall (RHa), Associate Non-Executive Director (part, via MS Teams)

Lynsey Neave (LN), Company Secretary

Stephanie Creek (SC), Deputy Company Secretary

Zoe Cooper (ZC), Head of Safeguarding for Cornwall Foundation Trust and Royal Cornwall Hospital Trust (for item 5)

Dr Sarah Coulter (SCo), Guardian of Safe Working Hours (for item 10)

Josie Dodgson (JD), Head of Midwifery (for item 11.1)

Tom Walker-Smith (TWS), Clinical Director (for item 11.1)

Casey Thomas (CT), Deputy Director of Estates (for item 12.3)

N.B: The order of the minutes may not reflect the order of the discussion.

1. Welcome and Apologies for Absence (26/27.84)

a. Apologies for absence from Trust Board members were **noted:**

   i) Isobel Down, Non-Executive Director

b. Apologies for absence from those usually in attendance were **noted:**

   i) Partial apologies from Rae Hall, Associate Non-Executive Director

   ii) Brian Johnson, Director of Estates and Facilities

2. Declaration of Interest in relation to Agenda Items (26/27.85)

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

3. Minutes of Previous Board meeting (26/27.86)

a. The minutes of the prior public meeting held on 2 July 2026 were confirmed as a correct record.

b. Additionally the minutes of the extraordinary meeting on the 23 July 2026 were also approved and confirmed as a correct record.

4. Matters Arising and Action Log (26/27.87)

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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 (26/27.88)

a. The Acting Chief Nursing Officer (BG) introduced the Board Story. The Board **noted:**

i) The Board received a video presentation on *Safeguarding After Death*. Members heard how the video had been developed to support learning and reflection on ensuring that patients are honoured with dignity and respect following death, recognising this as a fundamental reflection of the humanity that underpins the Trust's services. It was noted that the educational resource had been informed by recommendations arising from previous learning and review work.

b. The Board **discussed:**

i) The Chair thanked those involved in the development of the video and welcomed the powerful message it conveyed.

ii) ZC as Head of Safeguarding reported that the video had received a very positive response, both within the Trust and externally, with a number of other NHS organisations making contact to explore developing similar resources within their own services.

iii) Members reflected on the clarity of the safeguarding message and the importance of encouraging all staff, irrespective of role or seniority, to demonstrate professional curiosity and speak up where concerns arise. The Board acknowledged the relevance of the learning in light of national safeguarding concerns and recognised the role of leadership in fostering a culture in which concerns can be raised confidently and acted upon appropriately

iv) KOK thanked ZC for her leadership in developing the initiative and for her participation in the associated podcast. Thanks were also extended to BG for coordinating the Board Story and supporting the presentation to the Board.

c. The Board **resolved** to:

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

6. Chair's Report (26/27.89)

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

i) The update on arrangements for the forthcoming Annual Public Meeting (APM), which this year would be held as an in-person and online event on 17

September 2026. A number of exhibition stands had been organised to showcase the breadth of the Trust's work and to provide an opportunity for the public to engage directly with services and staff.

ii) The Chair encouraged support for the event and emphasised that members of the public would be warmly welcomed to attend and learn more about the Trust and its services.

b. The Board **discussed**:

i) AD welcomed the plans for the APM, commenting that the return to an in-person format was positive and represented an excellent opportunity to highlight and celebrate the work being undertaken across the organisation.

ii) RK rreferred to the extensive programme of ward and department visits described in the Chair's report and sought the Chair's perspective on whether confidence in organisational leadership and trust was improving amongst staff. In response, the Chair reflected on Kim's engaging and outgoing leadership style, noting that one of her immediate priorities on joining the Trust had been to improve organisational culture and strengthen engagement across the organisation.

iii) The Chair referred to practical actions undertaken during periods of extreme heat, including the provision of refreshments for patients and staff, and highlighted the positive response received during presentations of long-service awards.

iv) Board members supported participation in the APM and encouraged attendance and support for the event.

c. The Board **resolved** to:

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

7. Chief Executive's Report (26/27.90)

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

a. That seven national reports and policy developments had been reviewed during the reporting period, with those of particular significance reflected elsewhere on the meeting agenda;

b. Highlighted the continued priority being given to staff engagement, culture and recognition. Reported positive feedback from staff listening events and described ongoing efforts to celebrate achievements, recognise innovation and improve visibility and communication across the organisation;

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c. Recognised teams continue to work under significant operational and financial pressures, including urgent and emergency care demand, elective recovery, theatre productivity challenges, workforce capacity pressures and the impact of organisational change. However, the Acting Chief Executive emphasised the importance of maintaining visibility, openness and recognition for staff whilst addressing these challenges.

d. Additionally, the Board noted progress in relation to staff engagement, organisational culture and innovation. Improvement was reported in the proportion of staff who would recommend the Trust as a place to work. Whilst patient feedback regarding the care received remained consistently positive, it was acknowledged that staff survey responses relating to the quality of care did not always correlate with patient experience findings. The Board welcomed the open and honest discussions taking place across the organisation to better understand these perspectives and identify opportunities for improvement.

e. The Board heard examples of initiatives aimed at strengthening culture and staff recognition, including the use of thank you cards displayed within clinical and non-clinical areas and their incorporation into appraisal discussions.

b. The Board **discussed**:

i) (NL) welcomed the continued emphasis on staff communication and engagement. She commented that regular, transparent communication with staff was essential and supported the Acting Chief Executive's approach of openly discussing the operational and financial challenges facing the Trust

ii) Discussed the importance of creating an environment in which staff felt able to have difficult conversations respectfully and with dignity. The Board noted ongoing work to advance equality, diversity and inclusion and to ensure that all staff felt valued, heard and supported.

iii) The principal workforce concerns highlighted within the report were noted by the Board and members were assured that these issues were being addressed through the substantive reports presented elsewhere on the agenda.

iv) ATH highlighted the achievement of four members of staff being nominated for national BAME awards, alongside a number of other external recognitions and nominations. The Chair welcomed this achievement and congratulated those who had been shortlisted.

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v) NL welcomed the Trust's approach to regular and transparent communications, commenting that consistent and open engagement with staff made a significant difference and would continue to deliver benefits in both

the short and longer term. She extended her congratulations to those leading this work.

vi) Members welcomed this approach, recognising that acknowledgement and appreciation of colleagues made a significant contribution to positive organisational culture, despite requiring little resource.

c. The Board **resolved** to:

i) **Receive** and **note** the report; acknowledge the progress and achievements described; and note the principal delivery risks, mitigations and areas requiring continued executive oversight.

Section A: Matters for Discussion and Decision

8. Urgent and Emergency Care (UEC) Performance (26/27.91)

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

i) The update on urgent and emergency care performance and was directed to the section within the Chief Executive's report outlining the significant number of changes implemented since the previous Board meeting;

ii) Acknowledged the considerable effort from clinical, operational, estates, medicines management and support teams in delivering these changes at pace;

iii) Members heard that the Trust had delivered the actions it had committed to; however, performance outcomes had not yet improved to the level anticipated. Further deep-dive analysis was therefore being undertaken to better understand the factors influencing performance and to identify where additional improvements could be made.

iv) It was noted that all actions were being informed by an evidence-based approach, with clinicians actively engaged in reviewing performance and providing constructive challenge. The valuable contribution of system partners throughout this process was also acknowledged.

b. The Board **discussed**:

i) IDe highlighted the pace and scale of change delivered across the organisation since the last meeting and commended the leadership and operational teams for their work. He noted that the next challenge would be to strengthen understanding of the impact of individual interventions and to identify the characteristics of those periods when performance was

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demonstrably better. Understanding what constituted a “good day”, and how those conditions could be replicated more consistently, would be important in driving sustained improvement. The Board recognised the significant volume of change overseen by MK, BG and RJ and wished to formally acknowledge their efforts.

ii) RK welcomed the report, observing that the approach described was organisation-wide, evidence-based, staff-led and undertaken in partnership with the wider system. He sought further information on trends relating to corridor care, including the number of patients affected and the length of time patients were spending in corridor environments. In response, RJ advised that whilst corridor care remained present and performance continued to be measured on a binary basis, encouraging progress was being seen in reducing the amount of time patients spent in corridor areas. The number of patients experiencing extended waits in corridors had reduced, as had the overall duration of those waits. Members also heard that the number of patients waiting more than 12 hours in corridor settings was reducing, together with the amount of time spent beyond the 12-hour threshold. Work was now focused on progressively reducing waits further, with performance dashboards including an eight-hour measure to support this improvement trajectory. RJ emphasised that the Trust’s objective remained the elimination of corridor care, whilst recognising the importance of reducing harm and improving patient experience during the improvement journey.

iii) The Board heard that relatively small fluctuations in attendances or discharges could have a significant impact on the number of patients experiencing prolonged waits within the Emergency Department. Members noted the degree of operational sensitivity within the system and the importance of building greater resilience into patient flow processes.

iv) AJ welcomed the emphasis on respectful challenge and sought assurance regarding how differing viewpoints and concerns were being captured, discussed and fed back to staff. He highlighted the importance of fostering curiosity, constructive debate and organisational learning in order to build resilience and increase the frequency of positive performance periods.

v) RJ advised that the Trust was utilising a “Perfect Week” methodology to support improvement, while MK outlined arrangements for a weekly divisional flow meeting. This alternated between structured action-focused sessions and wider discussion and learning reviews, enabling analysis of changing data trends with representation from all divisions. Members noted that this approach helped maintain momentum and kept the conversation around flow and performance active across the organisation.

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vi) ES highlighted the importance of maintaining a partnership perspective and ensuring that system intelligence and neighbourhood-level insights informed decision-making. BG reflected that the Trust remained in an optimisation phase, with clinical engagement continuing to strengthen, although the organisation had not yet reached the point where good days consistently outweighed more challenging periods.

vii) RH stressed the importance of maintaining close and sustained Board oversight of urgent and emergency care performance, supported by regular progress reviews and ongoing challenge.

viii) NL welcomed the improvements being reported but sought assurance regarding attendances, recognising the impact that demand has on front door pressures. RJ confirmed that no significant reduction in Emergency Department attendances had been observed. NL noted this remained an area of concern and observed that recent data did not suggest that seasonal visitor numbers alone were responsible for current demand pressures.

ix) KOK emphasised the importance of maintaining a strong system-wide focus and ensuring that all partners were involved in discussions and decision-making. She highlighted the need to consider the wider impact of commissioning and service redesign decisions across the whole health and care system.

x) In concluding the discussion, the Chair reiterated that the Emergency Department remained available for those requiring emergency care, whilst encouraging members of the public to consider alternative services, including minor injury units and community-based facilities, where clinically appropriate. The Chair reflected on the pace with which recommendations arising from the Getting It Right First Time (GIRFT) review had been translated into action, including the establishment of the Urgent Treatment Centre and Discharge Ready Unit during August. Whilst recognising that the full impact of these initiatives would take time to emerge, he welcomed the speed of implementation and the strong clinical engagement that had supported these developments.

xi) The Board agreed that the elimination of corridor care would not be achieved immediately but noted the expectation that incremental, sustainable improvements should continue to be delivered. Members reaffirmed the priority attached to urgent and emergency care performance and agreed that progress should remain subject to regular Board review and challenge.

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c. The Board:

i) **Discussed** and **considered** the update report on urgent and emergency care and the actions and mitigations being taken.

9. Winter Plan Board Assurance (26/27.92)

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

i) The report provided the development of the Trust's Winter Plan and accompanying Board Assurance Statement;

ii) Noted that much of the content reflected the actions and challenges discussed under the previous urgent and emergency care agenda item. It was reported that the Plan remained under development with system partners and that a system-wide exercise scheduled later in the month would further inform the final submission. As a result, the final Plan was not yet being presented to the Board for approval and with a recommendation to delegate to Quality Assurance Committee for final approval ahead of deadline of 30 September 2026.

b. The Board **discussed**:

i) AB noted that the paper reflected a work in progress and queried whether the recommendation relating to substantial assurance was appropriate at this stage, particularly given the number of assurance criteria remaining rated red within the self-assessment. In response, RJ explained that the substantial assurance rating had been generated through the national assessment framework based on the responses already submitted against prescribed criteria. He acknowledged, however, that there was a distinction between assurance that appropriate plans and governance arrangements were in place and assurance regarding successful delivery of the required outcomes. It was agreed that this distinction would be made clearer in future reporting and at the Quality Assurance Committee.

ii) AB also sought clarification regarding any additional financial implications arising from the Winter Plan. RJ advised that the Plan itself did not identify any additional investment requirements. However, he noted that the Trust was currently incurring significant expenditure associated with escalation areas and that delivery of the urgent and emergency care improvement programme was expected to support a reduction in reliance on these arrangements. Should improvements not be realised as anticipated, there could be consequential impacts on the Trust's financial position. Members noted that the quality benefits associated with reducing the use of escalation spaces remained the primary driver for this work.

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iii) ATH sought assurance regarding opportunities to strengthen winter planning from an integrated system perspective. RJ confirmed that the Trust's submission formed part of a wider Cornwall system process, with individual organisational plans being brought together by the ICB into a single system-wide submission. He advised that there had already been ongoing engagement and triangulation between partners to ensure alignment across organisations.

iv) Building on this point, JF asked whether there were any concerns regarding the preparedness of system partners for winter. RJ acknowledged that all partners were facing significant operational pressures, particularly following recent activity levels experienced during August. He emphasised the importance of the forthcoming system-wide planning exercise and outlined work being undertaken to map anticipated demand against planned interventions across organisations in order to better understand system-wide mitigations and dependencies.

v) RH highlighted the importance of prevention and asked whether there were further opportunities to reduce avoidable admissions through closer integration with neighbourhood services and specialist teams. RJ advised that, whilst a range of admission avoidance schemes remained in place, the anticipated reductions in hospital attendances and admissions had not yet been fully realised. He noted that further work was underway at system level to review commissioned services, utilisation levels and outcomes to better understand effectiveness and opportunities for improvement. Members heard that there remained scope to strengthen alternative pathways for some patients who currently attended the acute site unnecessarily.

vi) MK provided assurance regarding the success of a number of existing initiatives, including Hospital at Home, the virtual ward model and the work of frailty and geriatrician teams. These services were supporting patients to remain safely at home and avoid admission wherever appropriate. RH welcomed this progress and encouraged consideration of how awareness of these services could be further strengthened within primary care.

vii) UB welcomed the development of predictive winter planning tools and sought assurance regarding their likely impact on operational decision-making. Robin Jones explained that predictive modelling tools were being used to forecast demand patterns and identify potential changes to service delivery or capacity. Whilst early in implementation, he advised that the intelligence generated was already helping teams understand demand trends and make more informed operational decisions.

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viii) Discussion also took place regarding vaccination uptake and public health messaging. UB referred to recent discussions at the People and Culture Committee regarding vaccination campaigns and the role these could play in

reducing avoidable admissions and winter pressures. BG advised that the team had reviewed approaches adopted successfully elsewhere and had incorporated learning into the Trust's vaccination and communications strategy. This included greater outreach activity and increased utilisation of staff networks to improve uptake. ATH noted that a further update would be presented to the People and Culture Committee, with current plans aiming to deliver a further improvement in vaccination rates.

ix) AD challenged the likelihood of achieving compliance against those Board Assurance Statement criteria that remained assessed as red and sought assurance that significant gaps could be addressed before final submission. RJ advised that some red ratings related to areas outside the Trust's direct responsibility, whilst others represented genuinely challenging requirements that may remain partially complete at the point of submission. He undertook to provide transparent narrative within the final assurance statement explaining the position of each outstanding criterion.

x) NL asked whether sufficient public awareness existed regarding alternatives to Emergency Department attendance. RJ advised that work was underway with communications specialists to ensure consistent and effective public messaging, recognising that public confidence depended upon both awareness of alternatives and confidence in accessing them. Members discussed the advantages and limitations of different communication approaches, including the use of video communications, as well as the challenges of communications fatigue and digital exclusion.

xi) In concluding the discussion, the Chair noted the concerns raised regarding the wording of the assurance recommendation and agreed that this should be amended to better reflect the current position. The Board recognised that further work remained to complete the Winter Plan and welcomed the additional assurance that would be gained through the forthcoming regional exercise.

c. The Board **resolved** as follows:

i) **Discuss** and **Consider** the Winter Plan and current Board Assurance Statement noting an Overall Assessment Rating of 4 – Substantial assurance.

ii) **Note** that the Plan remains under development and that the outstanding assurance actions are set out in Appendix 1.

iii) **Note** that the regionally led winter exercise will take place on 22 September 2026, after this Board meeting, and that resulting learning and actions will be incorporated before final BAS submission.

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iv) **Note** the Winter Plan brings together and coordinates multiple strands of existing programmes of work over the four-to-six-month winter period. Its primary purpose is to support delivery of the Trust's approved Annual Operating Plan, for which a Quality Impact Assessment has been completed and approved.

v) **Approve** delegated authority to the Quality Assurance Committee on 22 September 2026 to approve the final Winter Plan and Board Assurance Statement following the regional exercise.

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

i) The wording relating to substantial assurance should be amended to better reflect the current stage of development.

ii) The delegation of authority to the Quality Assurance Committee to approve the final Winter Plan and Board Assurance Statement on behalf of the Board.

10. Guardian of Safe Working Hours (26/27.93)

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

i) SCo articulated that it had been a relatively quiet reporting period. Whilst exception reporting numbers remained high, this was consistent across services, and no specific areas of concern had been identified. Members heard that the introduction of the new reporting platform appeared to have increased confidence in the reporting process, enabling resident doctors to raise concerns more readily and without apprehension, which was viewed positively.

ii) SCo highlighted two recurring themes within the report. The first related to the ongoing challenge of identifying suitable overnight rest facilities for resident doctors within Trelawny. Whilst significant efforts had been made over the past year to identify an appropriate location, a satisfactory solution had not yet been secured. SCo expressed frustration that progress had not yet been achieved despite continued attempts to resolve the issue.

iii) The second issue related to medical out-of-hours rotas. SCo noted that the most effective rotas were generally those with clear medical oversight and commented that the current out-of-hours arrangement did not benefit from the same level of clinical supervision. Discussions were planned with the relevant General Manager to explore potential improvements to governance and oversight arrangements.

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b. The **Committee discussed:**

i) In discussion, MK welcomed the report and agreed that it had been a relatively straightforward quarter. She also reflected positively on the introduction of the streamlined exception reporting process, noting that it appeared to have increased reporting confidence amongst resident doctors. MK further highlighted that, as part of the Trust's annual resident doctor awards process, SCo had received recognition from colleagues for her exceptional support to doctors in training. She wished to acknowledge publicly the significant contribution SCo continued to make in supporting the resident doctor workforce.

ii) AD referred to previous concerns regarding staffing levels at West Cornwall Hospital and asked whether the planned increase in staffing during August had been achieved. SCo advised that she understood this to have been the case but would confirm following the meeting.

iii) JF congratulated SCo on the award and sought assurance regarding progress on the provision of rest facilities, noting that this matter had been raised repeatedly through previous reports. He requested an update on actions being taken to address the issue given its importance to resident doctors.

iv) In response, MK advised that discussions had recently identified a potential location within the outpatient area; however, it was unclear whether this remained viable. SCo reported that further discussions with colleagues had indicated that the proposed option was unlikely to proceed. It was noted that several potential solutions had been explored but had not proved feasible. MK reassured the Board that work would continue with resident doctor representatives to identify a suitable location. She clarified that the issue related not simply to the availability of space, but to ensuring that facilities were located sufficiently close to clinical working areas to be practical and effective for staff.

v) IDe highlighted a typographical error within the report and requested that the dates be corrected for accuracy. He also suggested that a specific action be established to enable Board oversight of progress regarding rest facilities, rather than waiting for the next quarterly report. Members agreed that regular updates would be helpful given the length of time the issue had remained unresolved.

vi) AJ welcomed the discussion and noted that, once an appropriate space had been identified, there may be opportunities to seek support through Charitable Funds to enhance the facility if required. He also thanked SCo for her continued engagement with resident doctors, noting that her support was frequently recognised by colleagues across the organisation.

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vii) In closing the discussion, the Chair noted the widespread appreciation expressed by members and formally congratulated SCo on receiving the award. The Board recognised this as a fitting reflection of her commitment to supporting resident doctors and thanked her for her continued contribution to the Trust.

c. The Board **resolved** to:

i) **Receive** and **note** the Quarter 1 report (2026/27) report from the Guardian of Safe Working Hours.

d. The Board resolved to agree the following **action:**

i) Executive leads to continue work with resident doctors, estates colleagues and clinical leaders to identify an appropriate overnight rest facility and provide an update to the Board on progress.

Section B: Reports and Matters from Committee

11. Quality Assurance Committee (QAC) Assurance Report and Matters Escalated from Committee (26/27.94)

a. Rebecca Hopkins, Non-Executive Director introduced the report on behalf of ID who had given her apologies. The Board **noted**:

i) The report covered meetings held in July and August, together with the joint Quality Assurance Committee meeting held with Cornwall Partnership NHS Foundation Trust. Members noted that the joint arrangements supported a consistent approach to quality oversight across both organisations and helped drive high standards of patient care. Given the breadth of matters considered by the Committee, the Board acknowledged the significant level of scrutiny undertaken.

ii) RH highlighted that the principal item requiring Board approval was the NHS England Maternity and Neonatal 10-Point Plan Assessment prior to its submission.

iii) It was noted that urgent and emergency care continued to represent the Trust's most significant operational risk and remained subject to ongoing scrutiny through the Committee and Board governance structures. Workforce fragility had also been considered in detail through the biannual Safer Staffing Review. The Board was asked to receive the associated recommendations, which focused on ensuring appropriate ward leader supervisory time, improving equity, strengthening staff support arrangements and increasing appraisal completion rates.

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iv) The Committee had also reviewed information governance performance, noting that subject access request backlogs and wider capacity pressures continued to present significant challenges. National guidance relating to information governance and the misappropriation of patient records had been considered, with assurance sought regarding arrangements for proactive auditing, communication and oversight. These matters would return to the Committee for further review.

v) The Board noted that the Committee had considered and received assurance in relation to the Winter Plan, the Safeguarding After Death Board Assurance Statement, the Annual Controlled Drugs Report and the Organ Donation Report. Continued oversight was also being maintained in relation to the North Devon maternity service closure and potential impacts for the Trust, together with performance of the fractured neck of femur pathway.

vi) It was highlighted that 30 people across the United Kingdom had received life-changing organ transplants during the year as a result of 11 organ donors from Cornwall. The Board recognised the generosity of those donors and their families and recorded its gratitude in their memory. Particular thanks were also extended to the Specialist Nurses in Organ Donation, whose work continued to provide invaluable support to patients and families while facilitating the donation process.

vii) Members noted that changes to national guidance had resulted in a reduction in compliance with referral expectations, reflecting a requirement for a greater number of borderline cases to be referred for specialist consideration. An action plan was in place to address this. The Board also heard that Organ Donation Week would commence on 22 September, with local awareness-raising activities planned across the Trust. It was noted that 52% of adults in Cornwall were currently registered organ donors.

viii) The Committee Chair further highlighted the successful accreditation of the Endoscopy Service and thanked the team for the significant work undertaken to achieve this standard. Members also noted that quality surveillance arrangements with the Integrated Care Board remained stable and provided assurance.

ix) The Board heard that the Part 2 Quality Assurance Committee with Cornwall Partnership NHS Foundation Trust had continued to focus on cross-system quality issues including pressure ulcers, falls, infection prevention and control, and safeguarding. Members welcomed the benefits of a shared approach, noting evidence of improvements in infection prevention and control performance compared with the previous year. Increasing safeguarding referrals were also noted, reflecting improved identification and reporting of

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safeguarding concerns. The Board agreed that continued oversight of these shared quality priorities remained important.

b. The Board **discussed**:

i) In discussion, ATH highlighted the ongoing work to improve appraisal completion rates, noting the recognised correlation between staff appraisals, engagement and patient safety outcomes. Members heard that the Trust was promoting a streamlined appraisal approach and was seeking to maximise appraisal completion ahead of the implementation of eCare. To support this, a programme of communications activity was underway and an additional 20 training sessions had been arranged for managers.

c. The Board **resolved** to:

i) **Receive and note** the Quality Assurance Committee assurance reports from the July and August 2026 meetings, including the joint Quality Assurance Committee report with Cornwall Partnership NHS Foundation Trust.

11.1 Maternity and Perinatal Safety Report (26/27.95)

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

i) Receipt of the latest Perinatal Safety Report. BG welcomed Josie Dodgson (JD) and Tom Walker-Smith (TWS) to the meeting. Members noted that the report had been scrutinised in detail by the Quality Assurance Committee and that there were no matters requiring escalation to the Board. Since the Committee meeting, however, the service had been required to complete the national self-assessment against the NHS England Maternity and Neonatal 10-Point Improvement Plan and the National Maternity Triage Guidance. BG thanked JD, TWS and the wider team for the significant work undertaken to complete both the improvement activity and associated assurance requirements.

ii) JD outlined the two items requiring Board approval. The first was the baseline assessment against the NHS England Maternity and Neonatal 10-Point Improvement Plan. Members heard that a number of areas were already compliant, providing a strong foundation for further improvement. Over the coming months, work would focus particularly on strengthening clinical audit arrangements and governance oversight through the Clinical Effectiveness Group to support the maternity audit programme.

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iii) The second item related to compliance with the National Maternity Triage Guidance. JD advised that the benchmarking assessment demonstrated a number of principles to be either fully or partially compliant. Particular focus would be required in relation to the future development of maternity triage

services, including consideration of co-location with the labour ward in line with national guidance. Whilst maternity triage was currently located on the ground floor, further work would be undertaken with Estates colleagues to explore potential options.

iv) TWS explained that a further priority would be strengthening senior obstetric presence within maternity triage. Whilst the current model provided cover through the delivery suite obstetric team, national guidance recognised the importance of dedicated senior clinical oversight within triage settings. Work was therefore underway to explore how this could be achieved within existing resources and, if necessary, identify any additional workforce requirements.

v) Members also received an update regarding the temporary closure of maternity services in North Devon. The Board noted that the impact on RCHT maternity services had been minimal to date. Where requests for mutual aid had been received, the Trust had supported neighbouring services. Some increased demand had been experienced within neonatal services through higher bed utilisation, however this had remained manageable and had not adversely affected service provision at RCHT.

vi) The Board welcomed reports that stillbirths and neonatal deaths had reduced significantly over the previous nine months. Members were assured that robust Perinatal Mortality Review Tool (PMRT) processes remained in place to support learning and review of all relevant cases.

vii) The Chair thanked the team for the substantial amount of work required to respond to both national reviews and assurance requirements, noting that whilst the reports had not arisen directly from issues at RCHT, there had nevertheless been a significant expectation on services to undertake detailed assessment and planning work.

b. The Board **discussed**:

i) IDe highlighted the importance of ensuring that lessons from the national guidance were reflected within the design of the new Women's and Children's Hospital. He welcomed assurance that maternity triage co-location requirements had already been incorporated within the proposed design. He also asked whether comparative information would be available to enable benchmarking against other organisations. BG advised that regional comparisons would be available through established maternity networks and that clarification would be sought regarding any future national benchmarking arrangements.

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ii) ATH sought an update on implementation of Martha's Rule within maternity services. JD advised that implementation remained subject to a phased

national programme and that the Trust was actively engaged with regional planning arrangements. Learning from existing pilots was being reviewed, and local preparatory work was underway in conjunction with Trust leads already involved in implementing Martha's Rule in other services.

iii) BG further advised that a national maternity meeting had recently highlighted the forthcoming publication of the Thirlwall Inquiry report. Whilst no details of the recommendations were yet available, national leaders had indicated that any neonatal recommendations arising from the Inquiry would be incorporated into the wider maternity improvement programme. Members recognised that this would likely result in further work for the service over the coming months.

iv) In concluding the discussion, the Chair welcomed the progress reported, particularly in relation to reductions in perinatal mortality and improvements in neonatal staffing arrangements. He thanked the team for their continued commitment and leadership.

c. The Board **resolved** to:

i) **Discuss** and **approve** the September baseline assessment against the 10-point plan in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in appendix 2 ahead of the national submission date.

ii) **Receive** for assurance the PMRT Quarterly Report Q1 and the reduction in perinatal mortality in appendix 3.

iii) **Receive** for assurance the Maternity Incentive Scheme Year 8 update in Appendix 4.

iv) **Discuss** and **approve** the Maternity Triage Specification Benchmarking Audit Tool (Appendix 5) ahead of the submission date.

v) **Receive** for assurance the current update regarding the temporary closure of Perinatal services at North Devon District Hospital and current limited impact on RCHT services.

vi) **Receive** for assurance the improved position in relation to neonatal staffing and qualified in speciality staffing numbers.

11.2 Organ Donation Annual Report (26/27.96)

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

i) That the report highlighted the significant contribution made by the organ

donation team in providing patients with the opportunity for life-changing and life-saving transplants, while also supporting donor families through exceptionally difficult circumstances. Recognising the highly skilled and compassionate role undertaken by the Specialist Nurses in Organ Donation (SNODs), noting that they were involved in the vast majority of donation discussions and played a vital role in supporting families and facilitating the donation process.

ii) Noted the positive outcomes reported during the year, including the number of successful donations and transplants achieved. Members were reminded of the forthcoming Organ Donation Week, commencing on 21 September, and were encouraged to support activities aimed at raising awareness of organ donation and the difference it makes to patients and families.

iii) On behalf of the Trust, thanks were extended to the Organ Donation Lead and Specialist Nurses Team in Organ Donation, all staff involved in the organ donation pathway, donor families and those members of the public who had recorded their organ donation wishes.

e. The Board **discussed:**

i) IDe welcomed the report and asked whether future reports could include trend information and benchmarking against previous years and comparable organisations, to provide a clearer understanding of performance over time and relative to similar acute trusts.

ii) In response, MK advised that similar feedback had been received previously and that consideration would be given to including comparative information in future reports. Members were advised, however, that changes in national reporting requirements would make direct year-on-year comparisons more complex. New guidance now required all potential donor cases to be discussed with specialist organ donation teams, including cases that would previously have been excluded on clinical grounds. As a result, future reporting would need to be interpreted within the context of these revised requirements.

iii) In concluding the discussion, the Chair thanked RH for her leadership of the Committee and extended particular thanks to the Specialist Nurses in Organ Donation for undertaking sensitive and often challenging conversations with patients' families. The Chair reiterated the Trust's commitment to supporting organ donation through appropriately staffed critical care services, adherence to national standards and continued education and awareness-raising across the Trust, particularly within Emergency Department, theatres and critical care services.

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c. The Board **resolved** to:

i) **Note** the end of year report for Organ Donation activity at RCHT

ii) **Approve** the report and endorse the recommendations thus recognising the importance of organ donation and the ongoing commitment of RCHT to staffing Critical Care to nationally approved standards so that facilitation of the organ donation process can always happen and education for staff can take place throughout the trust (ED, Theatres and Critical Care).

11.3 Health Inequalities Update (26/27.97)

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

a. Progress in addressing health inequalities and noted that reducing health inequalities remained a core component of the Trust's strategy. MK introduced the report and highlighted the strong alignment between the Trust's approach, the Integrated Care Board's five-year commissioning strategy, the emerging national 10-Year Plan and the Trust's statutory responsibilities.

b. Members heard that the national policy direction recognised health inequalities as a system leadership responsibility. The Trust was therefore aligning its contribution with the Integrated Care Board's life-course approach of "Start Well, Live Well, Age Well", whilst continuing to fulfil its role both as a healthcare provider and as a major anchor institution within Cornwall.

c. The Board noted that health inequalities considerations were increasingly being embedded within service planning and delivery arrangements, with particular focus on those areas where the Trust could make a direct contribution to improving outcomes. Progress was being made against the Trust's priorities for 2026/27, and members welcomed recognition that the Trust's health inequalities dataset had been identified regionally and nationally as an exemplar, providing valuable insight to support service planning and decision-making.

d. MK emphasised the importance of ensuring that health inequalities work remained visible as it became embedded within business-as-usual activities. Whilst consideration of inequalities should form part of routine decision-making across the organisation, it remained important to maintain a clear strategic focus given the significant health inequalities experienced across Cornwall, including those arising from geography, deprivation and vulnerable population groups.

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b. The Board **discussed:**

i) RH welcomed the report and stressed the importance of ensuring that health inequalities remained visible within Board papers and organisational decision-making. She also highlighted the need to strengthen awareness amongst staff so that consideration of health inequalities became embedded within the Trust's culture at all levels.

ii) KOK supported this view and highlighted the importance of neighbourhood-based approaches. Reflecting on experience across both acute and community services, she noted that a significant amount of work was already underway but was not always visible at a system level. She emphasised the importance of ensuring that partners were collectively focused on reaching those communities most affected by deprivation and exclusion, particularly ahead of the winter period and recognising that many individuals only engaged with services when they had reached a point of crisis.

iii) The Chair reflected on previous approaches used elsewhere to address deep-rooted inequalities, including targeting interventions within specific geographical areas to better understand impact before wider implementation. He suggested that a similar approach could potentially be explored within Cornwall.

iv) ES advised that discussions were already underway with the North Kerrier Integrated Neighbourhood Team regarding a more targeted approach. Members heard that North Kerrier consistently featured amongst the areas experiencing the greatest health inequalities. ES noted that addressing inequalities often required a shift from equal provision towards equitable provision, with services tailored to meet the differing needs of communities. She highlighted opportunities arising through outpatient transformation and neighbourhood working to identify and intervene earlier for individuals at risk of poorer outcomes.

v) AD suggested that consideration be given to engaging with Cornwall Fire and Rescue Service, noting the significant amount of demographic and deprivation data they had accumulated over many years to support risk-based planning and prevention activity.

vi) RK welcomed the report and the principle of embedding health inequalities within ordinary business processes, supported by a strong evidence base. He suggested that future reports could place greater emphasis on specific population groups as well as geographical communities, particularly disabled people and Gypsy, Roma and Traveller communities. He also sought greater visibility of the actions being taken and the impact being achieved for particular groups experiencing poorer outcomes.

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vii) MK agreed and noted that future reports could include greater emphasis on priority population groups alongside geographical communities. She also suggested that learning arising from mortality and learning-from-deaths analyses could be incorporated to strengthen understanding of inequalities and inform future priorities. As integrated neighbourhood working matured, the Trust would increasingly be able to highlight specific examples of interventions and outcomes for particular communities and groups.

viii) In concluding the discussion, the Chair welcomed both the report and the discussion it had generated. He highlighted the comprehensive programme of work set out within the proposed next steps and sought assurance regarding the system's capacity to deliver this agenda. MK advised that, whilst there had been a period of transition across the system, the necessary leadership and resources were increasingly coming into place to support delivery.

ix) The Chair reiterated that, whilst statutory responsibility for health inequalities sat largely within the Integrated Care Board, the Trust had consciously chosen not to wait for system arrangements to mature and had continued to progress work wherever possible. Members agreed that this reflected the importance of the agenda and the opportunity to improve outcomes for some of Cornwall's most disadvantaged communities and population groups.

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

i) That future reporting should continue to consider both geographical communities and specific population groups experiencing inequalities.

d. The Board **resolved** to:

i) **Note** the Trust's ongoing commitment to addressing the health inequalities which exist within our population.

ii) **Note** that as a system partner, we continue to support system-led initiatives to address health inequalities; and endorse ICB leadership to health inequalities as per the Model ICB blueprint.

iii) **Note** and discuss the progress against the agreed health inequalities priorities for 2026/27 and proposed next steps.

11.4 Safer Staffing Biannual Report (26/27.98)

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

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i) In her presentation of the reports, BG expressed her thanks to ward leaders, Clinical Matrons, Heads of Nursing, Ian Moore Browning, Associate Director colleagues and Lisa Rodda for their extensive contribution to what remained a

substantial and highly detailed review process undertaken twice each year. Particular recognition was given to ward leaders for their exceptional engagement throughout the review.

ii) Members heard that the nursing review provided assurance that the Trust remained aligned with National Quality Board expectations regarding delivery of the right staff, with the right skills, in the right place at the right time. The review also identified areas where full compliance with specialty-specific national recommendations had not yet been achieved and set out clear recommendations and improvement actions.

iii) The Board noted a number of positive findings within the report, including strong registered nurse and support worker fill rates at Trust level, despite continuing operational pressures and the use of escalation areas. Ward staffing fill rates had exceeded 80% during the review period, a position welcomed by members. Significant progress had also been made in reducing nursing vacancies, alongside continued use of evidence-based workforce planning tools. The Trust also continued to benchmark favourably against peer organisations, remaining within the second quartile for nursing cost per weighted activity unit.

iv) Advised that the 13 ward-specific recommendations had been fully endorsed by both the Executive Leadership Team and the Quality Assurance Committee. Additional professional recommendations focused on strengthening incident reporting processes, including implementation of the red-flag reporting framework; improving validation and utilisation of evidence-based staffing tools; and developing divisional improvement plans where services were not yet achieving national standards.

v) Particular emphasis was placed on the importance of enabling ward leaders to undertake their supervisory leadership role consistently. Members heard that this function extended beyond appraisal and compliance activities and included coaching, mentoring, visible clinical leadership and support for staff in practice. Whilst operational pressures and workforce shortages had impacted delivery of this role in some areas, improvements in recruitment were expected to support progress over coming months.

vi) Noted that the Trust remained below national expectations for Professional Nurse Advocates. However, additional national training opportunities had become available and work was underway locally to strengthen capacity and increase numbers.

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vii) Turning to the AHP Safe Staffing Review, BG advised that the overall position remained mixed. Whilst no patient harm themes had been identified that were directly attributable to AHP staffing levels, sustained workforce pressures

remained evident across a number of services and continued to have implications for quality, patient experience and staff wellbeing.

b. The Board **discussed:**

i) Members noted that registered AHP staffing levels remained below national and peer averages, with the most significant workforce challenges continuing within occupational therapy and physiotherapy services. However, positive progress had been achieved through the inpatient therapies redesign programme, including workforce realignment and improved recruitment outcomes since the previous reporting period.

ii) The Board also welcomed developments within diagnostic radiography, where strengthened training and competency frameworks, together with greater use of technology and artificial intelligence, had delivered meaningful service improvements. Particular recognition was given to the leadership provided by Michelle Langford and the positive impact achieved within the service over a relatively short period.

iii) In conclusion, BG advised that the reports provided substantial assurance regarding the governance, oversight and review processes in place, whilst recognising that some workforce risks, particularly within AHP services, would require continued monitoring and management.

iv) The Chair thanked BG for the comprehensive reports and noted that both had been reviewed through the appropriate governance route.

c. The Board resolved to:

i) **Receive** for assurance the content of the Bi-Annual Safe Staffing Review Board Report which has been reviewed and endorsed by the Executive Leadership Team and Quality Assurance Committee.

ii) **Approve** the 13 case recommendations along with the further professional recommendations outlined in the report which have been endorsed by the Executive Leadership Team and Quality Assurance Committee.

12. Finance and Performance Committee (FPC) Assurance Report and Matters Escalated from Committee (26/27.99)

a. Adrian Davis, Non-Executive Director and Committee Chair introduced the report. AD advised that AB had chaired the July meeting and therefore focused his update on the August meeting and the key matters escalated to the Board. The Board **noted**:

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i) That the Committee had undertaken significant discussion regarding the Trust's revenue and capital position at Month 4 and, as a result, had agreed a number of issues requiring Board attention. The principal concern related to the deteriorating financial position and forecast year-end deficit, driven by under-delivery of recurrent savings, operational cost pressures and the Trust's position within the NHS oversight framework. Whilst it had subsequently been confirmed that the Trust should be categorised in South West Finance Intervention level 3 rather than level 4, the Committee remained concerned about the level of financial risk facing the organisation.

ii) The Committee therefore requested continued Board focus on financial grip and control, the robustness of recovery plans and the medium-term implications of recurrent savings under-delivery. Further assurance had also been sought regarding the adequacy of mitigating actions currently in place, and additional time had been allocated at a future Committee meeting to undertake a detailed review of recovery and mitigation plans.

iii) AD further reported that the eCare Programme and the Women and Children's Hospital Programme continued to represent significant strategic risks requiring ongoing Board oversight. The Committee had also discussed the implications of the revised NHS oversight framework and noted that increased scrutiny from regional teams was likely. Workforce culture and operational performance remained key areas of focus for improvement.

iv) The Committee additionally escalated concerns regarding delivery of the capital programme and requested further assurance regarding the consequences of any failure to achieve a balanced capital position, with continued monitoring through future governance reporting.

v) AB highlighted one additional matter arising from the July meeting. The Committee had received a detailed review of the Trust's previous Cost Improvement Programme and had considered lessons learned from delivery during 2025/26. Members noted the significant work undertaken to ensure that these lessons were reflected within the Financial Sustainability Programme for 2026/27 and beyond. The Committee welcomed the strengthened approach and emphasised the importance of maintaining a disciplined process of annual review and organisational learning to support future delivery.

vi) In response, the Chair thanked both AD and AB for their contributions and acknowledged the significance of the issues raised. He noted that, whilst a more detailed discussion of the Trust's financial position and recovery plans would take place later in the meeting and during the Board's private session due to commercial sensitivities, it remained important that the Board continued to discuss the financial position openly and transparently in public.

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The Chair noted that, although the Trust had received confirmation of the South West Finance Intervention level, significant risks remained and warranted continued scrutiny.

vii) The Board recognised that a number of the operational issues highlighted by the Committee had already been discussed elsewhere on the agenda, particularly in relation to urgent and emergency care performance, and agreed that these matters would continue to receive close oversight through existing governance arrangements.

b. The Board **resolved** to:

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

12.1 Month 4 Revenue Financial Report (26/27.56)

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

i) IDe advised that the Trust had moved off plan for the first time during the financial year, excluding the impact of industrial action. At Month 4, the Trust reported a variance of £0.4m adverse to plan, resulting in a year-to-date deficit of £4.8m against a planned deficit of £4.4m.

ii) Members heard that the principal drivers of the deterioration were the continuing costs associated with operational escalation areas, estimated at approximately £300k per month, together with a one-off revenue cost of approximately £75k arising from the temporary measures required following the sewage leak affecting the Tower Block.

iii) The Board noted that a number of key financial indicators had deteriorated during the month, including agency expenditure, which had increased to its highest level of the year to date. Concern was also expressed regarding the recurrent nature of savings delivery. Whilst the original plan assumed that 75% of savings would be recurrent, current delivery stood at just under 14%, with a revised forecast of approximately 50% by year end. Members noted that failure to achieve recurrent savings would increase the underlying financial challenge and place additional pressure on future years' savings requirements.

iv) IDe highlighted a potential income risk associated with elective activity. Due to coding and data-lag issues, the Trust was only now obtaining reliable data for April activity. Initial indications suggested performance may be below plan, creating a potential impact on income. Dialogue was already underway with the ICB regarding both the performance and financial implications of this position.

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v) The Board's attention was drawn to the revised year-end forecast. Members heard that forecast modelling had identified an unmitigated year-end risk of approximately £24m, with the underlying run-rate risk estimated to be between £20m and £24m if no further action were taken. Whilst work was already underway to identify and implement mitigating actions, IDe advised that there was presently insufficient assurance that existing recovery plans would return the Trust to its planned break-even position.

vi) To strengthen oversight and accountability, divisions had been required to submit detailed monthly assurance reports setting out forecasts, mitigation plans and delivery trajectories. Further challenge sessions had been undertaken with divisional leadership teams to test assumptions, identify additional opportunities and review controls. Members heard that the immediate objective was to develop a Trust-wide Financial Recovery Plan that combined divisional actions with any further measures required to achieve the planned year-end position.

vii) The Board noted that the Trust continued to implement national financial grip and control requirements. This included the establishment of a dedicated Non-Pay Board and detailed review of the national Grip and Control Checklist, both locally and within divisions. Particular focus would be given to areas of significant expenditure, including temporary staffing costs.

viii) Members heard that, although it had initially been reported that the Trust had moved from a Regional Finance Assessment rating of Level 2 to Level 4, subsequent clarification from the regional team confirmed that the correct position was Level 3. This represented a move from "moderate confidence of delivery" to "delivery at risk". Whilst less severe than originally reported, Members noted that the revised rating nevertheless reflected significant concerns regarding financial delivery and reinforced the need for urgent corrective action.

b. The Board **discussed**:

i) KOK emphasised the seriousness of the financial position and stressed the importance of transparency. She advised that, irrespective of the oversight rating applied by the region, Executive discussions had already recognised that the organisation was not where it needed to be financially. Members heard that the focus would be on collective accountability, strengthened financial controls, increased executive oversight and the development of a credible recovery plan. KOK stressed that this was not simply a financial exercise but an organisational priority requiring timely and decisive action.

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ii) AD suggested that consideration be given to inviting Board members to future Finance and Performance Committee discussions relating to recovery

planning, whilst the Chair noted that the availability of meeting transcripts provided an additional opportunity for broader Board engagement and oversight.

iii) AB sought clarification regarding the forecast reduction in recurrent savings delivery. IDe explained that the Trust's target remained 75%; however, the forecast had been revised to reflect the organisation's current realistic assessment of delivery. He emphasised that the ambition remained to maximise recurrent savings wherever possible, given the direct impact on the underlying financial position and future years' financial plans.

iv) RK sought further assurance regarding agency and bank expenditure and the balance between vacancy-driven costs and operational pressures. IDe advised that agency expenditure had reduced significantly in recent years, although a small number of high-cost medical vacancies and sustained pressures in key operational areas continued to drive spend. Members heard that further scrutiny of temporary staffing controls would form part of ongoing recovery work.

v) ES noted that achieving financial sustainability would require consideration of different models of service delivery, productivity improvements and potential opportunities for activity to be delivered in alternative settings where appropriate. She encouraged continued focus on quantifying these opportunities and incorporating them into future planning arrangements.

vi) ATH advised that work was already underway to develop project documentation specifically focused on productivity and efficiency opportunities as part of the wider Financial Sustainability Programme.

vii) In concluding the discussion, the Chair reflected on the Trust's track record of achieving financial balance in previous years and reaffirmed the Board's commitment to maintaining financial sustainability whilst protecting quality and patient safety. He noted that the current position required a greater sense of urgency and that additional actions might ultimately be required should existing arrangements fail to deliver the necessary improvement trajectory.

viii) Recognising the seriousness of the financial challenge, the Board agreed that it should do more than simply note the report. Members therefore agreed to formally empower the Acting Chief Executive, in her capacity as Accountable Officer, to take whatever actions she considered necessary to restore the Trust's financial position within her existing powers.

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c. The Board **resolved** to

i) **Note** the July (month 4) financial position which represents the fourth month of the 26/27 financial year position.

ii) **Note** the forecast risk assessment and the actions being taken to address this.

iii) **Note** the financial risks outlined in the paper.

iv) The Board supports the CEO to take all reasonable steps to recover the 2026/27 financial position within her delegated authority as CEO and Accountable Officer

12.2 Month 4 Capital Report (26/27.102)

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

i) That there had been positive progress since the previous Board meeting in reducing the financial risk associated with delivery of the capital programme. Members heard that the Trust had successfully secured confirmation of £1.5m capital brokerage funding, reducing the £4m level of brokerage support required during the current year. In addition, positive discussions were underway regarding a potential further £2.5m allocation through frontline digitisation funding. Whilst these developments were welcomed, IDe cautioned that until all mitigating actions were confirmed, the capital programme risk rating would remain at 20 (Extreme).

ii) Members noted that the capital programme continued to be reviewed monthly and that a full re-prioritisation exercise would be undertaken at Month 6. This would provide a more informed assessment of likely scheme slippage and enable further consideration of priorities across the programme.

iii) The Board heard that a number of significant capital projects continued to progress as planned, including implementation of the eCare Electronic Patient Record and the wider capital investment programme.

iv) IDe highlighted one item requiring Board approval: the receipt of additional Public Dividend Capital (PDC) of £2.49m to support Women and Children's Hospital project design fees. Members noted that contracts had been signed with the principal contractor at the end of July and that the additional funding was required to support progression into the next phase of the project. The request was within the approved overall scheme envelope but, in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation, required formal Board approval.

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b. The Board **discussed**:

i) AB welcomed the progress in securing capital support but sought clarification regarding the brokerage funding. IDe confirmed that the £1.5m brokerage would need to be repaid in the following financial year and would therefore have implications for the future capital programme.

ii) AB also sought assurance regarding the consequences of any breach of the Trust's capital expenditure limit. IDe advised that such breaches were uncommon and that discussions had already taken place with the regional capital team. Whilst no definitive guidance had been provided, it was anticipated that any overspend could result in a reduction to the Trust's future capital allocation. He emphasised the importance of continuing efforts to mitigate the current risk.

iii) NL asked whether capital schemes could be delayed ensuring expenditure remained within the available funding envelope. IDe confirmed that prioritisation and potential deferral of schemes remained an active consideration. Some projects had already been postponed as part of the revised capital plan, and further decisions would be reviewed at Month 6. However, these decisions needed to be balanced against the operational and strategic risks arising from delaying important investment programmes.

iv) The Chair summarised that, whilst the report principally required noting, the Board was also required to approve receipt of the additional Public Dividend Capital for the Women and Children's Hospital project.

12.3 Premises Assurance Model (26/27.103)

a. The Board received the Premises Assurance Model (PAM) report presented by Casey Thomas (CT). The Board **noted:**

i) That the national PAM assessment methodology had changed significantly for 2026, moving from a graded assessment framework to predominantly yes/no compliance measures. As a result, the current year's assessment should be treated as a new baseline, and direct comparison with previous years should be approached with caution.

ii) The Board heard that the Trust's overall assessed compliance score was 74.81%, with particular strengths identified within facilities management and patient experience. Areas requiring further improvement were predominantly within hard facilities management. Members noted that the risks identified through the assessment were already reflected within the Trust's existing risk management arrangements and that a costed action plan was being developed, with progress monitored through Estates governance structures and escalated through Trust governance as required.

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iii) It was noted that the report had previously been reviewed by both the Executive Leadership Team and the Finance and Performance Committee.

b. The Board **discussed**:

i) The Chair congratulated CT on his recent appointment as Deputy Director and thanked him for presenting the report. BG welcomed the positive findings relating to patient experience and acknowledged the significant effort invested by teams in achieving these outcomes.

ii) The Chair noted that the PAM remained a dynamic assessment and that ratings may continue to evolve as further work progressed. Members agreed to endorse the submission and were satisfied with the governance arrangements in place to oversee delivery of the associated action plan.

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

a. Richard Kramer, Non-Executive Director and Committee Chair introduced the report and thanked UB for chairing the Committee in his absence. The Board **noted**:

i) That the Committee had reviewed people metrics and identified particular concerns regarding training compliance and appraisal completion rates. Assurance had been sought that divisional recovery plans and hotspot analysis would support continued improvement, and that investment in leadership development would remain a priority given the impact of line management capability on these measures.

ii) The Committee had also undertaken a detailed review of occupational health and wellbeing, including mental health-related sickness absence. Members welcomed the targeted interventions being implemented in identified hotspot areas, including within urgent and emergency care services. The Committee requested that future reports place greater emphasis on outcomes and impact, particularly where this could support future investment decisions.

iii) The Board noted the Committee's continued support for the *We Are RCHT* culture programme and the investment made to date. As the programme matures, the Committee wished to see further evidence of measurable improvements in organisational culture, together with staff stories, examples of visible leadership and practical demonstrations of culture change.

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iv) Members also received updates on flu vaccination planning, the transformation of People Services through greater digitalisation, equality, diversity and inclusion matters, and medical appraisal and revalidation.

b. The Board **discussed**:

i) During discussion, AD sought clarification regarding the timeline for implementation of the national Band 5 nursing profile review and any associated financial implications. Members were advised that implementation would extend over several years, with further national returns required through to 2028. Work was being undertaken jointly between Nursing and People Services, in partnership with Staff Side colleagues, to develop an implementation plan. Whilst national funding had been identified to support the programme, the full financial impact for the Trust remained under assessment. It was noted that some services had already made workforce adjustments through skill-mix reviews and role development initiatives.

c. The Board **resolved** to:

i) **Receive** and **note** the People and Culture Committee assurance report from its recent meeting.

13.1. Annual Equality, Diversity and Inclusion Report (26/27.104)

13.2. Gender Pay Gap (26/27.105)

13.3. Workforce Equality Standards Report 2025/26 (26/27.106)

a. The Dual Chief People Officer, ATH, introduced the reports and advised that the Annual Equality, Diversity and Inclusion (EDI) Report, Gender, Ethnicity and Disability Pay Gap Report, and Workforce Equality Standards reports were closely aligned and therefore were to be presented together. The Board **noted**:

i) That the reports identified a number of continuing challenges, including disproportionate recruitment outcomes for some workforce groups, under-representation of protected characteristics in senior roles, and disparities within disciplinary processes. Members also noted evidence of differing levels of confidence in raising concerns across workforce groups, with ongoing work taking place alongside the Freedom to Speak Up team to better understand and address those differences.

ii) Particular attention was drawn to the experience of disabled staff. The Workforce Disability Equality Standard indicators demonstrated continuing inequalities in staff experience, career progression opportunities and access to workplace adjustments. Members noted that whilst progress had been made in a number of areas, including governance arrangements and the strengthening of staff networks, improvement had been slower than intended.

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iii) Noted the progress made in embedding inclusion within organisational priorities, including the introduction of the Board's anti-discrimination

commitment and the increasing role of staff networks in shaping policy and organisational development. ATH noted the valuable contribution staff networks had recently made to the development of the Trust's People Plan.

iv) With regard to the Gender, Ethnicity and Disability Pay Gap Report, progress had been made in reducing some inequalities; however, structural differences remained, particularly in relation to gender pay. It was noted that references to bonus payments reflected historic national medical payments rather than local bonus arrangements.

v) Noted improvements in reported experiences of bullying, harassment and abuse amongst ethnic minority staff, with indicators showing the most favourable position seen in recent years. However, recognised that the same improvement had not yet been achieved for disabled staff and that this would remain an area of focus.

vi) Noted the inclusion of Board equality objectives within the report and noted that, following the Lord Mann review, responsibility for these objectives now sat collectively with the whole Board rather than solely with the Chair and Chief Executive.

b. The Board **discussed**:

i) IDe welcomed the reports and recognised both the scale of the issues identified and the extensive action plans proposed. He sought assurance regarding organisational capacity to deliver the actions and how progress would be monitored. ATH advised that assurance would continue to be provided through the People and Culture Committee. She noted that accountability for many actions now sat within divisions, with the People and Organisational Development team providing support, oversight and enabling activity. Whilst significant work remained, a different operating model was being developed to support delivery.

ii) JF welcomed the reports and noted the close relationship between the issues highlighted. He emphasised the importance of recognising that the Trust's duties under the Equality Act extended beyond the workforce to include patients, carers and local communities. He also sought views on the principal barriers to achieving improvement.

iii) In response, ATH highlighted culture as one of the key challenges, particularly in creating an environment in which all staff felt comfortable declaring protected characteristics and engaging with staff networks. Members heard that further work was required to ensure inclusion was visibly valued across the organisation and to increase the profile and influence of staff networks.

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iv) RK noted the importance of strengthening engagement with staff networks and increasing their visibility within governance arrangements. He suggested there would be value in hearing directly from network representatives through future Committee discussions and strengthening connections between network activity, recruitment, progression and leadership opportunities.

v) KOK reflected on themes emerging from staff listening events, including powerful accounts relating to diversity, long-term health conditions and access to reasonable adjustments. She emphasised the importance of ensuring staff networks were visible and accessible from the point of induction so that staff knew where support could be found.

vi) ATH acknowledged that whilst reasonable adjustments were often considered at appointment, consistency could be lost over time as staff changed teams or managers. She noted the need to strengthen arrangements to ensure adjustments remained effective throughout employment.

vii) UB welcomed the summary of achievements included within the reports and suggested that feedback be sought from staff regarding engagement activities and events, to better understand participation levels and identify opportunities for improvement. She also sought an update regarding future EDI leadership arrangements. ATH advised that work was underway jointly with ES to develop a revised organisational development and EDI approach, with proposals to be brought through the appropriate governance routes.

viii) In concluding the discussion, the Chair summarised that the reports provided a clear picture of both progress achieved and the work that remained. Members supported the proposed priorities and action plan.

13.4 Medical Appraisal and Revalidation Annual Report and Statement of Compliance (26/27.107)

a. The Chief Medical Officer introduced the Medical Appraisal and Revalidation Annual Report and advised that it provided assurance that the Trust continued to meet its statutory responsibilities as a designated body for medical appraisal and revalidation. Members were asked to approve the annual Statement of Compliance for publication and submission to NHS England. The Board **noted** that:

i) Appraisal performance remained strong, with 78% of connected doctors completing an appraisal within the appraisal year and a further 10% not requiring an appraisal for legitimate reasons. Of the remaining 12%, none were categorised as non-engaged, with most appraisals either subsequently completed or delayed for valid reasons. Members were advised that the Trust

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had not required any referrals to the General Medical Council for non-engagement.

ii) Revalidation recommendations continued to be submitted on time. Whilst a number of revalidations had been deferred, this reflected expected circumstances such as insufficient evidence within a five-year cycle, periods of long-term leave, recently appointed doctors building their evidence portfolio, or delays in receiving patient feedback reports. Members were assured that these deferrals did not reflect concerns regarding engagement.

iii) Highlighted the robust arrangements in place for managing concerns relating to doctors, including oversight through the Responsible Officer Advisory Group. The multidisciplinary membership of the group ensured that concerns were reviewed from a range of professional perspectives and promoted consistency of approach across the organisation.

iv) The Board noted one emerging challenge relating to the increasing number of connected doctors, dentists and physician associates requiring appraisal. Work was therefore underway to increase appraisal capacity, reduce reliance on individual appraisers and establish more sustainable funding arrangements for the appraisal process.

b. The Board **discussed:**

i) RH welcomed the report and asked whether additional support could be provided to help doctors obtain patient feedback earlier in their revalidation cycle, thereby reducing the likelihood of deferrals. MK confirmed that this approach was already encouraged where possible, although some delays arose from external reporting processes rather than delays in gathering feedback itself. She noted that the Trust's position compared favourably with other organisations.

ii) ATH drew attention to a minor amendment required within the report to update a committee reference to the People and Culture Committee.

c. The Board **resolved to:**

i) **Note** the content of the report against Annex A - Illustrative Designated Body Annual Board Report and Statement of Compliance.

ii) **Approve** the Statement of Compliance

13. Audit and Risk Assurance Committee (ARAC) Assurance Report and Matters Escalated from Committee (26/27.108)

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a. Adam Broome, Non-Executive Director and Committee Chair, introduced the

report. The Board **noted**:

i) The Committee had considered the Trust's draft Artificial Intelligence Policy and, recognising the growing importance of artificial intelligence within healthcare and corporate services, recommended the policy for Board approval. AB thanked all those involved in the development of the policy, with particular recognition given to Adam Wheeldon for his work.

ii) Noted that a draft Petitions Policy had been reviewed by the Committee and was currently subject to Staff Side consultation. This would return through the governance process for consideration at a future meeting.

iii) Highlighted the Committee's continued focus on risk management and assurance. This included ongoing work to strengthen the Board Assurance Framework, review the Trust's risk appetite and further develop the Corporate Risk Register.

iv) The Committee had also considered an Internal Audit report relating to e-Rostering, which had received a Limited Assurance opinion. Members were assured that actions were being progressed to address the issues identified. In addition, the Committee noted the significant progress made in response to the previous Limited Assurance opinion relating to clinical audit governance and acknowledged the work undertaken by Merry and her team to strengthen arrangements in this area.

b. The Board **discussed:**

i) The Chair acknowledged the work of the Committee and noted the importance of the new Artificial Intelligence Policy in supporting the safe and appropriate use of emerging technologies across the organisation. He also recognised the assurance provided through the Committee's ongoing focus on risk governance and internal control arrangements.

c. The Board **resolved** to:

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

13.1 Board Assurance Framework (BAF) (26/27.109)

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

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i) LN advised that the BAF remained the principal mechanism through which the Board oversees risks to the delivery of the Trust's strategic objectives. Members noted that the six existing BAF risks remained unchanged since their approval in July, with only minor updates having been made during the

reporting period. The principal gaps in control and assurance remained largely unchanged.

ii) The Board noted that revised risk appetite statements had been approved in August and were now aligned to the Trust's strategic priorities, whilst retaining specific consideration of finance, estates and digital risks. Further work was underway to align the Board Assurance Framework to the revised risk appetite framework, including a review of risk scores, target risk ratings and timescales.

iii) Noted that feedback received from the Audit and Risk Assurance Committee would be incorporated into the ongoing review process. The revised Board Assurance Framework would return through the Audit and Risk Assurance Committee before being presented to the Board for final approval.

b. The Board **discussed**:

i) There was limited discussion on the detailed content of the BAF, reflecting the extensive consideration of many of the principal risks through earlier agenda items.

c. The Board **resolved to:**

i) Note the latest versions of the BAF elements and accept the minor amendments;

ii) Note the Board approved revised Risk Appetite Statements on 6 August;

iii) Note work is now underway to align the Board Assurance Framework with the revised risk appetite statements. The existing BAF will remain in place in the interim, with a revised version expected for consideration at the October Audit and Risk Assurance Committee and Trust Board.

14. Remuneration and Appointments Committee Assurance Report to Board (26/27.110)

a. The Board received the Remuneration and Appointments Committee Assurance Report. The Chair noted that, given the confidential nature of the Committee's business and its focus on matters relating to individual employees, the detailed content of the report was not appropriate for discussion in public session. The report was therefore taken as read.

c. The Board **resolved** to:

i) **Receive** and **note** the Committee assurance report from the July and August meetings.

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15. Integrated Performance Report (26/27.111)

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

i) Noted the continued development of the report, noting the significant improvement in its presentation and the increased contribution from Committees and Divisions. Particular recognition was given to the enhanced triangulation of information, which was supporting a more integrated understanding of organisational performance and providing greater transparency regarding key risks and challenges.

ii) The principal issues within the report had already been discussed under earlier agenda items, particularly urgent and emergency care, workforce metrics and financial performance. However, he drew the Board's attention to the elective care position, noting that waiting list sizes had increased above plan and that theatre activity levels remained below the position the Trust would wish to achieve. Members heard that this underperformance also had implications for income generation and therefore linked directly to the financial challenges discussed elsewhere on the agenda.

b. The Board **discussed:**

i) The Chair noted that the most significant performance issues had already been subject to detailed discussion during the meeting and welcomed the increasing focus on triangulation within the report, recognising it as an important area of ongoing development that was already strengthening Board assurance.

c. The Board **resolved to:**

i) **Discussed** and **considered** the Trust Board Section of the Integrated Performance Report.

ii) **Noted** 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.

Corporate Trustee

17. Charitable Funds Committee (CFC) Assurance Report to the Board (26/27.112)

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a. Richard Kramer, Non-Executive Director and Committee Chair, introduced the

report and highlighted three key areas of discussion. The Board **noted**:

i) The Committee welcomed the strong early performance of the Charity Lottery. In light of player recruitment levels exceeding expectations, the Committee approved an additional investment of £50,000 in the canvassing budget to accelerate further growth. Members noted that increasing participation would support the generation of unrestricted charitable income and strengthen the long-term sustainability of the charity's funding.

ii) The Committee considered a proposal to invest charitable funds in improving staff wellbeing facilities. Whilst members were supportive of the proposal in principle, they agreed that further work was required before approval could be granted. The Committee requested a more detailed implementation plan, including evidence of engagement with Divisions, Estates and Facilities teams, clearer alignment with staff survey findings, and assurance that staff would play a key role in shaping the proposals. A revised report would be brought back to the Committee in October.

iii) The Committee received a beneficiary story relating to the neuro-oncology wellbeing project. Members heard how the project had successfully brought together patients and carers through peer-support arrangements, helping to reduce isolation and improve wellbeing beyond traditional clinical interventions. The Committee noted the potential to explore similar approaches for other patient groups in partnership with the voluntary and community sector.

b. The Board **discussed:**

i) ID commented that the growth in the charity lottery represented an important achievement against the Charity's strategic objectives and should be recognised as a positive development.

c. The Board **resolved** to:

i) **Receive** and **note** the Committee assurance report from the August meeting

Section C: Matters of Report

18. Corporate Risk Register (26/27.113)

a. This was a starred item and was not discussed as no Board member had requested that it be unstarred prior before the meeting.

b. The Board **resolved** to:

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i) **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

ii) **Note** the risks approved onto the Corporate Risk Register

iii) **Note** the presented updates including changes to scoring

19. Policies: Matters Reserved for Board (26/27.114)

19.1 Artificial Intelligence (AI) Policy (26/27.115)

a. This was a starred item and was not discussed as no Board member had requested that the following be unstarred prior before the meeting:

b. The Board **resolved to:**

i) **Approve** the Artificial Intelligence (AI) Policy

19.2 Disciplinary Policy (26/27.116)

a. This was a starred item and was not discussed as no Board member had requested that the following be unstarred prior before the meeting:

b. The Board **resolved** to:

i) **Note** the changes made to the Trust Disciplinary Policy following review in partnership with Staff Side colleagues and consideration through JCNC, the Executive Leadership Team and the People and Culture Committee.

ii) **Approve** the revised Trust Disciplinary Policy as a matter reserved for Trust Board and note the proposed outcome monitoring arrangements.

Section D: Other Matters

20. Summary consideration of risk (26/27.119)

a. The Company Secretary introduced this item and provided a summary of key areas of assurance, risk and achievement arising from the meeting. The Board **noted**:

i) In terms of celebration, the Board noted the number of staff members and teams who had received external recognition and award nominations during the reporting period. Members welcomed the intention to continue highlighting these achievements within the Chief Executive's report to ensure that success and innovation across the Trust were appropriately recognised and celebrated.

ii) The Board also highlighted the positive impact of the Trust's organ donation programme, recognising the contribution of specialist staff and donor families in supporting life-changing transplantation opportunities for patients.

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iii) LN advised that the principal organisational risks discussed throughout the meeting were already reflected within the Corporate Risk Register, although further consideration would be given to how these were articulated within the Board Assurance Framework as part of the ongoing review. Particular areas of focus included urgent and emergency care performance and corridor care, the Trust's financial position, and delivery of the capital programme. Members also noted the importance of maintaining visibility of workforce-related risks, including cultural and people metrics, and ensuring that actions to address these issues were clearly reflected within assurance reporting.

iv) IDe highlighted the success of the Trust's charitable activities, particularly the strong early performance of the Charity Lottery. He noted that this represented an important strategic achievement in the Trust's role as Corporate Trustee and supported the long-term sustainability of charitable income generation.

b. 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 (26/27.120)

a. The Company Secretary introduced this item, having advised that a number of questions had been submitted by members of the public and staff in advance of the meeting, together with questions received during the meeting. The Board **noted**:

i) **Staff Experience and Culture**

In response to a question regarding what the Trust was doing differently to improve staff experience and organisational culture, ATH acknowledged that the 2025 Staff Survey results were below the levels the Trust aspired to achieve. She noted that organisational change programmes had impacted staff experience, but advised that the Trust had moved from simply reviewing survey results to implementing a more structured improvement approach, supported through the People and Culture Committee.

Members heard that a new People Plan had recently been approved by the Executive Leadership Team, informed through engagement with staff networks and colleagues across the organisation. Focus areas included appraisal completion, speaking up, leadership visibility, staff wellbeing and strengthening management capacity.

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ES highlighted the *We Are RCHT* culture transformation programme, which had been developed through extensive staff engagement and was structured around six core themes: leadership development, quality improvement,

inclusion and equality, wellbeing, confident engagement, and reward and recognition. She advised that the programme reflected priorities identified directly by staff, including the need for visible leadership, improved staff facilities and enhanced opportunities for engagement.

In responding to the question regarding whether improvements would be delivered through top-down or bottom-up approaches, ATH advised that successful culture change required a combination of both organisational initiatives and locally led solutions developed by teams.

ii) **Artificial Intelligence, Data Protection and Use of Technology**

Responding to a question regarding the use of artificial intelligence and software platforms such as the Federated Data Platform, KH advised that the Board recognised the wider public debate surrounding these technologies and remained mindful of associated information governance, ethics and data protection considerations.

Members heard that any use of such systems within the Trust was governed through established information governance arrangements, with additional oversight provided through reporting to the Finance and Performance Committee. Should further utilisation be proposed, this would be subject to formal review and approval processes.

ATH, in her role as Senior Information Risk Owner (SIRO), emphasised that the Board took information governance responsibilities extremely seriously. Appropriate data protection impact assessments and governance reviews were undertaken for digital systems to ensure continued compliance with information governance and data protection requirements.

iii) **Clinical Administration Review**

The Board also considered two questions relating to the Clinical Administration Review. The first sought assurance that proposed workforce changes would be sufficient to support services safely and effectively without increasing pressure on staff or adversely affecting patient care. The second questioned the timing of the review in advance of eCare implementation and sought assurance that the proposed changes would not have a detrimental impact on patient care, operational performance or staff wellbeing.

RJ thanked colleagues for raising the questions and advised that these issues would form part of the Board's detailed consideration of the Clinical Administration Review in the private session of the meeting.

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The Chair thanked all individuals who had submitted questions and welcomed the continued engagement of staff and members of the public in the work of the Board.

27. Evaluation of Effectiveness of the Meeting (26/27.121)

a. The Chair invited comments on the effectiveness of the meeting. No comments were raised.

28. Date of next meeting and move to Board in Private (26/27.122)

a. The Board noted its next meeting in public would be on **5 November 2026** and moved to its private session per the notice of motion on the agenda.

b. The Chair thanked members and attendees for their contributions and declared the meeting closed. **The meeting closed at 13.10 hours.**

The minutes were duly approved by:

Category	Information
Name	
Signature	
Date	

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KEY:

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

One + all | we care Royal Cornwall Hospitals NHS NHS Trust

Trust Board in Public Action Log

Min Ref	Action	Lead	Status	Due date	Update
(26/27.92) ci	**Winter Plan Board Assurance** The wording relating to substantial assurance should be amended to better reflect the current stage of development.	Chief Operating Officer	Propose complete	Nov-26	**Update October 2026:** Quality Assurance Committee reviewed the updated winter plan and board assurance statements in September following feedback from Trust board. Following further consideration and clarification this was approved via e-governance and submitted by the 30 September 2026 deadline.
(26/27.92) cii	**Winter Plan Board Assurance** The delegation of authority to the Quality Assurance Committee to approve the final Winter Plan and Board Assurance Statement on behalf of the Board.	Chief Operating Officer / Company Secretary	Propose complete	Nov-26	**Update October 2026:** Quality Assurance Committee reviewed the updated winter plan and board assurance statements in September and following further consideration and clarification this was approved via e-governance and submitted by the 30 September 2026 deadline.
26/27.93 di	**Guardian of Safe Working Hours** Executive leads to continue work with resident doctors, estates colleagues and clinical leaders to identify an appropriate overnight rest facility and provide an update to the Board on progress.	Chief Medical Officer / Chief Nursing Officer / Director of Estates and Facilities	Propose complete	Nov-26	**Update October 2026:** There are ongoing efforts to find rest facilities for on-call resident doctors in the Trelawney / Tehidy area of the Treliske site, noting that rest facilities are still available for use in the corridor adjacent to The Doctors' Mess, but just further away from some clinical areas than is ideal if ward presence to undertake tasks is needed overnight. Initial stated requirements that such facilities shoud be furnished with food preparation and storage facilities now mitigated by the openign of a 24/7 staff only area in the Royal Restaurant, equiped with a microwave and work stations.
26/27.97) ci	**Health Inequalities Update** That future reporting should continue to consider both geographical communities and specific population groups experiencing inequalities.	Chief Medical Officer	Propose complete	Sep-27	**October 2026 update:** to be provided through future reports (annual report)to Board and bi-annual report to Quality Assurance Committee. Propose complete
Jul-26					
(26/27.53) dii)	**Maternity and Perinatal Safety Report -** The Board recommended further work to strengthen consideration of health inequalities within maternity, learning from deaths and wider Board assurance reporting.	Acting Chief Nursing Officer	Propose complete	Oct-26	**Update August 2026:** Further strengthening of the report is taking place. **Update October 2026**: Action complete and will be included in future reporting.
(26/27.63) cii)	**Integrated Performance Report -** Future iterations of the IPR should consider incorporating additional maternity and health inequalities metrics, where appropriate.	Chief Operating Officer	Propose complete	September 206	**Update August 2026:** Further strengthening of the report is taking place. **Upatate October 2026**: We continue to strengthen the triangulation of issues. There is significant data on health inequalities and therefore working through how to present this in the most meaningful way. propose complete
Sep-25					
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	Propose complete	~~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. **Update August 2026:** report schduld for September Committee **Update October 2026** - the Board Diveristy Plan is in the process of review and scheduled to be presented to the November People and Culture Committee. This review will reflect on the progress of the actions and set out a considered approach for the future, taking learing from the previous plan. Propose complete as this is scheduled via internal governance routes for review and approval.

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Chair's Report – November 2026

1. Non-Executive Director (NED) Update and Membership arrangements

It is with sadness, but also with considerable gratitude and warmest wishes, that I note that this will be Adam Broome's final meeting of the Trust Board before he completes his tenure with the Trust on 15 November 2026.

Adam joined the Trust (for the second time) in November 2020, at an exceptionally challenging time for the NHS, the Trust and our local communities during the first year of the COVID-19 pandemic. Throughout his tenure, Adam has made a significant contribution to the work of the Board and the wider governance of the Trust.

As Chair of the Audit and Risk Assurance Committee, Adam has provided diligent and considered leadership, supporting the Board in maintaining effective oversight of risk, assurance and governance. He has also undertaken the role of Non-Executive Director lead for security, bringing careful focus to the Trust's responsibilities in this area. In addition, Adam has served as the Check and Challenge Non-Executive Director for the eCare programme, where his forensic approach, constructive challenge and attention to detail have been greatly valued.

On behalf of the Board, I would like to record our sincere thanks to Adam for his commitment and contribution to the Trust over the past six years and wish him every success and happiness for the future.

I am pleased that Niamh Lamond, currently an Associate Non-Executive Director, will take up the vacant Non-Executive Director role following Adam's departure, ensuring continuity through a carefully planned handover. Niamh will assume these responsibilities from 16 November 2026.

I therefore recommend that the Trust Board appoints Niamh as a member of the following committees:

- Audit and Risk Assurance Committee, as Chair
- Finance and Performance Committee
- Charitable Funds Committee
- People and Culture Committee

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I am also pleased to confirm that Niamh will assume the Non-Executive Director lead role for security and the Check and Challenge Non-Executive Director role for the eCare programme. She will also be the non-executive lead for net zero.

I am grateful to both Adam and Niamh for the commitment they have given to ensuring a thorough and effective handover, providing continuity in these important areas of Board oversight and assurance.

I would also like to recognise Jon Foster, who has spent the past year with the Trust as part of the NHS England NExT Director Programme. Jon has made a valuable contribution to the Trust Board, bringing thoughtful insight and constructive challenge to our discussions. As his placement concludes on 31 December 2026, I would like, on behalf of the Board, to thank Jon for his contribution and wish him every success in the next stage of his career.

Lastly, I recommend the Board approve Rae Hall, Associate Non-Executive Director to be a member of People and Culture Committee and Quality Assurance Committee.

2. Strengthening Board and Committee Reporting

Effective governance depends on the Board receiving timely, clear and evidence-based information, enabling it to scrutinise performance, assess risks and make informed decisions. Working with the Company Secretary, I have reviewed our approach to Board and Committee reporting and developed proposals to strengthen its quality, consistency and effectiveness.

The review responds to longstanding feedback from Board and Committee members, reinforced by the Well-Led Development Review and recent Board evaluation. Although improvements have been made, the volume of papers and variability in quality remain concerns. A comparison of public Board packs from seven NHS organisations found that RCHT's packs were the longest. Excessive information can obscure significant issues and reduce the time available for focused scrutiny and challenge.

Drawing on learning from other trusts I have proposed a strengthened protocol for Board and Committee papers and minutes. The intention is to reduce unnecessary volume substantially, with an aspiration towards Board packs of fewer than 300 pages, while improving the quality of information and preserving effective oversight. Shorter reporting is not an end in itself: papers must contain sufficient evidence, analysis and clarity to support appropriate assurance and informed decisions.

The proposed protocol establishes clearer accountability for report preparation. Authors would remain responsible for content, accuracy and revisions, with the relevant Executive Director reviewing and approving papers before submission. The Corporate Secretariat would provide advice and undertake quality review, rather than substantive redrafting. Submission deadlines would be enforced, with late papers deferred, and the Company Secretary authorised, with the relevant Chair and Chief Executive's support, to return papers that do not meet the required standards.

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Board papers would be tailored to the Board's oversight responsibilities rather than routinely reproducing Committee reports. Greater reliance on Committee scrutiny and assurance would help avoid duplication. Supporting detail would be available through a virtual Reading Room where appropriate, while papers presented solely for noting would not normally form part of the Board agenda.

A more proportionate approach to minutes is also proposed. These would retain material discussion and challenge, decisions, significant decision-making rationale and agreed actions, without routinely recording every individual contribution. Their adequacy as a corporate governance record—not a fixed page limit—would be the overriding measure. Draft minutes would be prepared within ten working days, with Chairs returning suggested amendments within five working days.

I have also addressed the opportunities and risks associated with artificial intelligence. Approved tools could support drafting and summarising, but their use should be transparent and subject to human review and validation. Accountability for accuracy and recommendations would remain with the report author.

The Board is being asked to consider and approve these proposals in the Private Board since there is reference in the report to the practices of third parties as part of the research process for preparing the paper. The desired outcomes are more focused scrutiny, clearer assurance, timely and well-informed decisions, stronger accountability and more efficient use of governance resources. Implementation would be monitored through paper quality, timeliness and pack length, alongside wider work on agenda planning, meeting duration and Board development. These changes are intended to strengthen, rather than reduce, the substance and transparency of Board oversight.

3. Annual Board Evaluation outcomes

As required by the NHS Code of Governance, a Board self-evaluation was undertaken internally by the Trust's Company Secretarial team during the summer of 2026. The purpose of this exercise was to ultimately identify strengths, bring to the surface any areas for improvement and subsequently create an action plan that would strengthen the Board's governance over time. It is to be noted that the Board last completed a similar exercise in 2024 and given the volume and breadth of Board changes since then, no direct comparisons have been drawn between these two sets of results. The next planned evaluation will be in 2027, and this will also be facilitated internally, with an external valuation anticipated in 2028. The questionnaire was distributed to all 20 Executive and Non-Executive Directors, including both voting and non-voting members of the Board, with a response received from every Board member, resulting in a 100% completion rate.

The results of the evaluation process were analysed by the Company Secretarial team, discussed with the Chair of the Board and then anonymised for wider circulation, with overarching themes and trends from the feedback highlighted rather than specific and attributable items of feedback. In considering how this feedback would be developed into an action plan, the anonymised themes were cross-referenced with the identified areas present in the existing Governance Improvement Plan, and it was found that there was almost a complete overlap with the themes identified in this year's evaluation. Review of the Committee Self-Assessments

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undertaken during 2025/26 identified findings which were highly consistent with those emerging from the Board Self-Assessment, which is unsurprising given the membership overlap. The Governance Improvement Plan has subsequently been updated to reflect these findings and will remain the principle tool for improving governance within the Trust. The Board's Development plan is in the process of being updated but nonetheless is based upon the themes and trends identified within the feedback. This means that the Board can take assurance that the planned areas for the Board's training and development are focused upon the areas identified as requiring improvement.

The results themselves do not identify significant concerns regarding governance, assurance or Board culture. Indeed, respondents generally agreed that the Board's committees provide effective scrutiny and assurance, and that matters are escalated appropriately where required. However, as discussed, they do reinforce several developmental priorities, particularly in relation to organisational culture; leadership; partnership working; strategic capacity, and the quality of Board discussion and information. Respondents expressed high levels of confidence in Board culture, whilst also recognising the importance of preserving challenge and avoiding complacency. Similarly, confidence in the organisation's strategic direction was accompanied by questions regarding capacity, prioritisation and deliverability. These findings do not suggest contradictions within Board performance; rather, they highlight the balance the Board must maintain between ambition and capacity, cohesion and challenge, and operational oversight and strategic discussion.

It is to be noted that some questions within the evaluation provided for respondents to supply narrative responses, which whilst valuable to receive, contained attributable or otherwise specific information and were therefore unable to be included in the general, anonymised feedback. These individual responses have been considered fully by the Company Secretarial team and discussed in detail with the Chair in order to ensure that all of the feedback that the Board members have taken their time to share will be considered and, to the appropriate level, will be incorporated into all development plans. The topics covered by this attributable feedback related to Non-Executive Induction programmes, the Trust's Equality, Diversity and Inclusion programmes, the Trust's sustainability agenda, organisational risks and partnership relationships.

Overall, the self-assessment presents a positive picture of Board effectiveness, underpinned by strong governance arrangements, positive working relationships and a clear commitment to continuous improvement. The identified themes for improvement provide a useful focus for future Board development activity and for ongoing consideration as the Trust continues to operate within a complex and challenging environment.

4. NHS Board Development Programme Cohort 2

I am pleased to confirm the Trust has been invited to participate in the Cohort 2 of the NHS Board Development Programme led by NHS England. The Trust, with its system partners including Cornwall Partnership NHS Foundation Trust will commence the programme in November 2026 for a 12 month period.

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The programme sits within the heart of the newly formed NHS College of Leadership and Management and aims to empower NHS Board – putting quality and Board accountability at the heart of the NHS and shaping the future of healthcare.

The programme provides development support, working with boards to build on their strengths and address the practical challenges they face. It focuses on strengthening the foundations of effective governance, oversight, constructive challenge and accountability, supporting boards to lead improvement and transformation.

The Chief Executive and I will shape the Board's development journey drawing on Board self-insights and input from regional colleagues to agree development priorities and intended outcomes. I would encourage the Board to engage fully with the programme. Its impact will be shaped not only by the support provided, but also by the openness, commitment, and collective engagement.

5. Walkarounds

I visited the Emergency Department on 7 October with the Chief Executive. I was grateful for the opportunity to meet staff and receive an update on current operational pressures, patient flow and future development plans for the department.

During the visit, we discussed proposed capital investment options within the Emergency Department, observed the challenges associated with maintaining flow through the department and visited the recently established Discharge Ready Unit. Staff spoke positively about the contribution the unit is expected to make to patient flow, while recognising that some initial operational challenges are still being addressed.

I would like to thank colleagues for taking the time to speak with us during the visit. The feedback received indicated that the walkaround was welcomed by staff and provided a valuable opportunity to hear directly about their experiences and priorities.

8. Podcast Recording

Following the Board in Public meeting in September, the Chief Executive and I recorded a podcast reflecting on several key priorities for the Trust. This included our commitment to eliminating corridor care, collaboration with partners across Cornwall to deliver more joined-up care and major developments such as eCare and the future Women's and Children's Hospital. We also discussed the importance of the NHS Staff Survey in informing organisational priorities and decision-making and shared reflections on the patients, families, staff and volunteers whose dedication and experiences continue to inspire us.

A link to the recording can be found here: https://www.youtube.com/watch?v=oev-9jGg8Mw&feature=youtu.be

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9. Meetings and Events (including system meetings)

The below activities occurred following the last Board in Public meeting:

Cornwall Chairs and CEO Meeting

I attended a meeting of Cornwall's Chairs and Chief Executives on 11 September to discuss opportunities to strengthen collaboration across partner organisations. The discussions built on a previous system workshop and focused on how organisations can work together more effectively to improve outcomes for local people and communities. This included consideration of shared priorities, opportunities for closer partnership working and arrangements to support the delivery of collective objectives across Cornwall during 2026/27.

Royal Cornwall Hospitals NHS Trust's Annual Public Meeting

We held our Annual Public Meeting on 17 September, which provided an important opportunity to reflect on the Trust's achievements and challenges over the past year, share progress against key priorities and engage directly with members of the public, patients, carers and stakeholders. The feedback we received following the event was positive and the information displays and engagement stands were well attended throughout the event. I am grateful to those Board members who attended and contributed to the meeting, and to the Communications and Company Secretary's teams for their considerable work in planning and delivering a successful event.

Cornwall Partnership NHS Foundation Trust's (CFT) Showcase and Annual Members Meeting

The Chief Executive and I attended CFT's Showcase and Annual Members' Meeting on 23 September. The event highlighted the strength of partnership working across Cornwall's health and care system, bringing together organisations from across the NHS, local government, higher education and the Voluntary, Community and Social Enterprise (VCSE) sector. It provided a valuable opportunity to celebrate achievements, share learning and strengthen collaborative working in support of improving outcomes for local people and communities.

Executive to Executive and NHS England Mid-Year Review of Delivery of Plan

I attended an Executive-to-Executive meeting with NHS England on 5 October as part of the Trust's mid-year review of delivery of its annual plan. The discussion focused on evidence of organisational progress, financial recovery and sustainability, operational performance, quality, workforce, governance arrangements and key system dependencies. The meeting provided an opportunity to review progress against agreed priorities, demonstrate Board oversight and accountability and discuss the support required to sustain improvement and delivery over the remainder of the year.

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RCHT Baby Remembrance Service

I had the honour of attending the Trust's annual Baby Remembrance Service on 11

October, organised by the Chaplaincy Team and Bereavement Midwives. The service provided a compassionate opportunity for families, staff and volunteers to come together to remember babies who have died and to reflect on their loss.

I was grateful to be part of such a moving and meaningful occasion, which highlighted the dedication and support provided by colleagues involved in bereavement care.

Black History Month

Board members attended the Trust's Black History Month Conference on 15 October. The event provided an opportunity to engage with colleagues, hear about their experiences and celebrate the contribution of our ethnically diverse workforce. Attendance by Board members demonstrated the Board's commitment to equality, diversity and inclusion and provided valuable support to the Trust's Ethnic Minority Network and wider colleagues.

The Trust was also recognised nationally through several nominations in the National Black, Asian and Minority Ethnic (BAME) Health and Care Awards, held in London in September, and received a Highly Commended award in the Outstanding Social and Community Care category. This national recognition reflects the commitment of colleagues and staff networks who continue to promote inclusion, belonging and cultural understanding across our organisation and communities.

One Devon System Planning Joint Committee

I attended a meeting of the One Devon System Planning Joint Committee on 20 October, which considered several strategic issues relating to system planning and transformation across Devon and Cornwall. Discussions included updates on the One Devon Transformation Programme, commissioning intentions, development of a draft Case for Change and early considerations for the 2027/28 financial position. The meeting provided an opportunity to consider how partners across the system can work together to support the delivery of shared priorities and sustainable services for local communities.

Recommendation

The Board is invited to:

- **Receive** the Chair's report.
- **Approve** the following membership changes to Committee:
    - Niamh Lamond, from 16 November 2026, as a member of the Audit and Risk Assurance Committee (as Chair), Finance and Performance Committee, Charitable Funds Committee and People

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and Culture Committee.

- Rae Hall, Associate Non-Executive Director, as a member of the People and Culture Committee and Quality Assurance Committee.

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Royal Cornwall Hospitals NHS Trust

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

Executive summary

This report brings together Chief Executive visits and national leadership engagement, service achievements, operational recovery, workforce and organisational change, infrastructure investment and national policy developments. Significant operational, financial, workforce and infrastructure challenges require sustained executive focus, coordinated delivery with system partners and close Board oversight. Alongside these pressures, the report recognises colleagues' commitment, improvements in care and colleague experience, research and digital innovation, and engagement with patients, families and communities. The Board is asked to receive and note the report, recognising both the achievements and the continuing risks.

Operational recovery and patient safety remain central priorities. The Trust remains off plan and in NHS Oversight Framework Segment 3. Ambulance handovers, four-hour performance and 12-hour Emergency Department stays have improved, but urgent care performance remains challenged. Corridor care observed during the October walk round contrasts with the position at the time of writing, when no base-ward or remaining ED corridor spaces were in use; sustaining this improvement and resolving early Discharge Ready Unit issues remain important. RTT performance is 71.5% against an ambition of 81% by March 2027, with a waiting list of approximately 45,200 and recognised delivery risk. Diagnostic and cancer faster-diagnosis improvements sit alongside continuing cancer treatment, stroke and fractured-neck-of-femur performance concerns. Formal feedback from the CQC's unannounced renal visits is awaited. Operational, workforce and financial recovery must remain aligned as we prepare for winter.

Protecting patient confidentiality and organisational resilience is non-negotiable. RCHT has zero tolerance for access to patient records without a legitimate work-related reason; allegations must be investigated promptly, consistently and fairly, with appropriate disciplinary action and patient notification where required. The gap analysis against all 38 NHS England recommendations identified that the Trust is not yet compliant with all requirements. A task and finish group is overseeing the action plan, and the Quality Assurance Committee has requested monthly assurance reporting until delivery and compliance can be demonstrated. Escalating cyber threats, supplier and supply-chain vulnerabilities and emerging agentic AI risks also require effective controls, mature governance, tested business continuity and incident response arrangements.

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Workforce resilience, organisational change and the care environment require continued attention. Consultant industrial action announced for the 25 and 26 November may disrupt elective activity; divisional business continuity plans are being developed under Chief Medical Officer oversight to protect patient safety. Clinical Administration staff begin moving into new roles from 2 November, with individual support and recruitment continuing, and colleagues seeking timely closure of the change process. Visits highlighted progress at West Cornwall Hospital and the new colleague-only dining space, alongside reception, accessibility, cleaning and staff-facility concerns requiring accountable owners and prompt remedial action. ED investment options remain funding-dependent beyond the approximately £8 million bronze option. The Women and Children's Hospital concept design is nearing completion, with 100% ensuite single rooms, a revised location and replacement parking, Willmott Dixon appointed and digital innovations being tested. Construction is targeted for the second half of 2028, with completion in 2032, subject to detailed design, planning, business-case approval and supplier readiness.

National policy developments require clear local delivery and assurance. Martha's Rule rapid-review arrangements are being extended into Maternity, Neonatal and Emergency Department services, with national ED implementation expected by March 2028. The organ donation response builds on established local identification and referral arrangements, while ICU staffing pressures have removed donation education from mandatory nursing training; alternative education is being explored. New accommodation and staff-facilities guidance requires an audit of 160 Treliske staff locations, for which no dedicated resource is currently available; shared support with CFT and capital reprioritisation options are being explored. Elective Single Point of Access implementation will require agreed clinical pathways and governance, protecting clinical judgement, patient choice and safety while improving access to specialist advice and care closer to home.

The report also recognises the breadth of contribution across RCHT: the return of the Annual Awards, national inclusion awards recognition, University of Plymouth placement appreciation, renewed Endoscopy Joint Advisory Group accreditation, Investing in Volunteers accreditation and infection prevention leadership and shared learning. ENT's second consecutive ASPIRE Gold accreditation, the Renal Remembrance Service and colleagues' response to disruption during outpatient building works illustrate the importance of compassionate care and patient experience. Community engagement, the Inclusion Passport and work to strengthen belonging sit alongside efforts to widen participation in MS research through TRUSTED. These achievements provide a strong foundation, but do not diminish the need for evidence-based assurance, clear executive accountability and sustained delivery of the improvements our patients, communities and colleagues expect.

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Chief Executive Visits

1. Chief Executive Welcome Event

On the 15 September, I attended a Chief Executive welcome event in London. The event provided a valuable opportunity to engage with fellow Chief Executives and reflect on the leadership required to build effective teams, deliver high-quality care and discharge our responsibilities as NHS leaders. We also considered NHS England's priorities, including an update from Sir Jim Mackey.

2. NHS Leadership Event

On the 22 September, I attended an NHS leadership event in London with Sir Jim Mackey, and other senior health and social care leaders. The morning provided national, financial and strategic updates, including discussion of the Thirlwall report, while the afternoon focused on the practical leadership needed to sustain strong performance through winter. Our operational, workforce and financial recovery plans must be delivered with pace and discipline to secure sustainability, achieve financial balance and work effectively with system partners for the benefit of our communities and colleagues.

3. Renal Remembrance Service

On the 12 September, I attended the Renal Remembrance Service at Truro Methodist Church. We were welcomed by Tariq Baig, Consultant Nephrologist, and the service was led by the Reverend Dom Whitting. It was a moving and humbling occasion, characterised by compassion, support and humanity. I valued the opportunity to spend time with those attending and to thank the Renal team for the exceptional care they provide to patients and families at some of the most difficult moments in their lives.

4. Board Walk rounds

On the 7 October, the Chair and I visited the Emergency Department (ED), where we had a walk and talk briefing on capital investment options. The bronze refurbishment option would use approximately £8 million of available capital, while the silver and gold options remain dependent on additional funding.

Environment and patient flow. We observed three trolleys in the main corridor and one immediately behind the consoles in majors, constituting corridor care. We were also advised of congestion in the paediatric area. Otherwise, the department was busy but controlled, with SWAST drop-and-go arrangements being enforced.

MRATS reception. We visited the MRATS area but did not enter because of the level of activity. The team described a proposal to enlarge reception by relocating a cardiology staff room, with the aim of reducing corridor congestion.

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Discharge Ready Unit. The visit to the new Discharge Ready Unit (DRU) identified two initial operational issues:

- Some discharge-ready patients remain on wards for minor procedures that could be undertaken in the DRU.
- Some patients are transferred to the DRU before they are discharge ready, resulting in stays beyond the two-day maximum.

The team is addressing these early operational issues and expects performance to stabilise as the model becomes established. While this work continues, the DRU seeks to avoid returning patients to wards, to minimise disruption for patients.

Ear, Nose and Throat Department. On the 8 October, I met with the Ear, Nose and Throat team, which has achieved Gold in our ASPIRE ward accreditation programme for the second consecutive year. This achievement reflects strong leadership, effective management and outstanding teamwork, alongside a welcoming environment for patients and colleagues. A huge congratulations and thank you for inviting me to be a part of your well-deserved celebration.

WCH Estates and Facilities. On the 12 October, the Director of Estates and Facilities and I visited West Cornwall Hospital following concerns raised by the local estates team. Together with Greg Burton, we undertook a behind-the-scenes review and discussed the wider estates improvements under way to support colleague wellbeing and improve the environment across the Trust.

It was encouraging to see the progress made by the Estates team in clearing accumulated items and equipment and creating a cleaner, more welcoming working environment, including an improved rest area. Our walk around the site demonstrated the team's engagement and ambition, with projects including new gates and fencing, improved lighting and decoration in patient corridors and the renal unit, and new televisions for renal patients funded by RCHT Charity. Greg and the team also shared further ideas for improving the hospital environment.

Main Reception Trelawny Wing. On the 16 October, I visited the main reception in the Trelawny Wing at Royal Cornwall Hospital. The reception was managing a busy and varied workload involving patients, visitors and colleagues. The visit identified several concerns requiring prompt attention:

- **Entrance environment:** Smoking outside the Trelawney entrance.
- **Wheelchair availability:** Wheelchairs not being returned to Trelawney.
- **Public facilities:** The cash machine had been out of order for a prolonged period.

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- **Cleaning:** Lack of cleaning in the reception desk area.
- **Staff facilities:** No functioning kitchen with hot water.

I have asked the Senior Leadership Teams to investigate each concern and confirm the accountable owner for each issue. Remedial action must be taken without delay.

Main Reception General Out Patients Department. On 16 October 2026, I visited the OPD main reception during building works, associated upheaval and moves. Despite this disruption, staff were friendly and informed, and welcomed patients warmly. They were proud of their team and looking forward to the works being completed. I also noted the seasonal decorations being enjoyed by staff and service users alike.

5 IPAC Link Practitioner Study Day – 19 October

I was delighted to open the IPAC Link Practitioner Study Day on 19 October, bringing together colleagues from RCHT and CFT. The event focused on patient and staff safety, professional networks and the sharing of good practice, with strong attendance and positive feedback. I thank our link champions for their leadership, curiosity and commitment.

News items

1. Our RCHT Annual Awards are back!

Our RCHT Annual Awards are back, giving the opportunity to celebrate the incredible people who make a difference to patients, colleagues and our communities every day.

The We are RCHT Annual Awards recognise colleagues, volunteers and teams who live our values, improve care and enable others to be their best. They provide an important opportunity to celebrate outstanding patient care, innovation, colleague support and the contribution made by those working behind the scenes.

Colleagues may nominate individuals and teams across categories including Rising Star, Outstanding Team, Living Our Values and Lifetime Achievement. Patients and relatives may submit nominations for the Patient Choice category. Nominations close on 13 November.

2. Celebrating equality, inclusion and excellence across health and care

We were delighted that five colleagues and RCHT were shortlisted in this year's National B.A.M.E Health and Care Awards, which recognise significant contributions to equality, inclusion and excellence across health and care services. The shortlisted nominees were:

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- Anna Cairns, Fundraising Director – Ally of the Year.
- Nycki Gray-Cooper, Executive Assistant and Equity, Diversity and Inclusion Allies Network Chair – Ally of the Year.
- Sandra Mitchelmore, Biomedical Scientist – Outstanding Social and Community Care Award and winner of a Highly Commended Award.
- Paola Pilapil, Clinical Practice Educator – Educator or Workforce Developer of the Year.
- Rachel Cowley, former Associate Director of Equality, Diversity and Inclusion – Trailblazer in Inclusion Excellence Award.
- Royal Cornwall Hospitals NHS Trust (RCHT) – Inclusive Organisation/ Trust of the Year

The recognition reflects the values and impact of work being developed through the RCHT Ethnic Minority Network, alongside wider efforts to strengthen inclusion, equity, cultural understanding and belonging across our organisation.

3. Students praise outstanding placement support across RCHT

Certificates of Recognition were awarded to 25 individuals and teams across RCHT following this year's University of Plymouth Placement Host Appreciation nominations. Students described how colleagues made them feel welcome, valued and part of the team while supporting the development of their knowledge, confidence and clinical skills.

4. Royal College of Physicians - Joint Advisory Group Accreditation

Following an annual review by the Royal College of Physicians, RCHT's Endoscopy services were awarded Joint Advisory Group accreditation on 24 September. The accreditation confirms that the service meets recognised best-practice standards across quality and safety, patient experience and workforce arrangements.

5. Volunteers receive UK quality standard award

Royal Cornwall Hospitals NHS Trust (RCHT) has successfully achieved the Investing in Volunteers Quality Standard – the UK quality standard for good practice in volunteer management. Following a comprehensive assessment in September 2026, we received a 'Met' outcome across all six quality areas, recognising the outstanding contribution made by our volunteers and the excellent support provided throughout the organisation.

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6. Cornwall nurse elected Vice President of the Infection Prevention Society

Joanne Taylor has been elected as the next Vice President of the Infection Prevention Society, one of the UK's leading organisations for infection prevention and control. Joanne is Director of Infection Prevention and Control and an Infection Prevention and Control Consultant Nurse across Cornwall Partnership NHS Foundation Trust and RCHT. Her election by IPS members is a significant professional achievement and reflects the strength of infection prevention leadership in Cornwall. Congratulations Joanne, your continued passion and expert knowledge is greatly valued.

7. Consultants Industrial Action

On 26 October, the British Medical Association announced two days of consultant industrial action on 25 and 26 November 2026 as part of a national dispute concerning pay and working conditions. Emergency cover will be based on Christmas Day staffing arrangements. Elective activity may be disrupted, depending on participation levels. To protect patient safety and minimise disruption, divisions are developing business continuity plans, overseen by the Chief Medical Officer's office.

8. New colleague-only dining space

On the 19 October, I formally opened the new colleague-only dining area in The Royal restaurant at the Royal Cornwall Hospital site. The space responds directly to colleague feedback and provides a private, comfortable environment in which staff can eat, connect and access a computer workstation.

The facility was made possible through the determination and collaboration of the Facilities team, RCHT Charity and other contributors. It demonstrates how inclusive leadership and effective partnership can translate colleague feedback into practical improvement.

This project is a strong example of listening to our people and delivering a tangible improvement to colleague wellbeing. We are now considering opportunities for similar enhancements at St Michael's Hospital and West Cornwall Hospital.

9. Cornwall helping to shape the future of MS research

People living with multiple sclerosis are being invited to help shape future research through a streamlined national registration tool.

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TRUSTED (Trials and Registries Unified Sign-up Tool for Equitable Discoveries) allows people with MS to register their interest in up to three national MS research registries using one secure form. The project aims to make research more accessible

and inclusive, deepen understanding of MS and its impact, and help develop more effective treatments and care.

Operational performance and recovery

1. CQC visit to Renal Department at Royal Cornwall Hospital and West Cornwall Hospital

The Care Quality Commission undertook unannounced visits to the renal units at Royal Cornwall Hospital and West Cornwall Hospital on the 29 and 30 September 2026. Inspectors thanked colleagues for their welcome and constructive engagement. We await formal feedback and will respond promptly to any areas requiring action.

2. Senior Information Responsible Officer Update

Current cyber and information-risk intelligence indicates a continuing escalation in threats to organisations delivering critical public services, including the NHS.

The principal risks include vulnerabilities within third-party suppliers and supply chains, increased nation-state activity targeting critical infrastructure, and emerging governance challenges associated with agentic artificial intelligence. Recent incidents demonstrate that cyber-attacks can cause significant operational disruption as well as data compromise. This reinforces the need for robust cyber resilience, tested business continuity arrangements and effective incident response.

In parallel, NHS Chief Executive Sir Jim Mackey has written to NHS organisations following a number of high-profile inappropriate accesses to patient records, making clear that there is a duty on all NHS Boards to ensure patient confidentiality is protected, that unjustified access to records is identified and addressed promptly, and that organisations maintain a culture in which confidentiality is understood as fundamental to patient trust. The correspondence emphasises the requirement for Boards to assure themselves that effective monitoring, audit, investigation and disciplinary arrangements are in place, alongside workforce education and leadership oversight, to prevent and respond to breaches of confidentiality. Against this backdrop, the Board will seek assurance that controls protecting patient information remain effective, that inappropriate access to records is actively monitored and acted upon, that supply chain and cyber risks are appropriately managed, and that governance arrangements for both cyber security and AI deployment are sufficiently mature to protect patient care, organisational resilience and public confidence.

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3. Operational Update

The Trust remains off plan and in NHS Oversight Framework Segment 3, despite targeted improvement. Sustained recovery depends on coordinated divisional

delivery because workforce capacity and culture, patient flow, productivity, quality and financial sustainability are tightly linked.

This update highlights the operational issues requiring Board attention. The Integrated Performance Report provides the detailed operational position, alongside the additional paper on Urgent Care Delivery.

T**he key elements to draw from the Integrated Performance Report are**

- The elective recovery plan aims to achieve 81% of patients treated within 18 weeks of referral by the end of March 2027 and has seven core areas of focus. The Finance and Performance Committee received additional detail on the 18-week elective performance recovery plan, including the additional oversight process.

- RTT performance is 71.5% and the waiting list is approximately 45,200; 18-week breaches increased by 645, while 52-week waits reduced to 435.

- The Finance and Performance Committee noted the level of ambition and risk in the elective recovery plan.

- The Trust's ambition is to end corridor care by the end of October. At the time of writing, corridor care spaces on the base wards are not in use. The number of corridor care spaces in the Emergency Department has reduced to 6, with none currently in use.

- Mean ambulance handover time fell from 89 to 45 minutes, while the proportion of handovers involving waits over 15 minutes reduced to 76.33%. These measures improved materially despite Treliske attendances being 12% above last year.

- Four-hour performance improved for the third month in a row at Treliske although it remains low at 47.17%.

- 12 hour stays in ED have improved for the third month in a row to 14.31%.

- Diagnostics reached 95.95% of activity plan and 82.85% of patients having a test within six weeks, supported by the endoscopy backlog cleared.

- Cancer faster diagnosis is above standard at 82.13%; 31-day treatment (91.46%) and 62-day performance (78.73%) require over-delivery.

- SSNAP remains E, although stroke performance has improved from earlier in the year. Of patients, 56.6% reached the stroke unit within four hours and 91.23% spent at least 90% of their stay there. CT within 12 hours remained strong at 98.15%.

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- Fractured-neck-of-femur surgery within 36 hours improved to 56% but is subject to a formal improvement plan.

4. Organisational Change

Phased implementation of the Clinical Administration programme continues, with staff moving to their new roles from 2 November. All staff have been offered individual one-to-one meetings as part of the change programme. Recruitment to vacancies has commenced, including supervisory and leadership posts in the new structure.

Some staff have expressed upset and anxiety about the changes, underlining the importance of finalising the moves. Other staff have reported satisfaction with the new positions and pay they will be moving to.

There is a consistent message from colleagues to draw this process to a conclusion.

5. Women and Children's Hospital update

The Women and Children's Hospital's updated concept design is almost ready to reveal. We've been working with our clinical teams and key stakeholders to make sure the updated design aligns with the national New Hospital Programme's mandated guidelines - the biggest change being the requirement for 100% single rooms, all of them ensuite. We have a new location, too, to accommodate the bigger footprint - across the main car parks in front of the Trelawny Wing main entrance. (We will re-provide the lost parking, and it also means we will have a new main entrance for the Royal Cornwall Hospital site!)

Our main construction partner has been appointed. It is Willmott Dixon who are currently building the Emergency Care Department at University Hospitals Plymouth (Derriford). We are excited to have them on board with us. We look forward to working with them and we envisage a lot of local construction and supply chain businesses in Cornwall benefitting from working alongside Willmott Dixon.

This new hospital will be modern and spacious and will make use of lots of digital technology. For example, the building will be more energy efficient, secure, and easier to navigate (light and heat sensors / airlock doors / digital wayfinding). Patients and staff will also benefit from simple yet highly effective innovations like silencing our call bells, biometric entry points on wards, and patient-centred ordering. We are already successfully testing a number of solutions which other new hospitals are now looking to include in theirs.

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Our aim is to get building in the second half of 2028, and complete in 2032. We're working with the national New Hospital Programme team to do everything we can to keep to these timelines. Between now and then, we have to develop more detailed designs for the new hospital, ensure all planning permissions are granted, have our

full business case approved at the very highest level of government and make sure all our suppliers are lined up and ready to go. We have needed a new Women and Children's hospital for more than 20 years - it now feels very real.

6. Equality Diversity and Inclusion

As part of the Trust's commitment to equality, diversity and inclusion, the Black History Month Conference on the 15 October 2026 brought together colleagues, community organisations, local media and senior leaders under the theme "Honouring Our Communities". Led by Sandra Ojok Mitchelmore and the Ethnic Minority Network, the event celebrated the contribution of Black and ethnically diverse communities while promoting learning, inclusion and meaningful community engagement.

The programme included presentations and exhibits focused on lived experience, community partnership, cultural heritage and inclusive practice. Participation from colleagues, Executive Directors, community representatives and local media created valuable opportunities for dialogue, learning and stronger relationships.

African and Caribbean cuisine provided by Bev from Coco Bean Cornwall offered a further opportunity to recognise and celebrate the cultural traditions and heritage of African and Caribbean communities.

The conference strengthened awareness of equality and inclusion, amplified underrepresented voices and demonstrated the Trust's continuing commitment to a workplace in which every colleague feels valued, respected and able to thrive.

Colleagues also visited Truro Mosque following a racially aggravated attack in September. The visit strengthened understanding of faith, culture and the experiences of Muslim colleagues and communities in Cornwall, while reinforcing our commitment to positive community relationships and greater cultural awareness.

We have continued to develop the Inclusion Passport, which supports constructive conversations between managers and colleagues about individual needs, workplace adjustments and practical support. This work contributes directly to our ambition to improve colleague experience, wellbeing and belonging.

National and Policy Updates

1. Implementation of Martha's Rule in Emergency Departments

On 21 September, NHS England announced plans to extend Martha's Rule to every Emergency Department in England. The expansion will give patients, families, carers and colleagues a clear escalation process when they are concerned that a person's condition is deteriorating, matching the process already available in adult and

Neave Lindsey
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paediatric inpatient services. Trusts are expected to begin implementation through the following actions:

- Building on existing escalation and governance arrangements.
- Aligning ED processes with current outreach and Martha's Rule escalation pathways.
- Working across multidisciplinary teams to adapt implementation to local requirements while maintaining the core Martha's Rule standards.

Implementation is expected to be completed by March 2028. Each Emergency Department will receive £10,000 to support delivery of Martha's Rule.

The Trust currently provides 24-hour rapid review through the Critical Care Outreach Team in adult inpatient areas. These escalation arrangements remain operational and available to colleagues, patients and relatives.

Next steps - We will continue the planned expansion of Martha's Rule rapid-review arrangements into Maternity, Neonatal and Emergency Department services. Engagement is under way across Maternity and Neonates, supported by participation in regional and national networks. A Trust-wide escalation route map will provide consistent and effective rapid review across all services and maintain alignment with emerging national guidance and quality indicators.

2. **Organ Donation – An Urgent Call to Action**

On the 18 September, the National Medical Director for the Department of Health and Social Care and the Chief Medical Officer for NHS Blood and Transplant wrote to NHS trusts seeking urgent support to address the decline in organ donation and its impact on access to life-saving transplantation.

Organ donation activity continues to decline across England. Donors following brain-stem death have fallen by around one-third since 2019/20, while the overall eligible donor pool has reduced by 20%. The transplant waiting list is at a record high, with approximately nine people dying each week while awaiting a transplant.

Over the past year, both the donor pool and the number of deceased donors has fallen by around 13%. Family consent rates have declined from 67% in 2020/21 to 57%, and early data for 2026/27 indicates that the downward trend is continuing.

NHS Blood and Transplant has launched an Organ Donation Action Plan focused on improving donor identification and referral, increasing consent, strengthening operational oversight and raising public awareness. Family consent rises to 90% when an individual's donation decision is recorded and discussed with relatives, compared with around 50% when their wishes are unknown.

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Actions requested of NHS organisations:

- Prioritise identification and referral of potential donors.
- Support timely diagnosis of death by neurological criteria where appropriate.
- Work closely with Specialist Nurses in Organ Donation.
- Ensure staff have the training, time and support to recognise donation opportunities and support families.
- Empower Organ Donation Committees to address local barriers and review performance data.
- Champion organ donation through executive and clinical leadership teams.

Each donor can save up to nine lives. We must therefore ensure that every potential donation opportunity is recognised, referred and supported through effective local processes and visible executive and clinical leadership.

At RCHT, the Critical Care team works with colleagues in ED and Specialist Nurses in Organ Donation to recognise and refer potential donors and support the donation process from beginning to end. The Trust reports high performance in these areas. The service currently operates as a level 2 unit, with between 6 and 10 referred patients per year proceeding to organ donation; this range has been exceeded in recent years.

Ongoing staffing pressures on ICU have led to organ donation education for nursing staff being removed from mandatory training. The Organ Donation Committee is exploring alternative ways to deliver this education and opportunities for interested staff to attend regional collaborative meetings twice each year. The committee also provides education and support on ICU and addresses issues and anomalies identified through the Potential Donor Audit (PDA), which runs continuously throughout the year. A new Chairperson and NED, Dr Rebecca Hopkins, is leading and supporting the committee through these challenges. With her support, the committee hopes to develop new projects, including tissue donation.

3. Preventing Unlawful Access to Patient's Records

On the 25 September, Sir Jim Mackey, Chief Executive of NHS England, wrote to NHS trusts regarding unauthorised, inappropriate and unjustifiable access to confidential patient information. The letter establishes a clear zero-tolerance position and states that, in almost all cases, unauthorised access to patient records constitutes gross misconduct. Our response as an employer must reflect the seriousness of any breach of patient confidentiality.

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Trust leaders have received guidance on managing allegations of gross misconduct alongside established local policies and procedures. RCHT will ensure that concerns are identified, investigated and addressed promptly, consistently and fairly, with clear accountability throughout.

Where notification requirements apply, patients must be informed promptly about the breach and the action being taken in response. Delay can compound distress for patients and families and further undermine confidence. The Board requires evidence that monitoring, investigation, communication, and disciplinary arrangements are effective, and that learning is translated into sustained improvement.

The Trust developed a Trust-wide action plan designed to strengthen staff understanding of what constitutes appropriate access and to enhance the monitoring and oversight of access to patient records. This was followed by a further communication on 25 September 2026 which reinforced the need for organisations to conduct audits and to take appropriate action where access has been considered inappropriate.

Furthermore, the Trust has undertaken a gap analysis against the NHS England expectations for preventing and monitoring unlawful access to health and care records. The assessment is against all 38 recommendations and records the Trust baseline position, supporting evidence and required actions. The Quality Assurance Committee reviewed the assessment in October noting the Trust was not compliant with all the requirements, and a task and finish group had been established to have oversight. The Committee requested monthly assurance reporting until sufficient assurance can be demonstrated that the action plan is being delivered and compliance achieved.

4. Provision of single-sex services and facilities

On the 15 October guidance was received from NHS England for the provision of same sex accommodation for patients along with new guidance on the provision and use of NHS staff. The Privacy, dignity and safety in hospital accommodation guidance reaffirms the NHS Constitution's commitment to single-sex accommodation and sets out how providers should meet their responsibilities to all patients. To maintain hospital accommodation as single sex under the Equality Act 2010, trans people and others with the protected characteristic of gender reassignment should be accommodated in line with their biological sex.

The new staff facilities guidance recommends that organisations review provision for toilets and changing, washing and shower facilities, as well as staff accommodation with shared (no single-sex) facilities and consider arrangements for the provision of lockable single-occupancy facilities. Organisations must continue to ensure that all staff have access to facilities to protect their privacy, dignity and safety and that

Neave Lindsey
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decisions are taken ensuring that no one is left without suitable and sufficient provision.

We require an audit of our 160 staff locations across the main Treliske campus, recent work at WCH and SMH means we already have an audit against which an assessment can be made. Following review of the published requirements we have no resource currently to carry out an audit and with this year's significantly constrained capital programme there is no capital currently for outsourced resource. The Director of Estates & Facilities is exploring jointly with CFT who are in a similar position and are looking to bring in shared external resource to assist with an audit. At the same time, a submission is being made to Capital Approvals Group (CAG) to request i) any slippage funding that may arise later in year or ii) for CAG to consider de-prioritising current planned work or expenditure to meet this requirement.

5. **Elective Single Point of Access**

Elective Single Point of Access: technical guidance helps integrated care systems deliver the priorities in the Medium-Term Planning Framework for providing more specialist care closer to home, whether through neighbourhood services, community care or primary care.

The guidance describes the elective Single Point of Access model and sets out the actions required of systems and partners to expand Advice and Guidance, improve digital assessment through the NHS e-Referral Service, and implement the model locally.

Single Point of Access does not alter the clinical threshold for referral or override GP clinical judgement. Once a referral decision is made, the model provides timely senior specialist input so that primary and secondary care clinicians can review the patient's needs and agree the most appropriate next step.

For general practice, the model provides a consistent and transparent route to specialist advice, with clear response times and earlier support for managing patients in the community where appropriate.

Once a referral is submitted, secondary care is responsible for directing it to the most appropriate pathway, including another specialty, sub-specialty Single Point of Access or service where necessary. The model recognises general practice's role as patient advocate and provides a responsive interface through which named consultant expertise informs care.

By embedding timely specialist clinical review at the front of the pathway, the model should improve access to the correct clinic or diagnostic service first time, increase the value of initial appointments and reduce avoidable hospital visits.

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Elective Single Point of Access aims to improve equity, consistency and sustainability across the healthcare system; there are no national diversion targets. Local implementation will require clear governance and agreed clinical pathways, with assurance that patient choice and safety remain central.

6. Recommendations

The Board is asked to **receive and note** the report, recognising the achievements described and the continuing operational, financial, workforce and infrastructure challenges requiring sustained executive focus and Board oversight.

Neave,Lynsey
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Meeting: Trust Board In Public

Date of Meeting: 06 November 2026

Item Number: 08

Title of Report: Freedom Of Information Staff Data Breech Patient Safety Incident Investigation Report & Action Plan

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Naomi Burden, Patient Safety Specialist & Lead for Safety Culture, Bernadette George, Acting Chief Nursing Officer.

Email Address: Naomi.Burden@NHS.Net

Purpose of the Report:

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

This report shares high-level findings and the action plan from the approved, externally commissioned Patient Safety Incident Investigation undertaken by Capsticks into RCHT's Freedom of Information staff data breach.

Consultation:

The report has been endorsed by the Information Governance Group and approved by the Trusts Patient Safety Incident Response Group before final approval by the Acting Chief Nursing Officer. Quality Assurance Committee received the PSII and the report has been shared with all board members.

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	Not applicable
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The incident did not directly affect patient care but exposed weaknesses in information governance, data handling and organisational assurance. The breach risked undermining staff confidence and trust in organisational systems, potentially affecting engagement, culture and service quality. The investigation strengthened controls, governance and information management oversight.
Sustainable and efficient use of NHS resources by RCHT	The incident required sustained, significant input from executive leadership, information governance, communications, legal, human resources and operational teams, with additional resources for notifications, staff support, regulatory requirements and corrective actions. The investigation highlights the importance of robust preventative controls to avoid resource-intensive incidents and ensure efficient use of NHS resources.

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Recommendation(s):

The Board **is recommended to:**

- **Receive** for assurance the patient safety incident investigation report and action plan
- **Endorse** the proposed recommendations and approach for improvements outlined in the report and action plan.

Neave,Lynsey
30/10/2026 09:31:09

1. Situation / Executive Summary

This report presents the findings and action plan from Capsticks' independently commissioned Patient Safety Incident Investigation into the Trust's Freedom of Information staff data breach.

An Excel spreadsheet published in February 2023 exposed hidden sickness absence data, including sensitive health information, relating to 7,715 Trust staff and 288 non-Trust workers, with a small number of unidentified records. The information remained publicly accessible until November 2025. No financial or contact details were disclosed, and patient care was not directly affected; however, the breach caused significant staff distress, loss of trust and substantial operational demands.

The investigation identified weaknesses across data preparation, review, sign-off and publication, including inadequate safeguards against hidden spreadsheet data and failure to follow the requirement to convert the response to PDF. Following discovery, the Trust removed the data, notified regulators and affected individuals, provided staff support and strengthened controls.

The report records that the Information Commissioner's Office subsequently closed its case following implementation of its recommendations.

Further improvements are needed across all data sharing, digital literacy, technical safeguards, incident preparedness, communications and trauma-informed support. People, financial, legal and reputational risks remain relevant.

The Dual Chief People Officer, as Senior Information Risk Owner, is responsible for the action plan, with monthly oversight by the Patient Safety Incident Response Group.

The Acting Chief Nurse and Acting Chief Executive are overseeing the arrangements to feedback the report and its recommendations to our past and present Trust staff.

The Board is asked to receive the report for assurance and endorse the recommendations and improvement approach.

2. Background

This Patient Safety Incident Investigation Report and action plan relates to an incident from a Freedom Of Information (FOI) request response published in February 2023.

An Excel spreadsheet released as part of that response contained hidden pivot table data that could be accessed by interacting with certain cells. This underlying information included staff sickness absence records dating from 2018 onwards.

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The breach affected 7,715 Trust staff members, 288 non-Trust workers, and a small number of unidentified records. Importantly, no financial information, bank details, National Insurance numbers, addresses or contact details were disclosed. However, health-related information is highly sensitive and confidential, and should never have been accessible in this way.

The issue remained undiscovered until November 2025, when a member of the public informed the Trust. Once identified, the Trust removed the information, notified regulators, contacted affected individuals and implemented a significant incident response programme, including staff support arrangements and a review of governance processes.

The Trust externally commissioned Capsticks to independently undertake the Patient Safety Incident Investigation with the support of the Trusts Patient Safety Specialist.

As Acting Chief Nursing Officer, I am deeply sorry for the distress, anxiety and loss of trust this breach has caused our current and former staff. You entrusted us with deeply personal information, and we failed to protect it. I recognise that the impact may continue and that an apology alone cannot restore your trust. Alongside the Acting Chief Executive, I am continuing to share the investigation findings and recommendations with you, recognising the importance of openness, compassion and listening to your concerns.

The full report and action plan is attached in Appendix One and Two.

3. Assessment

3.1 Key Findings: How the Incident Occurred

The investigation concludes that this was not the result of a single mistake or a single individual.

Rather, it arose from a combination of process weaknesses, system vulnerabilities and missed opportunities for detection.

Firstly, the spreadsheet was prepared outside the team with the greatest expertise in managing large workforce datasets.

Secondly, existing controls did not adequately identify the risks associated with Excel pivot tables and hidden information.
Thirdly, reliance on Excel's document inspection tools created false assurance, as these tools do not remove hidden pivot table data.

Finally, the Trust's own process requiring conversion to PDF before publication was not followed. Had that occurred, the risk would have been substantially reduced.
The key lesson is that the incident was created by weaknesses across the whole process, from data extraction and manipulation through to review, sign-off and publication.

3.2 Recommendations: Preventing Recurrence

The report recognises that the Trust has already undertaken significant work to strengthen its arrangements.

The investigators found substantial improvement in FOI controls, and these changes align with Information Commissioner's Office guidance.

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However, the recommendations extend beyond FOI processes. The investigation recommends:

- Strengthening FOI governance and organisational culture.

- Extending safeguards beyond FOI responses to all forms of data sharing.
- Increasing digital literacy training, particularly around spreadsheets, pivot tables and hidden data.
- Considering technical solutions to supplement human checking processes.
- Increasing use of safer information-sharing mechanisms such as SharePoint and other controlled-access platforms.

A key theme throughout the report is that as organisations increasingly manage large and complex datasets, similar risks may exist in many operational settings and therefore require organisation-wide learning.

3.3 Trust Response: What Went Well

The report is clear that once the incident was identified, the Trust acted promptly and in good faith.

The organisation immediately removed the data, reported the breach externally, notified affected individuals, established support mechanisms and strengthened safeguards.

The Trust met its key reporting obligations and implemented the recommendations issued by the Information Commissioner's Office. The ICO subsequently closed its case.
The investigators specifically acknowledge the significant commitment shown by staff across the organisation in responding to a highly complex and emotionally challenging situation.

The report also commends the contribution of the Patient Safety Specialist describing her support throughout the investigation as outstanding.

3.4 Trust Response: Areas for Improvement

Whilst recognising the strength of the organisational response, the report identifies important lessons.

Many affected staff experienced significant distress, loss of trust and ongoing anxiety regarding their personal information. Staff supporting the response also reported considerable emotional pressure.

The investigation highlights opportunities to improve:

- Preparedness for large-scale data incidents.
- Business continuity arrangements.
- Capacity and resources for high-volume contact operations.
- Consistency of communications.
- Support for staff managing complex and high-profile incidents.
- Integration with broader Emergency Preparedness, Resilience and Response planning.

A recurring theme is the need to ensure organisations are not overly reliant on single individuals holding critical knowledge and expertise.

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3.5 Recommendations for Future Incident Management

The report recommends that future responses should include. Appropriate staffing and resources for large-scale contact exercises including, robust deputisation and knowledge-sharing arrangements.

Closer alignment between data breach management and EPRR processes. Continued commitment to trauma-informed engagement with those affected. Routine debriefing and learning capture following major incidents.

These recommendations are not solely about information governance. They are about organisational resilience, leadership, preparedness and maintaining trust when unexpected events occur.

3.6 Continued Governance Oversight of Action Plan

The Patient Safety Incident Investigation report has been endorsed by the Trusts Information Governance Group and approved by the Patient Safety, Incident Response Group who will have oversight of the action plan on a monthly basis.

4. Risk

- **People Risk:** The breach exposed sensitive personal health information relating to approximately 8,000 current and former staff, resulting in distress, loss of trust and concerns regarding confidentiality, wellbeing and the organisation's ability to safeguard employee information.
- **Financial Risk:** The incident generated significant direct and indirect costs associated with incident management, specialist advice, staff communications, regulatory engagement and the implementation of strengthened information governance controls, alongside potential future costs arising from legal claims or remedial actions.
- **Legal and Regulatory Risk:** The unauthorised disclosure of special category personal data created risks relating to compliance with UK GDPR and the Data Protection Act 2018, requiring notification to the Information Commissioner's Office (ICO) and exposing the Trust to potential regulatory scrutiny, legal challenge and reputational damage.

5. Accountability

The Executive Director for the investigation was Bernadette George, Acting Chief Nursing Officer.

The Dual Chief People Officer is the Senior Responsible Officer for the action plan as Senior Information Risk Owner for the Trust.

Recommendations

Neave Lynsey
30/10/2026 09:31:09

- **Receive** for assurance the patient safety incident investigation report and action plan
- **Endorse** the proposed recommendations and approach for improvements outlined in the report and action plan.

NHS
Royal Cornwall Hospitals
NHS Trust

Staff Data Breach Investigation Report

PSII 255748

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30/10/2026 09:31:09

Important note

This report is addressed to and for the benefit of Royal Cornwall Hospitals NHS Trust (the Trust) and was prepared for the purpose set out in the terms of engagement agreed between the Trust and Capsticks.

No other person or organisation may rely on this report, and it must not be reproduced in whole or in part without first consulting the authors. Capsticks accepts no duty of care to any other person or organisation.

This report and any accompanying appendices or documents contain confidential information that has not been redacted and may be legally privileged. Care should be taken to ensure that material not intended for wider disclosure is not shared in error. The interviews and legal advice are privileged and are not included with the report.

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1. Executive summary

1.1. This report examines the inadvertent disclosure of staff sickness absence data by Royal Cornwall Hospitals NHS Trust in response to a Freedom of Information (FOI) request. In February 2023, the Trust published an Excel spreadsheet as part of its FOI response and disclosure log. Although the visible spreadsheet appeared to contain only aggregate information, interacting with certain cells revealed underlying pivot table data showing line-by-line sickness absence records for April 2018 to January 2023 (with predicted absences extending up to May 2023). This included reasons for absence and duration or dates for named, or potentially identifiable, staff. Some reasons were highly sensitive. In other cases, the material exposed contained entirely typical reasons for sickness. However, all employee health information should be treated as confidential. This data should not have been included. Although the disclosure was accidental, the system of work did not prevent it. The hidden data included names and workplace information for 7,715 current and former Trust staff, similar information for 288 non-Trust workers, and a small number of unmatched records. No financial, banking, national insurance, address or contact information was disclosed.

Summary of key findings

1.2. The incident arose from process failures and system weaknesses in handling the FOI response. Although the Trust had an FOI process in place:

- The spreadsheet was prepared outside the team with the greatest expertise in handling complex workforce datasets, with a long chain of people involved in the creation and review of the material prior to its disclosure.
- The controls in the FOI response process at the time did not effectively address pivot table risks. In particular, the Trust's reliance on Excel's document inspection tools at that time was insufficient, because those tools would not themselves remove the hidden pivot table data or explicitly flag that personal information was hidden in the spreadsheet.

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- The Trust's requirement to convert Excel disclosures to PDF before publication was not followed. The incident therefore resulted from weaknesses across the FOI process, from data extraction and preparation to checking, sign-off and publication, rather than a single failure.

Summary of areas for improvement and safety actions

1.3. Since the original file was disclosed in response to the FOI request in 2023, the Trust has made significant changes to the FOI process. Additional safeguards now reflect much of the Information Commissioner's current good practice guidance for public bodies on managing disclosure risks in FOI responses. These safeguards still rely on people, but if applied carefully, consistently and with a second check, they should reduce the risk of similar incidents in future, at least in the FOI context. We recommend that the Trust incorporates the Information Commissioner's Office's other tools and good practice guidance into its processes.

1.4. However, FOI responses are just one way in which incidents of this kind may occur. As organisations process and share increasingly large volumes of data, similar incidents may occur in other contexts. We recommend that the Trust considers:

(1) Rolling out some of the safeguards now in place for FOI requests more widely, for other kinds of disclosures/information sharing exercises it undertakes.

(2) Widening training on digital literacy, particularly for staff in roles using pivot tables.

(3) Considering whether there are reliable electronic tools which could provide additional safeguards to supplement human checks on data and documents prior to sharing. However, the selection of any such tools must not interfere with the legitimate disclosure and sharing of information by the Trust which is vital for patient care and the efficient work of the Trust more generally.

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1.5. The Trust identified the incident in November 2025 after a member of the public alerted it to the material on the Trust's website. The Trust promptly removed the material, reported the breach externally, and launched an extensive internal response. This included notifying current and former staff, setting up a dedicated contact centre, holding staff briefing sessions, and reviewing historic disclosures. The FOI response process was immediately strengthened with additional safeguards to prevent similar spreadsheet disclosures. This was the first incident of its kind in terms of the scale and severity, and accordingly, the Trust's response was necessarily evolutionary. There are lessons from the way this incident occurred which were unknowable during the incident itself and have become apparent only with reflection. The investigation considers that the Trust acted promptly and in good faith once the incident came to light and met its reporting obligations overall. The Information Commissioner closed its case after the Trust's self-report and issued advice, which appears to have been fully implemented. The investigation identified lessons on preparedness, staff support, consistency of communications, and ensuring adequate resources for any future incident of this kind. The Trust could also, if it wished, make a further attempt through other channels to ask the original FOI requester to delete the information.

1.6. The scale and sensitivity of the data exposed had significant consequences for affected individuals and for the Trust. The response was resource-intensive and placed substantial pressure on those managing it. Some staff were left deeply upset, reported a loss of trust in the organisation, and remained concerned about possible misuse of their personal information, especially where the data related to sensitive health conditions or personal circumstances. However, the investigators found no evidence that the data has in fact been misused.

1.7. The report concludes that the Trust should continue to strengthen both its technical and organisational controls for disclosing information, particularly where spreadsheets or large datasets are involved. Key recommendations in this area include:

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(1) Ensuring that the FOI response process is updated to require that data files be converted to CSV wherever possible before disclosure.

(2) Embedding clearer guidance on pivot tables and hidden data risks into FOI procedures (particularly for 'information holders') – although this recommendation is applicable for any such disclosures.

(3) Maintaining the second-stage review of disclosure material.

(4) Clearer delineation of responsibilities between information-holding teams and the FOI function in the Information Governance (IG) team.

(5) To increase use of SharePoint or other file sharing mechanisms (rather than emails) which allow for access to data to be 'turned off' if it is disclosed in error, and to explore other technical data loss prevention tools; and

(6) Widening role-specific training on data handling across the organisation (not limited to the FOI context, but for all staff who are routinely involved in data analytics where large pots of data may be shared externally or with large audiences in their work).

1.8. The Trust should also capture the operational and strategic lessons from the extensive incident response, including by ensuring that in future cases:

(1) There is an appropriate level of support and resources for staff managing high-volume contact operations.

(2) There are effective deputization and knowledge sharing arrangements so that the Trust is not over-reliant on single members of staff to coordinate or deliver key steps in incident responses.

(3) The data breach process is integrated into the Emergency Planning and Resilience Response (EPRR) processes more generally and incident planning factors in data loss events as well as cyber-attacks (or other recall or large-scale staff/patient contact exercises).

(4) future engagement exercises with affected individuals in any incident continue to be timely, consistent and trauma informed.

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1.9. Taken together, these actions will reduce the risk of recurrence and improve the Trust's resilience should a similar incident arise in future.

1.10. The Trust should continue to de-brief with the affected teams that were involved in the incident and the response.

1.11. We finish this executive summary with a note of sincere thanks to all the staff that contributed to this investigation. Everyone did so voluntarily, openly, honestly and frankly, and in line with the Trust's values, through participating in interviews or by providing documentation and other resources in a timely manner, or by taking the time to provide survey responses. The independent investigation team at Capsticks would like to highlight the work of Naomi Burden who has provided outstanding support and assistance throughout.

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2. Background and context

Overview

2.1. The safe handling and security of information in the UK is governed by regulations and legislation that are used to define local systems of work. Organisations must comply with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, and 'common law' duties of confidentiality when processing both patient and staff data. The Information Commissioner's Office is the independent regulatory body responsible for upholding information rights. It enforces data protection legislation as well as the Freedom of Information Act 2000 (FOIA).

2.2. Staff information is held in relation to employment and includes personal sensitive information that is legitimately collected, such as contact details, financial information and health information.

2.3. Within the legal framework provided for, workers would expect health information to be handled carefully and not used in ways that have an unjustified adverse effect on them. This therefore necessitates clear working processes for processing health information internally through policies and restricting access. The Royal Cornwall Hospitals NHS Trust, like all organisations, must ensure appropriate information governance arrangements, including:

- Maintaining an Information Security Management System (ISMS) to monitor and improve data security practices.
- Annual completion of the Data Security and Protection Toolkit (DSPT), demonstrating compliance with national data security standards.
- Management of FOI requests through designated Information Governance teams to ensure compliance, appropriate redaction, and secure handling of information.

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2.4. The FOIA provides a statutory right of access to recorded information held by public authorities, including NHS Trusts. It promotes transparency and accountability, with disclosure as the default unless a lawful exemption applies.

2.5. Key principles include:

- Right of access: Anyone can request information, regardless of identity or motive.
- Timeliness: Responses must be provided within 20 working days.
- Duty to assist: Organisations must help clarify requests where needed.
- Recorded information only: There is no requirement to create new information.

2.6. FOI disclosures are effectively public releases and must be considered suitable for wider publication. There are exemptions that can be applied and a formal refusal notice issued.

The Freedom of Information Act 2000

Freedom of Information requests: general principles

2.7. NHS Trusts are public authorities under the FOIA. FOIA gives any person a statutory right to request recorded information held by a public body (i.e. make an FOI Request). It is intended to promote openness, transparency and accountability across the public sector, including the NHS. The Trust has 20 working days to respond.

2.8. The general principle with FOIA is that the Trust should take an 'applicant and motive blind' approach in responding to FOI requests. However, the Trust is aware that in the context of this specific case, the original FOI applicant used a Gmail account which appears likely to have been created as a 'burner' account, solely

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for use to make FOI requests relating to absences from stress for the purposes of producing an article regarding the same. Disclosure under FOIA is 'to the world' and in the terms of FOIA itself, the Trust does not have any control over how the FOIA response, including any information disclosed within it, may be used by the person to whom it is disclosed. This means there is no practical or legal control over how such material is used. Although there is a framework to impose licence conditions on material disclosed under FOIA in response to requests for reuse by members of the public under the Reuse of Public Sector Information Regulations 2015, this specifically excludes the reuse of personal data.

2.9. Online searches suggest the FOI request at the heart of this incident formed part of a 'round robin' sent to multiple NHS organisations. Gloucester Health & Care NHS Trust, South East Coast Ambulance Service, and Birmingham and Solihull Mental Health NHS Trust each published responses to similar requests on their websites.

2.10. Section 11 FOIA requires the Trust to respond to a request *"by communicating information by any means which are reasonable in the circumstances"*. In deciding what is reasonable, the Trust may take into account the form in which it holds the information, the volume of information to be communicated and any other relevant factor. There is no absolute duty on the Trust to disclose the information in a particular format, in response to a request. It is required to do so only *"so far as reasonably practicable to give effect to that preference".* Questions of information security may be a relevant consideration in determining what is reasonable. Good practice under FOIA is that information is presented in a re-usable format. Where the information is from or constitutes a dataset (and arguably, the information requested here is that), there is a particular obligation to consider presenting it in a reusable format. The ICO's current (undated) guidance on this issue (https://ico.org.uk/for-organisations/foi/freedom-of-information-and-environmental-information-regulations/means-of-communicating-information-section-11/) states:

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"When providing information in a re-usable format, you should take steps to ensure that any exempt information in the underlying data is redacted to avoid inadvertent disclosure. For example, you should ensure that any personal data is redacted so it is not unintentionally disclosed. The risk of this happening occurs with spreadsheets in particular. Therefore, you should ensure that requested information is prepared safely for release. For example, when data is presented in the form of a 'pivot' table, the source data is retained. If possible, you should consider disclosing the information in a CSV file format instead. "[1]

2.11. It is important to recognise that Personal Data (that is, information about a living person who is identifiable from that information or other information which would render them identifiable) is potentially exempt from disclosure under section 40(2) FOIA. There is no absolute prohibition on the disclosure of personal data in response to FOI requests – the legal test is whether it is fair, lawful and necessary to disclose that personal data in response to an FOI request. However, in the case of 'special category' (sensitive) personal data (including information about a person's health), this is highly likely to be exempt from disclosure under FOIA. It is important to recognise that had the original request been for personal data, this would have been exempt from disclosure and the FOI request would not have been progressed.

Specific ICO guidance on avoiding disclosure in error in response to FOI requests

2.12. The disclosure of sensitive information in error in FOI responses is a common problem across the public sector and has been for many years, and a large number of incidents have been publicly reported involving both the NHS and other public sector bodies. There is an underlying tension between FOI law (which requires information to be disclosed promptly by public authorities in response to requests, insofar as possible without restriction on how the data may be used) and

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[1] See also, section 11 FOIA.

requirements under confidentiality and data protection law (which say that information must be protected from accidental or unauthorised disclosure or use). This tension has been made more complex as organisations increasingly digitise their systems and processes, which enable large amounts of data to be contained within a single database, typically with the facility to export that data in a format which in turn allows it to be requested and disclosed under FOIA. As a result of this there is a significant inherent risk that the 'wrong' information may be disclosed in error in response to an FOI request.

2.13. In consequence of the recurrent nature of this problem, the Information Commissioner's Office ("**ICO**", which regulates FOIA and data protection issues) has published various pieces of guidance specifically concerning the importance of removing 'hidden' personal data when disclosing information. The first version of this was originally published in 2015, with significant updates in 2018 post-GDPR. The guidance from that time remains publicly available at: https://ico.org.uk/media2/j2wpmnw2/ic-415122-c5k2-disclosure.pdf.

2.14. This is the guidance that would have been in place at the time of the incident which is the subject of this investigation. The guidance is not legally binding. It was (in the ICO's view) supposed to provide a practical "how-to" document aimed at preventing accidental disclosure of personal data when organisations release information in response to FOI/EIR requests (as here), as well as other kinds of request such as subject access requests and disclosures for re-use of public sector information. It focuses on the ways personal data can remain embedded in files even when it appears removed, particularly through hidden data risks in spreadsheets (e.g. hidden rows/columns, additional worksheets, pivot tables, charts and functions) most specifically in paragraphs 33-48. As regards pivot tables, it says:

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Copy the pivot table and paste only the values to a new workbook. This is sometimes referred to as a 'paste special' operation. The copied data can also be checked by double-clicking cells within the copied pivot table to ensure there is no link back to the source data. However, exporting the data to CSV would provide a greater assurance and provide greater compatibility with other software packages.

2.15. The ICO guidance in force at the time also included as an appendix structured checklist intended to be used as prompts for repeatable pre-disclosure control (referencing Pivot Tables), although this does not contain any information about action to take in response.

2.16. We analyse in paragraph 4.15 below the extent to which the Trust's systems and processes in place at the time of the incident were compatible with that guidance.

2.17. In the summer of 2023, and then in 2025, following a series of national incidents, the ICO issued updated guidance on this risk (respectively, their guidance can be found at https://ico.org.uk/for-organisations/eir-and-access-to-information/information-commissioner-s-office-advisory-note-to-public-authorities/ and https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/security/disclosing-documents-to-the-public-securely/). The updated ICO guidance focuses on redaction techniques, avoiding hidden data, and secure handling for FOI and Subject Access Requests. The guidance contains various recommended steps to help check documents for hidden personal information and to remove or redact it, where appropriate. It also contains guidance and links to help organisations consider an appropriate format for disclosure and 'how to' videos and checklists to support the development of policies, procedures and training.

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2.18. This ICO guidance does not specify a single method as to how material should be removed, but rather emphasises the need for effective controls. It points out that password protection is a method that can be used to protect documents, but that it can be prone to error, and therefore removal of sensitive material (instead of just making it technically difficult to access) is also an important consideration. The guidance does include that converting spreadsheets into a simpler file format (e.g. CSV) can expose previously hidden information.

2.19. In November 2023, the ICO further published a non-mandatory good practice 'checklist' tool for disclosures of datasets in Excel files. This resource is not well-signposted on the ICO's website, but provides a more practical reference point for issues to look out for with spreadsheets to avoid inadvertent disclosure, see https://ico.org.uk/media2/for-organisations/documents/4026755/disclosure-checklist-v1_0.docx . It is strongly recommended that this guidance is incorporated into the Trust's process as a way of tracking that checks have been undertaken on files prior to disclosure.

2.20. There is also national government guidance regarding the issue of wrongful disclosure in response to FOI requests, updated in December 2023 (and therefore also post-dating the incident). This is not designed for the NHS but contains general useful tips: https://www.gov.uk/government/publications/cabinet-office-and-freedom-of-information/freedom-of-information-guidance-communication-by-spreadsheet . As best the investigators are aware, there is no NHS-wide, specific/practical guidance on avoiding accidental disclosures. The Trust could, as part of learning from this incident, contact NHS England to see what interest there is in providing national guidance on this issue, given that the incident under consideration is not unique to the Trust.

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Description of the Incident

2.21. On 18 January 2023, the Trust received an FOI request related to staff sickness information. The wording of the request was as follows:

For each financial year (i.e. (a) 2022/23, (b) 2021/22, (c) 2020/21, (d) 2019/20, (e) 2018/19):

1) How many days have trust staff taken off (sick leave not holiday)?

2) How many days have trust staff taken off for stress or anxiety?

3) Please provide a staff breakdown for the figure for question two – i.e., how many days were taken off by doctors, nurses, porters, cleaners, admin staff etc.

4) How many days have trust employees taken off due to (a) covid and (b) Covid contact-related self-isolation?

5) How many trust staff have taken more than a month off in one given year due to stress or anxiety.

6) What was the longest period a single member of staff has taken due to stress or anxiety? Please provide their job type or role if possible and an answer for each year.

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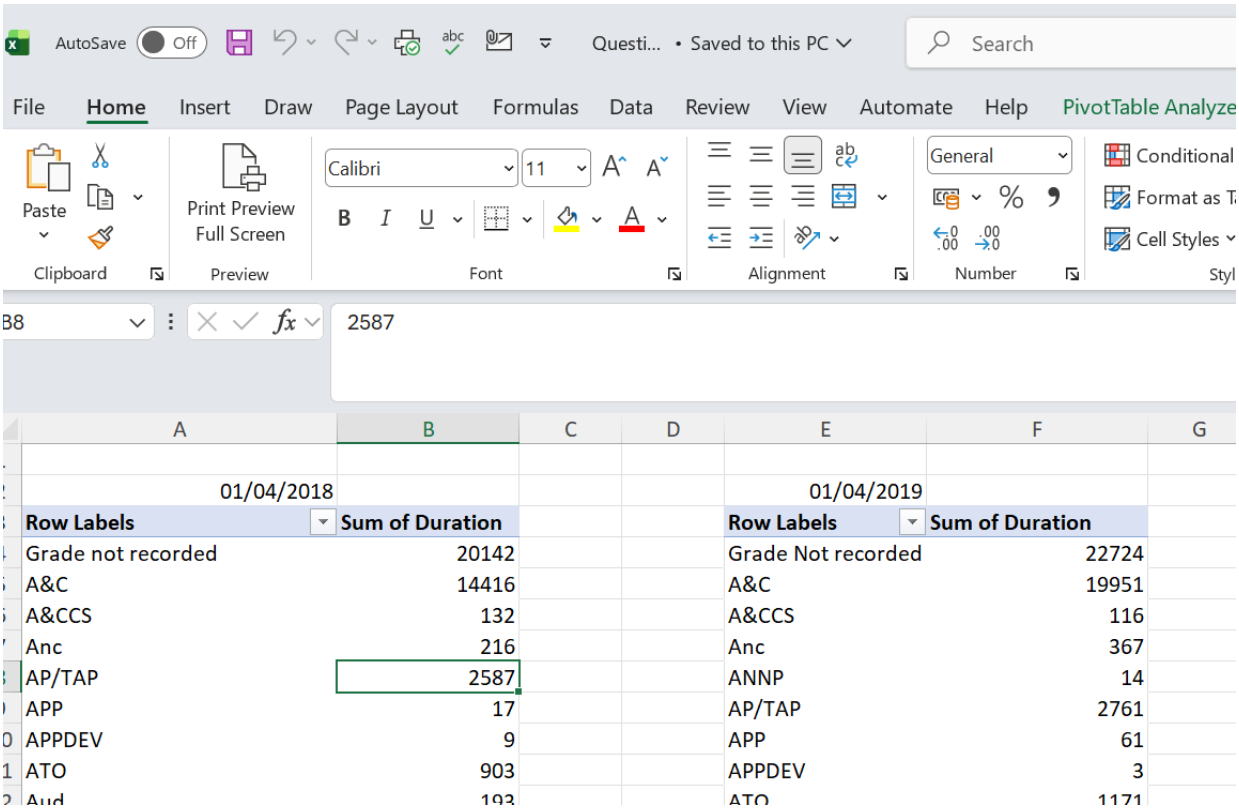
2.22. The Trust operates a 'hub and spoke' model for handling FOI requests, which is common in NHS organisations and many other public sector bodies. In this model, a central team is responsible for coordinating the overall response to the FOI request on behalf of the organisation. The central team will contact relevant departments which may hold or be able to access the information in the request (typically via a designated 'champion' member of staff or single point of access). The department will collate the information from systems, databases or other information sources available to them (and/or advise if it considers any information which is within the request is exempt, etc.), and then return it to the central FOI management team, who will then produce and send the final response to the FOI applicant. That is broadly what happened in this case, although as described below, there were a number of departures from the Trust's FOI standard operating procedure (SOP) in the handling of this request which the investigators consider are significant factors in the incident occurring.

2.23. The Trust responded to the applicant via email on 1 February 2023 (and therefore within the 20-working day statutory deadline required by FOIA). The FOI response was also posted onto the Trust's public facing website within the 'FOI disclosure log' page in February 2023. The response provided aggregate information within a letter for questions 1-2 and 4-6, and attached an ostensibly single page Excel spreadsheet which provided the breakdown requested in question 3. This spreadsheet had been generated from within an HR system holding the information within the Trust.

2.24. Unfortunately, the Excel spreadsheet in question used to provide the response to question 3, and included with the response, contained a pivot table feature which included an extract from the HR system's underlying data about staff sickness within it.

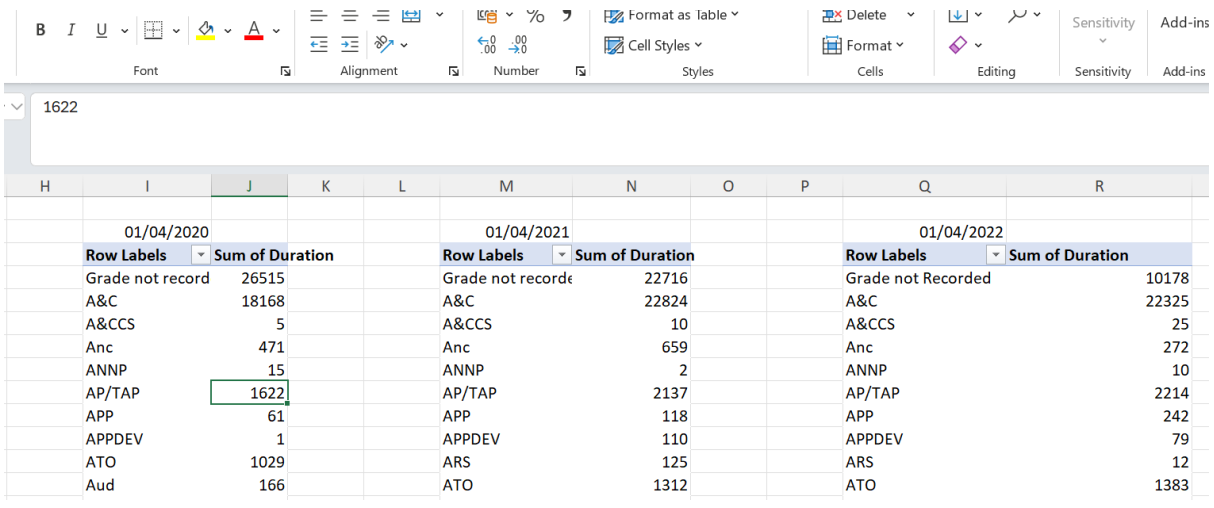
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2.25. The baseline format of the spreadsheet on opening it is shown in the screenshots below:



	A	B	C	D	E	F	G
	01/04/2018				01/04/2019		
	Row Labels	Sum of Duration			Row Labels	Sum of Duration	
	Grade not recorded	20142			Grade Not recorded	22724	
	A&C	14416			A&C	19951	
	A&CCS	132			A&CCS	116	
	Anc	216			Anc	367	
	AP/TAP	2587			ANNP	14	
	APP	17			AP/TAP	2761	
	APPDEV	9			APP	61	
	ATO	903			APPDEV	3	
	Aud	193			ATO	1171	

Figure 1 - Screenshot (1) of the spreadsheet disclosed (left hand columns)



	H	I	J	K	L	M	N	O	P	Q	R
		01/04/2020				01/04/2021				01/04/2022	
		Row Labels	Sum of Duration			Row Labels	Sum of Duration			Row Labels	Sum of Duration
		Grade not record	26515			Grade not recorde	22716			Grade not Recorded	10178
		A&C	18168			A&C	22824			A&C	22325
		A&CCS	5			A&CCS	10			A&CCS	25
		Anc	471			Anc	659			Anc	272
		ANNP	15			ANNP	2			ANNP	10
		AP/TAP	1622			AP/TAP	2137			AP/TAP	2214
		APP	61			APP	118			APP	242
		APPDEV	1			APPDEV	110			APPDEV	79
		ATO	1029			ARS	125			ARS	12
		Aud	166			ATO	1312			ATO	1383

Figure 2 – Screenshot (2) from spreadsheet disclosed (right hand columns)

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2.26. However, the data in the *'Sum of Duration'* columns in Excel spreadsheet were drawn from pivot tables. This meant if you double-clicked on any of the numerical value cells in the 2020, 2021 and 2022 *"Sum of Duration*" column (e.g. any cell in the column containing the one highlighted in

2.27. Figure 2), hidden tabs would then open. These comprised "spreadsheets within a spreadsheet", showing detailed individual absence records. The data fields within these hidden spreadsheets comprised:

a) Surname.

b) Unit.

c) Forename.

d) Grade (or Grade Type and Category).

e) Job Band.

f) Reason for absence (e.g. Covid +, Infectious disease, stress/anxiety etc.).

g) Start date (i.e. of sickness).

h) End Date (i.e. of sickness).

i) Duration (i.e. of sickness).

(i) Working Days.

(ii) Hours.

j) Contract Hours.

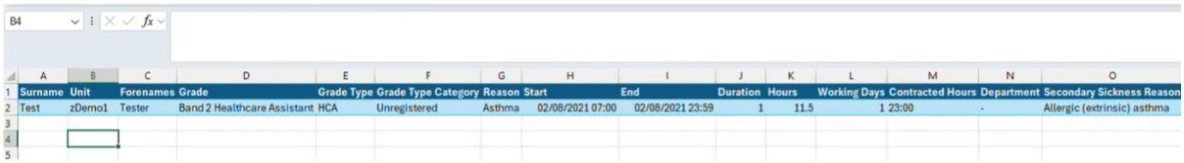
k) Department.

l) Secondary Sickness reason.

2.28. It is important to note that **no** financial, bank account, national insurance number, address, dates of birth or contact information was included in the spreadsheet and this therefore did not feature in the incident.

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2.29. An example of the presentation of the data fields and format is shown in Figure 3 below.

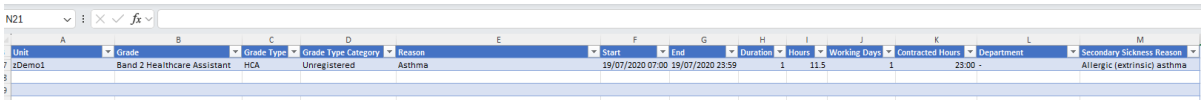


Surname	Unit	Forenames	Grade	Grade Type	Grade Type Category	Reason	Start	End	Duration	Hours	Working Days	Contracted Hours	Department	Secondary Sickness Reason
Test	zDemo1	Tester	Band 2 Healthcare Assistant	HCA	Unregistered	Asthma	02/08/2021 07:00	02/08/2021 23:59	1	11.5	1	23:00	-	Allergic (extrinsic) asthma

Figure 3 - Example of Information Disclosed for 2020, 2021 and 2022 (as shown in Data Breach Information and Q&A sessions)

2.30. If a numerical cell in the 2018 and 2019 *"Sum of Duration"* columns (e.g. the cell showing 2587 in Figure 1 above) was clicked on, a hidden tab would also open. This includes similar data fields to the 2020-2022 fields. However, the individual absence records for these years did not include the names of the staff members concerned. This would be regarded in data protection law terms as likely to constitute 'pseudonymised' data – there is still enough information included in the spreadsheet for (e.g.) a member of staff with knowledge of the department to triangulate and to deduce, or at least make an educated guess, of who the staff member concerned is, and therefore why they were off sick, although it is harder to work out. In some cases, no specific individual may be identifiable, in which case the information is 'anonymised'.

2.31. An example of the data fields for 2018 and 2019 is shown in Figure 4 below.



Unit	Grade	Grade Type	Grade Type Category	Reason	Start	End	Duration	Hours	Working Days	Contracted Hours	Department	Secondary Sickness Reason
zDemo1	Band 2 Healthcare Assistant	HCA	Unregistered	Asthma	19/07/2020 07:00	19/07/2020 23:59	1	11.5	1	23:00	-	Allergic (extrinsic) asthma

Figure 4 - Example row of information contained within the spreadsheet for the 2018 and 2019 fields

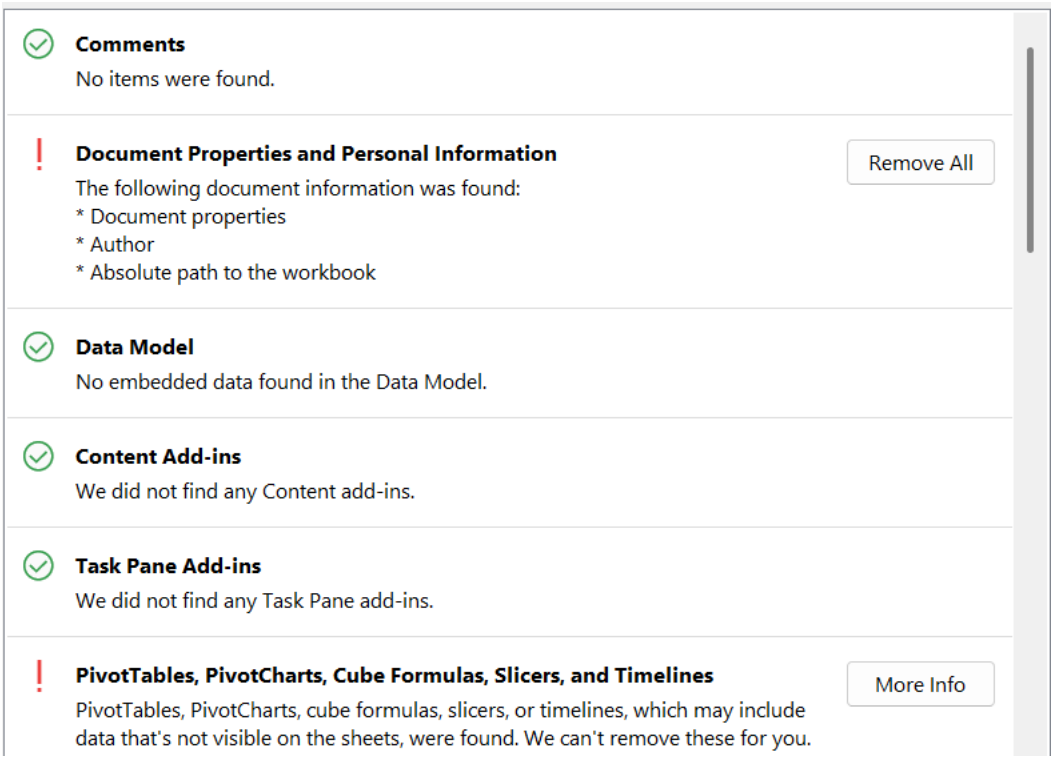
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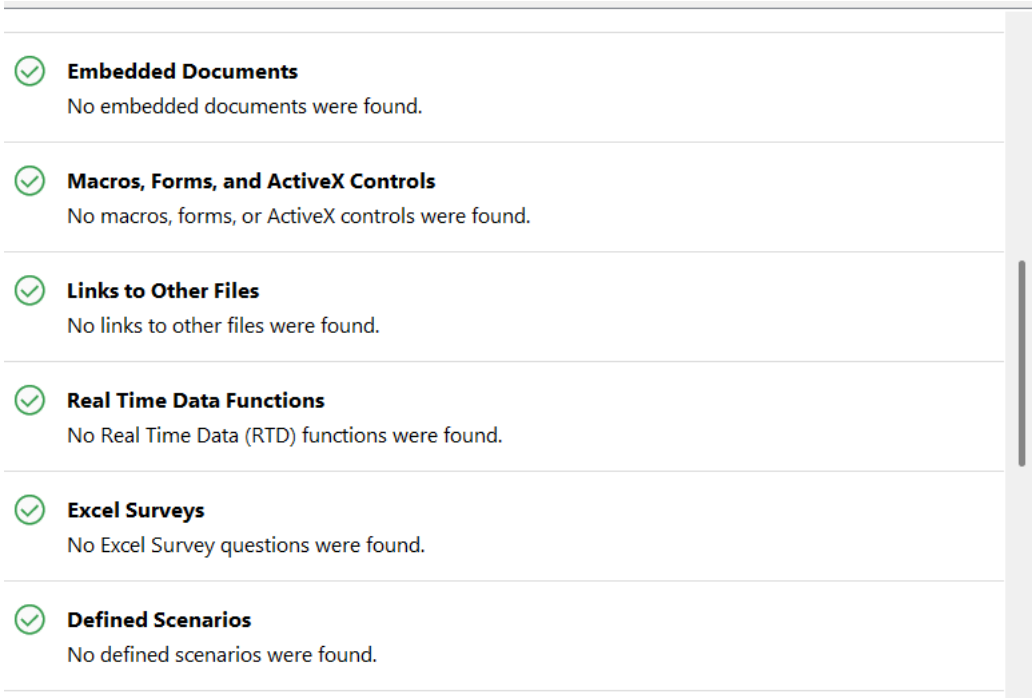
2.32. It is important to note that there was and is nothing immediately visible within the spreadsheet at first glance which shows that it contains hidden data or personal information. There is only one worksheet. Not all cells can be clicked into, to reveal underlying data (e.g. clicking on the cells in the adjacent columns shown in Figure 1 and

2.33. Figure *2* do not open the hidden spreadsheets). However, the file size of the spreadsheet is 2.75MB. This is larger than might be expected for the 'visible' data in the spreadsheet which totals approximately 2000 cells. Even then, however, it is not so large as to be patently obvious, and this assessment requires some knowledge of file sizes and what that is likely to mean in terms of the volumes of data within the file. In the version of Excel the investigators are using, it is only when one of the relevant cells is selected that the 'pivot table' work tools tab appears, and only when the cell is double-clicked into that the hidden personal data is visible.

2.34. In the course of the investigation, we have, in line with the ICO's guidance on using the 'Document Inspector' tool (see further, section 2.13 above), assessed whether the inbuilt tools in Excel will recognise that the spreadsheet contains the hidden data. The results of that are shown in Figure 5 below:

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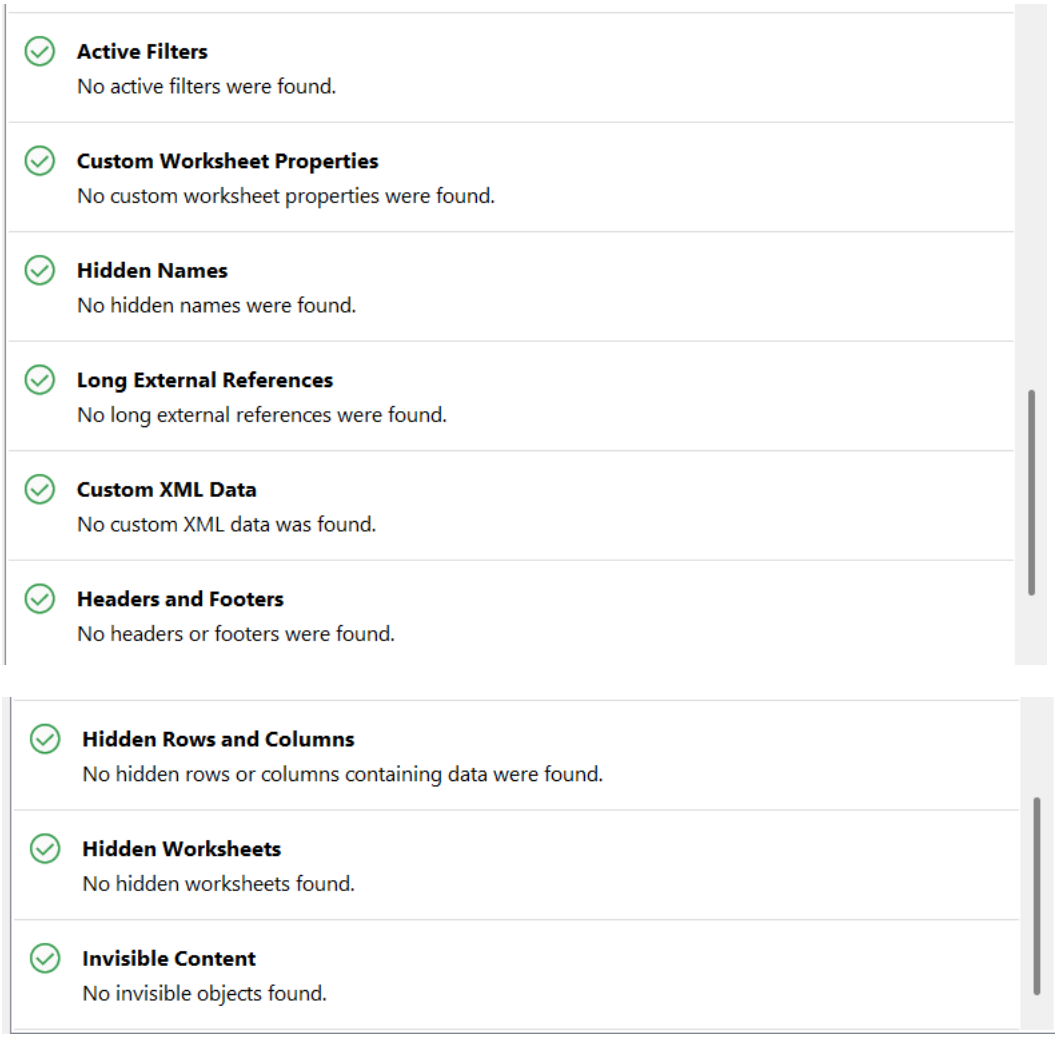


Figure 5 - Screenshots from the 'Document Inspector' tool applied to the spreadsheet disclosed in error

2.35. Many indicators commonly associated with hidden data, such as hidden rows, columns, worksheets or invisible content, were not flagged by the Document Inspector when applied to the spreadsheet disclosed in this case. Identifying the risk therefore required additional knowledge of the kinds of hidden data that can sit within spreadsheets.

2.36. Using the 'remove document properties and personal information' function does not remove the underlying data (i.e. the 'personal information' which could get removed are entries such as metadata of the author of the file, rather than the content of the spreadsheet itself).

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2.37. The staff-member data is hidden in a pivot table, but this is not identified by Excel as a ‘hidden worksheet’ or ‘hidden row or column’.

2.38. As can be seen in the screenshots above, Excel does warn that there is a pivot table included (which is the issue at the heart of this incident). It does not, however, offer an automatic tool to remove the pivot table or warn that the pivot table contains personal data. The people involved in looking at the spreadsheet would need to know what a pivot table ‘is’, that they are considered ‘high risk’, and what to do in response to them (see further paragraph 0 below).

2.39. Accordingly, just using the ‘Document Inspector’ tool would not have prevented the incident from occurring in terms of removing the underlying data from the spreadsheet.

2.40. The investigators then re-saved the Excel spreadsheet (XLSX) file as a CSV (comma separated value) file. This reduced the file size to 6KB, and taking this step **did** remove any ability to access the pivot tables and the hidden data. This is the only way we have identified which would appear to actually remove the data which was exposed.

2.41. Finally, the investigators also used an enterprise-licenced version of Microsoft Copilot on the spreadsheet, to see whether it could identify that personal data was present. However, Copilot did not (in its initial pass) detect the pivot table and it was only when specifically prompted to look for it that it identified there was personal data in the spreadsheet. Accordingly, using Copilot would **not** provide a further safeguard in relation to this kind of data, and attempting to use general AI tools as a safeguard should be approached with extreme caution.

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Who was affected?

2.42. The individuals whose information was contained in the spreadsheet were staff of RCHT, bank workers and agency staff, students from either placements at RCHT or seconded from Cornwall Partnership NHS Foundation Trust. Some of the staff on the spreadsheet were Kernow Health Community Interest Company (otherwise known informally as Cornwall CIC) employees, for whom RCHT was rostering their staff during this period.

2.43. During the incident response process, an analysis was undertaken by the Trust of the number of staff impacted by organisations. A fully anonymised version was provided to the investigation team and is as follows:

Staff Grouper	Unique People Impacted
RCHT Staff	7715
Students – External	122
CIC (111 service) – External	66
Agency – External	49
Unidentifiable[2]	51
TOTAL	8003

2.44. The hidden data was not directly relevant to the FOI response and was not intended to be disclosed in response to it. If an FOI request had been made for it, it would have been exempt from disclosure under FOIA.

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[2] 'Unidentifiable' are staff members who, as a result of the discrepancies in the data and IT systems used, were unable to be identified in data stratification processes during the Trust's incident response. For example, they were listed under a specific team with initials, however, no person in the team at the time had those initials.

2.45. The data continued to be published on the Trust's website from February 2023 to November 2025. The Trust maintains 12-month logs of how many times webpages on its website have been accessed. Accordingly, it is not possible to say how many times the file was accessed between when it was published in February 2023 and November 2024 (being 12 months prior to when the incident was identified). In the period November 2024-November 2025 it was accessed 340 times. It was said during one of the staff briefings in response to the incident that this was 'slightly higher' than typical, but the investigators were unable to draw any conclusions from this. It is impossible to say whether the hidden data in the file was accessed by anyone accessing the file online, or if it has been copied or downloaded, and therefore any assessment of the risk here is hypothetical/conjectural. For instance, some access to the file may have been from automatic web-crawlers undertaking indexing activities, rather than any specific person.

2.46. On 17 November 2025, a member of the public who had accessed the Trust's disclosure log and the spreadsheet on the Trust's internet pages contacted a member of staff at the Trust via email, to say that they had found the hidden data. Paragraph 0 onwards of this report explains and considers what happened in response to the incident.

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3. Investigation approach and terms of reference

The Investigation Team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:	BG	Acting Chief Nursing Officer	Corporate
Learning Response Lead:	NB	Patient Safety Specialist	
Independent Investigation Team	TDS AL		Capsticks

Scope and Terms of Reference

3.1. The scope and Terms of Reference for this investigation are set out below. The conclusions in response to each of the terms of reference, insofar as they have been ascertained by the investigating team, are set out against these requirements, with explicit responses to points in the Terms of Reference highlighted as appropriate.

Scope

3.2. The investigation reviewed what led to the disclosure of staff information following a FOI request and also reviewed the incident response the Trust provided. The learning response also considered the impact upon staff but has remained separate from any personal complaints and claims processes.

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Terms of reference

Part 1: Events leading and contributing to the incident.

- TOR1 Clarify the background of the individual/organisation requesting the information, the purpose, and justification for data use (e.g. patient safety review, compliance, audit).
- TOR2 Details on who may have accessed this information from data logs.
- TOR3 Understand the systems in place for sharing information with individuals, teams, or external bodies the data was shared, this should include the method of sharing (secure transfer, encrypted email, etc).
- TOR4 Any restrictions or conditions on use for this FOI request or other FOI requests.
- TOR5 Establish the facts surrounding the data breach incident including:
  - Identify how the breach occurred by understanding the system of work in place that resulted in the incident.
  - Who had access to the data (roles, not just names), How access was granted and monitored. Retention period and disposal process.
  - Assess the impact on affected individuals and the organisation.
- TOR6 Evaluate the adequacy of existing controls (including access. monitoring, retention and disposal processes) as risk reduction strategies.
- TOR7 Evaluate data incident response procedures to minimise impact.

Part 2: Learning and Improvement

- TOR8 Provide actionable recommendations for remediation and prevention by an independent SME.

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- TOR9 Ensure compliance with relevant data protection regulations and reporting obligations.
- TOR10 To evaluate the Trust's response to the incident, including the learning from the effect on staff providing support to those affected/impacted by the data breach.

Summary of investigation process

3.3. The incident was brought to the attention of Information Governance via email who notified the senior executive team and the incident was reported on the Trust reporting system. A system-based investigation was commissioned with agreement from the Chief executive to follow the Patient Safety Incident Response Framework (PSIRF) due to the knowledge, skill and experience of the team in complex investigations.

3.4. An initial safety review was undertaken to ensure immediate improvements were in place, support scoping and commissioning of a further and more detailed investigation. This allowed terms of reference to be formed and the procurement of independent subject matter experts to lead the investigation with the support of the Trust's Patient Safety Specialist to act as Learning response Lead and ensure alignment with PSIRF.

3.5. The learning response team which included the independent subject matter technical experts identified key information sources, commenced memory capture and document review to inform the investigation.

3.6. Once complete, the PSII will go through the Information Governance Group and Patient Safety Incident Response and Oversight Group (PSIROG) for endorsement and approval, before sending to the investigation commissioner. The report will also be shared at JCNC for information. Actions will be overseen at the Information Governance group with oversight from the Quality Assurance

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Committee. An approved copy of the report will be published for full transparency to those affected.

Information gathering

3.7. Information has been gathered from several sources to formulate the findings of this report. A systems-based methodology has been used to identify contributory factors which lead to the disclosure and evaluate the organisational response.

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4. Findings: The Initial Incident

The FOI Request

Terms of reference 1 and 4

People Factors

4.1. The background to the individual requesting the information appears to be a journalist preparing a newspaper article about stress within NHS organisations. However, an individual does not need a particular reason for making an FOI request, and using FOI for data journalism is entirely legitimate. As we explore below, the issue in this case was the wrong information was disclosed by the Trust in response to the request (i.e. the information about individual staff was not what the applicant had asked for), as well as the actual response information.

4.2. There are effectively no restrictions or conditions of use on how information may be used in response to an FOI request normally. There is a hypothetical legal argument that a duty of confidentiality would attach to the parts of the hidden data disclosed in error and this should prevent the user from misusing it.

4.3. In practical terms, it is impossible to stop anyone from downloading and making their own copy of the FOI response spreadsheet or the information within it. Were this to have happened, this will not be known about by the Trust. As is set out elsewhere in this report, website logging tools available to the Trust say that the webpage was accessed 340 times in the 12 months prior to its removal, and the webpage was available for approximately 21 months before the logs begin.

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4.4. In legal terms, there are no legal restrictions in FOIA itself over how the information may be used by those that are given access to it. There is arguably an implied ethical obligation of confidentiality that attaches to obviously confidential

information which has been obtained by a recipient in error. The obligation would arise if the recipient knew or had notice that the information is confidential, even if they did not actively seek it out or if it was disclosed by mistake. If they found it, a reasonable person would likely have regarded the information buried in the spreadsheet as having been disclosed in error, and having the necessary qualities of confidentiality about it, based on the substance of the information.

4.5. The investigators consider it likely that the email account used for the FOI requests was a temporary ‘burner’ account. Given the lack of response from when the Trust identified the incident and sought to contact the requestor via that account, the account was thought to be no longer in use or actively checked by the original applicant. The investigators triangulated the name of the requestor with other sources and identified an individual, believed to be a journalist, who they considered may be the original FOI applicant. The Trust established contact with that person via other contact details and requested deletion of the information that had been sent in error. Shortly after the investigation concluded, and just before the report was finalised, the journalist confirmed that the information had been deleted in accordance with the Trust's request.

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Systems of Work

Terms of reference 2

Governance and handling of FOI requests at the Trust

Organisational factor: Information Governance Team structure

4.6. The Information Governance team at the Trust is structured as follows:

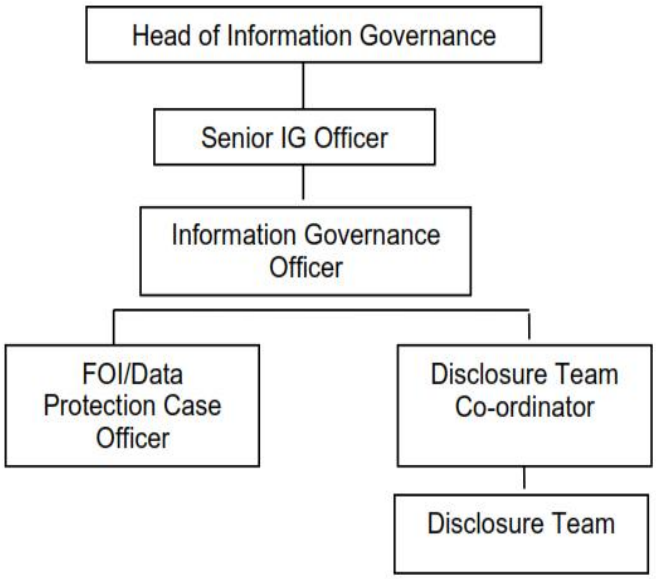


Figure 6 - Information Governance Team Org Chart

4.7. The FOI (Case) Officer[3] who was in post at the time of the incident no longer works at the Trust and therefore we have not been able to speak to them in the course of this investigation. The Information Governance Officer who was in post at the time of the initial incident has also left the Trust subsequently, and this role was vacant until 2026. Turnover of staff was raised as an issue by those we interviewed in this investigation.

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[3] Although the org chart in Figure 6 uses the term "FOI Case Officer" most other documents, including the FOI SOP, use the term "FOI Officer" - which we have used in the report to describe the role.

4.8. We would observe that there is no standard approach to the role description of FOI officers nationally, in terms of the knowledge required for the role or the degree of autonomy associated with it. The Trust operates the 'FOI Officer' role at the more junior end of the spectrum, and this is reflective of the view of the role at the Trust as primarily an 'administrative' one. Other organisations place greater emphasis in the role including the application of exemptions and with a higher degree of operational independence, as well as in collating the responses and administering the process.

4.9. Day-to-day management of FOI requests sits (and sat) with the FOI Officer, while escalation and overall oversight rested with the Head of Information Governance. In practice, however, the Head of Information Governance was not generally involved in the routine handling of individual requests, but rather would be involved to assist in direct queries from the FOI Officer or those raised by information holders, during periods of absence if extra hands were needed, or if a request was made for internal review (so that there could be a 'fresh pair of eyes').

4.10. The FOI Officer has day-to-day responsibility for handling FOI requests. They co-ordinate the identification and preparation of requested information. The job description states that the FOI Officer "*will be involved in all aspects of administration of the FOIA process and processing of personal files and preparing them for disclosure to a tight deadline. The department is fast paced and would suit someone that can cope with pressure and has good IT literacy skills."* The evidence suggests that the FOI Officer's role was focused on checking that *"the relevant department answered all the questions"* and that they *"haven't missed something".*

4.11. During the investigation, we heard that more senior members of the Information Governance team were not routinely involved in deciding what information should be disclosed in each FOI response. Their role was primarily to provide advice and act as points of escalation where queries arose. In practice, questions would

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ordinarily be raised by the FOI Officer first with the Information Governance Officer, then escalated to the Senior Information Governance Officer if unresolved, and thereafter to the Head of Information Governance where necessary. Responsibility for reviewing the accuracy and sensitivity of the substantive content of FOI responses sat with the department providing the information and in the relevant sign-off process with the executives.

Organisational factor: Information Use Framework Policy

4.12. Appendix 4 of the Information Use Framework Policy provides a summary of the FOI process in general terms. It does not touch on security of information or removing hidden information, however, in general terms it speaks to the process followed by the Trust in relation to FOIs:

(1) Summary of FOI requests.

(2) Identifying and recording a Freedom of Information Act request.

(3) Responding to a request.

(4) Applying exemptions and the public interest test.

(5) Refusal to disclose.

(6) Complaints / review processes.

Task Factor: FOI Standard Operating Procedures

4.13. In accordance with the SOP version 21 from March 2021, which was in place at the time of the incident, the usual process for responding to FOI requests was (in summary) as follows:

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(1) FOI requests could arrive via multiple channels (email, letter, online form, PALS). Once sent to the FOI team, the FOI officer was expected to check

validity (name, contact address, FOI scope, clarity), note the 20-working-day deadline from the next working day, and if valid, log the request on the risk and incident management system (Datix) to generate a unique FOI reference number, and create a folder in the FOI Mailbox.

(2) The FOI officer would acknowledge the request within 48 hours (not including weekends) using a standard template and/or request further information if needed.

(3) The FOI officer would then collect the information by filling out the response template with the questions to be answered, identify the correct department and nominated FOI lead, and share the response template with them asking them to provide the relevant information (copying in the Care Group Manager). The FOI officer would provide clear deadlines, chase responses, and prepare the final disclosure.

(4) The FOI officer would then compile and finalise the response i.e. inserting departmental replies into the response section if they haven't been inserted already, updating header/footer, collating response etc. This step also includes preparing attached documents for sharing. In relation to Excel spreadsheets, section 7 of the SOP provides as follows:

> "*Sometimes, information will be returned in 'Excel' format, if this format is essential to understanding the request (e.g. lots of data that may need to be sorted/extrapolated), or, has been specifically asked for by the applicant, leave in Excel form when responding; however, you must remember to 'prepare for sharing' to remove any hidden data (see instruction below).*"

4.14. In relation to Excel documents, section 7I of the v. 21 SOP provided that FOI officer should click in Excel: *file – info – check for issues (prepare for sharing) – inspect document) – proceed (with all options clicked) – in Document Inspector click 'remove all'* for any data located.

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4.15. In this regard, the SOP in place at the time therefore corresponded with at least some of the steps set out in the ICO's guidance in force at the time, set out in paragraph 2.12 onwards above, and indeed the SOP specifically included a link to the ICO guidance in a section headed Handy Sources of Information/Guidelines/Advice. However, the SOP only described using the 'Document Inspector' tool (and specifically highlights the 'removal of personal information' feature within it). It does not discuss converting material to CSV to remove pivot tables or mention pivot tables expressly. The Trust has now put in place further alternative controls which do provide a higher degree of protection against this risk (see paragraph 5.2 onwards below). In the course of the investigation there was no evidence that there was any wider drift from the standard operating procedure. No other near misses or incidents have been identified and an audit of FOI responses as part of incident response did not identify any cases. However, it is also worth saying that this request was not perceived as being a particularly contentious one at the time it was received. The legal requirement of needing to respond promptly to FOI requests (together with the wider volume of work) is likely to have been a contributing factor in this case.

4.16. Prior to sending the response to the applicant, the SOP in use at the time (v. 21) stated that the FOI Officer:

"…should convert the 'Word' response template to Adobe PDF (when posting the response to the Disclosure Log, you will only use Adobe PDF documents, this includes conversion of 'Excel' worksheets/workbooks)."

4.17. Instructions are provided with pictures demonstrating how to do this. Instructions are then provided as to how to amalgamate the documents into one PDF. The SOP explains that the response will then be sent and published on the Disclosure Log of the Trust webpage Royal Cornwall Hospitals Trust / Internet / Documents Library / Freedom Of Information / Disclosure Logs .

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4.18. This stage of the SOP was not followed at the time the FOI response in this case was given, and the information was published. The version of the spreadsheet published on the Trust's website was in .XLSX format, rather than PDF. In the course of preparing this report we have investigated processing the spreadsheet (limited to the main workbook) into a PDF. This has a file size of 435kb, and it appears that once this is done, it is **not** possible to click through to the hidden data. Had the conversion to PDF happened, the level of risk from disclosure of/publishing the spreadsheet would therefore have been much reduced. However, we would highlight that we are not able to give an assurance that the PDF does not still contain hidden data which it could be technically possible to access, albeit it is plainly much harder to do so than where the data in the native (.XLSX) format. To our knowledge, CSV format, which is one of the simplest ways of formatting information (albeit which is still openable and workable in Excel) is the only way of positively confirming that there is no hidden data, and this is a step which is repeatedly highlighted in the ICO's guidance above.

Tools and Technology Factor: Use of digital technology

Terms of reference 3, 6 and 8

4.19. The Trust should note (and disseminate) the limitations of using and relying on the 'Document Inspector' tool as a control measure against accidental disclosures. Relevant staff should be trained further in how to identify pivot tables, the risk they pose, and how to remove them. This is relevant for staff involved in the FOI response process, but we also recommend that the Trust should undertake a wider training needs analysis of other staff that might be routinely collating, working with, publishing or sending out information in large datasets/data files (e.g. business intelligence roles, communications and other governance roles) to potentially untrusted or large groups of recipients, so that they are confident in understanding what data may be being disclosed. We note the Trust has produced some internal guidance on this issue, but it would be beneficial to consider how this is disseminated and for active training to be given on its

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application to relevant staff. We understand that a different pivot table incident involving the accidental disclosure of personal data to a contractor working with the Trust had previously been raised in the summer of 2022 (albeit not in the context of FOI) and this indicates that although the potential impact of disclosure of such data under FOIA is typically regarded as more significant (as it is 'disclosure to the world', as set out in paragraph 2.6 above), the underlying problem of the wrong data being included and disclosed in data files is more universal. Again, we emphasise that wider use of Sharepoints and other systems which allow access to data to be restricted or removed (rather than emailing data backwards and forwards) can provide a degree of technical protection after an incident, but addressing the underlying problem is multifactorial and requires staff to understand and identify pivot table risks. More training (on a needs-assessed basis relevant to job roles) and wider resources on this issue may assist. However, there is a paradox that the staff that work most often with pivot tables will be more attuned to the risk than staff that work with them uncommonly, but who are less likely to have training.

4.20. The spreadsheet was shared in 'open' (non-encrypted) email with the recipient and then posted on a public website. This is common for FOI responses and promotes interoperability of the information. Simply sending the email in an encrypted or password-restricted format would have had a minimal impact on the incident here, because (1) it was the posting of the material on the website which posed the wider risk of access, and (2) even if the email had been encrypted, the wrong material would still have been in it. It would be open to the Trust to consider using an encrypted email format or file transfer system for FOI responses, which could provide an additional safeguard in enabling the Trust to remove access to any file in terms of it being (re-)downloaded, if an error is found within it. This would not, however, prevent inappropriate material from being included in the first place.

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4.21. **Recommendation**: It is recommended that wherever possible, data files should be disclosed in a CSV format (and if the Trust considers it appropriate, the CSV file converted to PDF). This is most reflective of ICO guidance, and CSV files also potentially assist with promoting the interoperability of data (i.e. it can be harder to accurately copy data from a PDF). Prior to sending data files externally (or published on the Trust's website) the underlying file should be saved as a CSV, opened, and the 'Document Inspector tool' re-run on it, to check for any information which should not be included within it. This should be verified by another member of staff. This step can be taken in conjunction with the other controls that the Trust now has in place (see section 5 below). The FOI SOP and other relevant policies should be updated accordingly.

4.22. These safeguard steps are ultimately human-reliant organisational measures and 'soft controls'. The Trust should consider whether there are further 'data loss prevention' tools (technical IT measures, including any automated steps – although note paragraph 2.41 above) which could be used to seek to stop inadvertent or inappropriate disclosures of information (whether in the FOI context or more generally). However, the investigators appreciate that the Trust is an organisation which needs to communicate rapidly and effectively with patients, the public, clinicians elsewhere and partner organisations, and this will include the need for sharing of information including identifiable information in spreadsheets and other formats. Any deployment of additional technical or organisational measures designed to minimise the risk of inappropriate data being disclosed elsewhere must not make the **appropriate** exchange of information more inefficient or ineffective. A careful risk-benefit analysis and operational impact analysis would need to be undertaken before any such measures are deployed.

4.23. **Recommendation**: The Trust's web design team should continue to assess the extent to which any webpages on the Trust's website should not be indexed or automatically findable and consider controls to minimise the vulnerability of such systems, in line with NHS cyber security guidance, good practice in external attack surface management and wider penetration testing.

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Task factor: Freedom of Information Guidance for Information Holders

4.24. The FOI Guidance for Information Holders is provided to the 'spoke' staff, who are responsible for gathering information, along with the wording of the FOI request itself. The document explains the responsibilities of Information Holders and sets out the key legal duties to identify whether information is held and to provide it within the required timescales. It also gives practical guidance on how to interpret requests, carry out thorough searches, seek clarification where requests are unclear, and handle situations where answering would exceed the cost limit.

4.25. In addition, the document outlines how to assess concerns about disclosure, including applying exemptions (primarily referring to instances where information is commercially sensitive and the public interest test where relevant). It also answers common questions about extensions, inaccurate information, response formats, and complaints or reviews.

4.26. However, this guidance does not mention provision, protection or removal of personal data.

4.27. The Guidance also says, "*You should send rch-tr.foi@nhs.net the information in the Word response template unless otherwise specified in our request to you."* It is unclear whether this means it is expected that the information handler should copy any and all information for an FOI response into Word (and at least one staff member appeared to think so during interviews undertaken during the investigation). Depending on how the information is formatted, conversion to Word might provide a partial guard against inadvertent disclosure. However, embedding material from other formats into Word files can also present a risk, because it can also preserve the original underlying data, and because the data is then embedded in a Word document an additional layer of complexity or ineffective 'masking' of the data is applied to it. We therefore do not regard it as a particular problem that FOI information is not returned to the FOI team solely in a Word

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format, as long as steps are then taken to protect the data before it is disclosed. Irrespective of the risks and benefits of copying material into Word, it would appear both from the way this request was handled, and the terms of the FOI Officer SOP, that the general expectation was that that information could be returned to the FOI team in an Excel format (rather than simply Word).

4.28. The Guidance for Information Handlers does not itself discuss steps to take to protect Excel spreadsheets or other formats of data provision. There therefore is a tension between the expectation described in paragraph 4.43 and shared by some staff members, which was that the department providing the information should be checking that the information is appropriate for disclosure, and the lack of documentation to this effect in the FOI Guidance for Information Holders. It may be prudent for the Trust to also consider explicitly requiring the 'upstreaming' of the conversion of datasets into a CSV format, as an additional control, by updating the FOI Guidance for Information Holders. In this way, the entire FOI/IG team, in collating the response for publication, will be looking at the version of the material for potential publication 'with fresh eyes' as a way of managing the possibility of inadvertent disclosure.

System Weaknesses: Key Contributory Factors (CFs)

Organisational, Task and People factors -

Term of reference 5 and 6

CF1: Allocation of 'Information Holder' staff responsible

4.29. Appendix 2 of the FOI SOP includes a contacts list for FOI requests. The investigators heard that the FOI contacts list is, in practice, an aid for the FOI officer. It is not meant as a prescriptive list of those who should be contacted. There will be names of staff who the team know can provide cover or assistance beyond that list. This includes requests relating to HR related issues. In

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accordance with this SOP, the FOI request was circulated by the FOI officer to the relevant member of the e-rostering team. The FOI officer also copied in the People Information Unit (PIU) central mailbox and a further colleague (Member of Staff 2). We note that neither the further colleague who was copied, nor the PIU mailbox, are on the main distribution list in the SOP, and therefore were likely included by the FOI Officer based on previous/informal practice. The FOI Officer requested a response by 6 February 2023

4.30. It appears there was initially some uncertainty about ownership of the response to the request, and which team was responsible for providing the relevant information. Clarity was sought through email exchanges between staff on who was best placed to respond to the FOI request given the information required and capacity to respond within the 20-day window. As a result of that exchange, the FOI request was redirected in full to the Rostering team with a return date of 6 February.

4.31. During the investigation, the significance of this transfer and the implications for how the FOI was handled was highlighted as the PIU were identified as holding greater expertise in complex data management and associated tools, therefore relying on rostering, who were less experienced in this inadvertently introduced additional risks in data handling.

4.32. The expertise of PIU in handling large datasets and responding to potential breaches is highlighted by evidence of a previous incident in which PIU service manager identified hidden data within a pivot table shared by People Partners. This was flagged immediately with the relevant People Partner and Head of Information Governance for resolution, and further guidance was also given to both parties around the use of pivot tables. In January 2022, concerns were raised internally about a pivot table that had been shared externally, which contained embedded personal data that could be revealed by interacting with the spreadsheet. It was specifically noted that the functionality of pivot tables was not

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fully understood by those authorising the disclosure, raising questions about whether informed approval had been given. This earlier incident demonstrated a known risk associated with handling complex spreadsheet outputs without adequate technical understanding, although the investigators have not identified any particular evidence to suggest it was actively being considered in relation to the FOI request in question.

4.33. Against this background, the process of responding to the FOI request in question involved extensive data extraction and manipulation within large Excel spreadsheets, work that would ordinarily fall within PIU's remit. The investigation heard mixed evidence regarding whether such complex Excel outputs would typically be within the remit of PIU or rostering. Ultimately, it seems that Rostering held the information but not the experience, and PIU had the experience but not all of the information. The fact that the request was ultimately handled by Rostering, a team without equivalent training or system ownership, demonstrates a potential misalignment between the technical demands of responding to the FOI request and the expertise of the responding team. In circumstances where similar data-handling risks had already been identified historically (we understand this learning was not shared with the rostering team), this allocation to them likely increased the risk of errors and inappropriate disclosure. Ideally both teams would be equally experienced in handling large datasets such that they would both be comfortable handling a request, or the rostering team compile the information for PIU to process.

4.34. **Recommendation:** The Trust should review its FOI handling request process to ensure an agreed route for requests which aligns asset ownership with data handling expertise. Training on handling large excel spreadsheets should be provided to teams that are responsible for collating information in large quantities, or an agreement for support with data expertise. If informal relationships have developed or are being used to collate material in response to FOI requests, they should be standardised into the policy documents to ensure appropriate training is completed for the staff involved.

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CF 2: Creation of the spreadsheet

4.35. The rostering team prepared the information. Due to the passage of time, it is difficult to ascertain how exactly the information was collated. The investigators heard evidence that two different staff from the Rostering team prepared the information. The investigators heard there was some confusion as to where the data had been downloaded from, the eRostering system and electronic staff record were possible sources however, concluded based on feedback that the data was most likely extracted from the eRostering system. For clarity, eRostering is not the same IT system as the Electronic Staff Record (ESR). Although they are two distinct IT systems they are interconnected; whilst e-rostering generates day to day schedules and attendance (including reasons for absence), the data is then integrated into the central ESR to ensure matters such as pay and workforce reporting are performed. The data extraction from eRostering is identifiable from the pivot table (rows) data released, as well as the column titles in the underlying data – the row acronyms for grade and job role only exist in the eRostering system as do some of the other column headers. Another identifier that the data was roster data is that CIC, students and agency were included. The investigation heard that this information would ordinarily not have been found on ESR.

4.36. The data was analysed to prepare information relevant to the FOI request. The information relevant to the FOI request was synthesised into the final pivot table. The investigators heard that this is the process followed by e-rostering when sending information to remove the raw data and only supply information without any identifiers. We heard that pivot table was then likely copied into a new Excel spreadsheet. At the time of the incident, the team believed that this process would prevent sensitive information from leaving the department, they do not send raw staff data to the FOI team, and therefore the team attempted to remove the raw information and only send the high-level pivot chart. It is unclear why some information from 2019 and 2020 had been anonymised prior to analysis; it was hypothesised that both members of the rostering team contributed to the analysis, one doing the first two years and the other doing the last three, and then one of

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them doing the final copy paste to the new spreadsheet and providing it. If this was an attempt to cleanse the data, it would have been helpful for a warning to have been given to the FOI team that this had been done. Though the investigators heard that given the team considered the raw data had been removed (and were unaware of the dangers of pivot tables) they did not consider this would be required as there was no concern about sensitive data potentially sitting within the spreadsheet. During investigation interviews, one member of staff highlighted that the FOI material should have been put into a Word document, demonstrating that there was no certainty about the proper format in which information should have been provided back to the FOI team.

4.37. There was no intention to send personal information to the FOI team. Exclusion of the individual sickness information before the data was returned to the FOI team would represent a 'first safeguard' in an FOI response, i.e. the information provided back to FOI team to collate the response to the request would then be in essence 'fit for purpose'. However, because the e-rostering team were unaware of the risks of hidden data lying behind pivot table, they considered that this 'first safeguard' had in fact been successful. Further training should have been provided to staff handling large datasets on the risk of hidden data being found behind pivot tables, to ensure the safeguards in place did not fall through as they did in this case.

CF3: Processing of the FOI request by the Information Governance team

4.38. On 30 January 2023 at 15:12 the information (including the Excel spreadsheet) was returned by a member of the e-rostering staff to the FOI Officer in the information governance team. At 15:46 the same day (around half an hour later) the FOI officer sent the information on for checking.

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4.39. Evidence provided confirmed that, at the time, there was a clear Standard Operating Procedure governing the release of Excel spreadsheets. As mentioned above, section 7 of the SOP provides as follows: *"Sometimes, information will be returned in 'Excel' format, if this format is essential to understanding the request (e.g. lots of data that may need to be sorted/extrapolated), or, has been specifically asked for by the applicant, leave in Excel form when responding; however, you must remember to 'prepare for sharing' to remove any hidden data (see instruction below)."* Section 7I of v. 21 of the SOP provides that FOI officer should click in Excel: file – info – check for issues (prepare for sharing) – inspect document) – proceed (with all options clicked) – in Document Inspector click 'remove all' for any data located. As is set out above, however, the Document Inspector does not include an automatic response to a pivot table. The SOP went on to say that all material should have been converted to PDF before the response was sent out.

4.40. It is reasonable to conclude that the required steps were not completed as expected by the FOI officer role, given the occurrence of the data breach and that the document was not converted to PDF. If those checks had occurred comprehensively, there would have been a potential opportunity to identify the hidden data and remove it from the final Excel spreadsheet disclosed. As set out in paragraph 4.19 above however, the comprehensive **removal** of information (rather than simply reformatting it in a way which makes it hard to access) requires some knowledge of the necessary action to take in response to pivot tables which Excel does not do automatically.

4.41. We considered that v. 21 of the FOI SOP (or its practical application) had some ambiguity as to whether these checks should be done before or after the response was sent to colleagues for sign-off – see further paragraph 4.43. In our view, it is preferable for this to occur before sign-off, because then the information is presented for sign-off in the format it will be disclosed to the applicant, and it avoids a single point of failure at the very end of the FOI process. The current version of the FOI SOP (v. 26) explicitly says that checks should be undertaken

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before sign-off and therefore addresses this risk. We note that this is confined to Excel spreadsheets and the Trust should consider incorporating a similar process for other redacted (exempt) material.

CF4: Approval / Sign off

4.42. On 30 January 2023 at 15:46, the information requested, including the accompanying Excel spreadsheet, was sent to the relevant Senior Manager for an accuracy check. On 31 January 2023 at 16:25, the Senior Manager confirmed that the information was approved, subject to executive approval. Following this accuracy check, the information was forwarded on 1 February 2023 at 08:17 to the relevant Executive Officer, for executive-level approval. The Executive Officer confirmed their approval at 09:02 the same morning. Subsequently, at 12:30 on 1 February 2023, the information (including the spreadsheet) was returned to the applicant.

4.43. The investigation heard that the head of IG would have expected the 'check for appropriateness of sharing' process should have been completed by the FOI officer before the information was escalated for approval/sign-off. Therefore, the head of IG would not have expected executives to be checking for hidden data as part of their review. This was affirmed by the Executive Officer who undertook the sign-off, who described the executive review process as focusing on whether the information aligned with the requester's questions, whether a complete response had been provided, and whether there were any potential concerns relating to communication, reputational impact, or adverse media. The Executive Officer also noted that data protection considerations were addressed through the Trust's standard data protection policies and that Executive Officer assumed any pivot tables or hidden data had already been removed prior to executive approval.

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4.44. The sign-off process was a potential opportunity for there to be a 'third' layer of check which could have identified the hidden data. However, formal checking of

the material for extraneous information was not incorporated in the FOI processes at the time of the incident, and so it is not surprising the hidden information was not identified. In terms of current practice and in light of the incident, it seems that executives (also) checking for hidden data has now become a standard but undocumented/informal practice. For instance, the investigation was told that one executive saw '*an example from another colleague the other day where somebody was trying to provide a spreadsheet and I saw that executive colleague pushing back.'* Equally, however, the final sign-off process is often done under time pressure and therefore there is a competing imperative to finish responses. Those that are undertaking sign-offs do not have dedicated/protected time in which to do it.

4.45. **Finding:** There was a large chain of people involved in collating the FOI response. There is no evidence of inappropriate access to data; those that had access to it had routine access as part of their roles. However, no-one appears to have considered (or at least actively communicated) that the spreadsheet might have been tainted with a pivot table. It is likely that the people further down the chain were not aware that the pivot table was included, and/or in any event, had assumed that the spreadsheet had been checked further up the chain. The ultimate responsibility for checking this in the SOP, however, was with the FOI Officer.

Training and supervision of FOI officers

4.46. The FOI Officer role description appears to be intended to be primarily administrative. Training was described as comprising the following main elements:

(1) FOI training QTC/BCS

(2) a comprehensive SOP setting out the FOI process in detail (i.e. the SOP described in paragraphs 0 to 4.18 above); and

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(3) iterative, tailored on-the-job training adapted to the individual's experience and needs.

However, the junior/'administrative' nature of the role means that in practice, the FOI Officer role was not designed to be working as an autonomous subject matter expert in FOI. There is a tension or ambiguity in the role, in that the expectations were that the FOI officer was able to apply FOIA, and also, they would make decisions on disclosure (rather than more senior colleagues) with limited operational supervision. More generally, there had been a high turnover of staff within the information governance team and the team more generally is responsible for a number of information rights response processes with statutory time limits with overwhelming levels of demand.

4.47. In relation to point (3) above, the investigation heard that training was 'on the job' delivered in a practical, informal and step-by-step way. The FOI Officer in place at the time would sit with the Information Governance Officer colleague, who would demonstrate each stage of the process and run through the role with them. This would progress to the FOI Officer dealing with some FOI requests themselves and the Information Governance Officer supervising them as they completed tasks themselves, such as logging a new FOI request. This allowed the 'trainee' to learn the process gradually while receiving immediate support and feedback.

4.48. If at any time clarity was needed or a pattern of not adhering to process was raised, it was expected that additional supervision would be given informally or formally through a personal development plan to support consistent and compliant practice.

4.49. We spoke to a more recent FOI officer who had a similar experience of training and supervision to that described above as being in place at the time. However, throughout their own tenure, the IG Officer role was empty, so the more recent FOI Officer reported directly to the senior IG officer and Head of IG. The more recent FOI officer role also saw the FOI officer role primarily as administrative and,

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after about two weeks of hands-on training with the previous FOI officer, felt able to understand the general patterns of the processes. While the more recent FOI officer did not have a dedicated work buddy, they did receive support and guidance from colleagues whenever they were unsure or found tasks complex. They pointed out that *'everything starts and ends with the SOP'* and so they followed this closely. They confirmed that in accordance with the SOP they would check for macros, remove them, save the file, and then send it for approval.

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5. Changes to information governance arrangements for publishing FOI responses since the breach

Terms of reference 6

5.1. An updated version of the FOI Officer SOP (v. 24) was published in September 2023. The current version of the FOI SOP (v. 26) was published in February 2026.

5.2. In relation to Excel documents, section 7I of the SOP now provides that after completing the 'prepare for sharing' checks, the FOI Officer must lock/protect the Excel workbook, with an illustrated description of the process to be followed to achieve this:

a) You must always lock/protect the Excel workbook before disclosing.

b) To lock the Excel workbook: Review - Protect workbook - Add password.

c) Then 'save' the workbook.

d) This has now protected the workbook, and any hidden data is now inaccessible.

e) Any request where there is an Excel document forming all or part of the response must be sent to [senior staff members in the IG team] to obtain sign off ahead of the Executive approval for disclosure.

f) Once the Excel has been approved by [the senior staff members in the IG team] then the request can be sent for Executive approval as per the SOP.

5.3. We have tested this approach using the spreadsheet which is the subject of the incident. Password protection does prevent the hidden data in the spreadsheet from being accessible to others, and therefore provides an effective combination of controls (in conjunction with the 'second pair of eyes' safeguards used by the Trust to ensure that it has been applied correctly). It therefore seems that the Trust has put in place a reasonable control and this conforms to multiple elements of the ICO's current guidance described in paragraph 2.17 above. However, we note that when taking this approach, the Excel file size still appears to be 2.75MB

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which means that the personal data is presumably still 'hidden' within it (but simply has been rendered technically inaccessible without the password).

5.4. On 27 November 2025 (and in light of this incident), the Trust Information Governance Team circulated via email a revised protocol for managing FOI requests, including involving spreadsheets. This also included the conversion of Excel spreadsheets to CSV as an additional control. In this regard, therefore, the arrangements that the Trust has put in place subsequent to the incident comply generally with the principles set out in the ICO's current guidance on minimising inadvertent disclosure of information in spreadsheets (i.e. multiple controls, including the use of passwords and file conversion), although the FOI SOP itself (v. 26) does not include the 'convert to CSV' point. It would be prudent to clarify whether this is still required, and to update the FOI SOP if so. We recommend that it is.

5.5. The Trust could also expressly integrate the ICO checklist described in paragraph 2.19 above into its processes as well.

5.6. Going forward, we recommend that the Trust substantively updates its other policies and procedures to incorporate the steps set out in the email described at paragraph 5.4 to ensure there is permanent adherence to these arrangements. The disclosure log on the Trust's website does appear to still include some older .XLSX files (the disclosure log webpage appears not to have been updated online since August 2025, and older files have been removed, but there are various spreadsheet files online for the period 2023-2025)[4]. However, in light of the incident, we understand an audit has been undertaken of spreadsheet material on the Trust's website to assess whether any personal data has been inadvertently disclosed, with no high-risk material located (see paragraph 6.9(15) below).

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[4] Publishing an FOI disclosure log is not a legal requirement.

5.7. The context in which this incident occurred was an FOI response, but the nature of the organisation means that there may be disclosures of other large data files within the Trust. The PIU lead has produced a helpful guidance note entitled *"Data sharing tips, tricks and pitfalls* ", which is not specific to FOI issues. We recommend that this guidance is disseminated more widely within the Trust. The E-rostering team have also implemented an SOP setting out clear guidance on how information should be prepared, what data must be removed, and the correct processes for securely sharing information going forward. Consideration should be given to assessing which members of staff are more routinely involved in data sharing exercises and this guidance (and the opportunity for additional training) targeted towards them.

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6. Findings: Responding to the incident and Incident management

Terms of reference 5, 7 and 10

The personal impact of the data breach

6.1. It is first appropriate to mark the sensitivity of the incident for many of the individuals affected, and the impact in terms of compounded harm (for instance, where a staff member had a sensitive or enduring health condition or personal circumstance to begin with), only for this to be 'broadcast to the world' in the spreadsheet disclosed. Whilst it is important to note that no financial, bank account, national insurance number, address, date of births or contact information were included in the spreadsheet, and the Trust sought to communicate this], many staff were left very upset by the actual information that was disclosed and have said that it undermined their trust in the organisation. Some staff appear to remain uncertain about what was actually disclosed (i.e. they remained concerned that financial or other personal information had been disclosed). This illustrates the challenges in trying to communicate effectively the details of a data breach at scale. Furthermore, managing the incident itself had a serious emotional impact on staff who have worked on it – particularly those working in the call centre, who found the experience very difficult and without feeling they had much agency in their involvement. Sadly, some members of staff who were upset by the incident itself did not always behave kindly to colleagues involved in the response.

6.2. The work and effort undertaken to respond to the incident and personal sacrifices undertaken by many staff to seek to address the incident were commendable. Senior staff told the investigators how proud they were of the staff who contributed to the incident response. Although we note (see paragraph 6.48 onwards below) that some staff surveyed in response to the incident felt that the Trust was not transparent enough about the incident, we consider that the Trust met and sought to exceed its legal duties in relation to the management of the incident, and to be as candid as possible about what happened. Nevertheless, some staff questioned

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the sincerity with which the Trust said sorry, or considered that the actions did not match the words.

6.3. Overall, we consider the Trust mobilised efficiently and effectively in a difficult situation. The Trust was able to notify an extremely large number of people about the incident, and used a range of methods to seek to do so. The Trust's existing incident management processes provided a framework which worked overall but this was an incident without precedent. There is no single or perfect way of responding to incidents such as this; decisions which overall were taken with a view to ensuring a comprehensive and timely response left some people unhappy. Any shortcomings addressed below are for the purposes of ensuring constructive learning going forwards.

6.4. The Trust maintains a Data Breach Policy and the overall response to this incident accords with the framework provided by that policy, although it would appear that this policy is designed for smaller incidents. A mass cyber or data loss event should be factored into the Trust's business continuity exercises and a closer link drawn between the Trust's Data Breach Policy and business continuity or Emergency Preparedness, Resilience and Response (EPRR) arrangements. The scale of this incident meant that there were departures from the Data Breach Policy, ordinarily to take a more involved approach to incident management.

6.5. We have considered the Trust's Emergency Preparedness, Resilience and Response (EPRR) Strategy. We understand that consideration was given to whether the incident should have been considered a 'critical incident' under that framework, and some contributors to the investigation were disapproving of the decision that it was not. The definition of a critical incident within it is *"any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions."* By reference to this

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definition, we do not consider that the threshold for declaring a critical incident was met here (in other words, the Trust legitimately concluded that this was not a 'critical incident'), although this conclusion should not detract from its seriousness. We have been informed that aspects of the critical/major incident response process were incorporated into the Trust's response. We have also considered the applicability of the Civil Contingencies Act 2004 (CCA), which requires NHS organisations and providers of NHS-funded services to show that they can deal with large-scale emergency incidents while maintaining services. However, we do not consider that this type of event would have reached the threshold for it to be considered an "emergency" to which the CCA would apply.

6.6. That said, the numbers of staff affected and the resources needed to manage the incident were very significant and at times were significantly underestimated by the Trust, and some of the limitations of practical resources (e.g. space within the hospital) meant that staff 'on the ground' found the incident difficult to deal with. Some said they felt under-supported, and that the failure to call a critical or major incident meant that the pressures of other work remained present and dedicated resources (e.g. an appropriately sized incident management centre) were not available. Some staff members gave up holiday or worked long after hours or over weekends in order to contribute to the response. As one staff member commented, *"it's typical NHS, it runs on goodwill".* The Trust should factor the experience from this incident into its business continuity response plans, particularly in cases where only one staff member has specialist knowledge of systems necessary for incident responses. This leads to overreliance on that individual and poses a failure-risk in future cases (for instance, if that individual is unavailable for whatever reason). Ensuring there is training and knowledge sharing amongst staff, and effective deputization arrangements, is very important.

6.7. Necessarily a response to an incident of this kind will be evolving/iterative. Choices had to be made about the allocation of staff time and in the case of some staff that would normally work with patients, their working day was reallocated to working on the incident response. Some of those staff felt that they consequently

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had let patients and their families down, because meetings had to be rearranged or work reprioritised so that they could contribute to the incident response process.

Context: morale among some staff affected by the incident

6.8. The investigators have been told that the incident came to light during a period of organisational change, triggered in part by the Trust's need to deliver a cost improvement plan of £49.3m, and which had included a proposed redundancy/restructuring programme affecting some staff. This context then impacted negatively on some staff morale and behaviours in the course of managing the incident.

Timeline of incident response

6.9. The following is a general timeline of key steps which took place in the incident response. A very wide range of incident response measures were operating in parallel/quick succession, particularly during the early phase of the incident response. A more comprehensive list of the various strands of response are helpfully set out in greater detail in the Trust's documented action plan/task-and-finish tracker, which we do not repeat in full here. Having described the key steps undertaken, we discuss various elements of the response in greater detail, so as to seek to provide 'lessons learned' for the Trust:

(1) 17 November 2025, 11:23: The existence of the spreadsheet was reported to the Trust via email, by a third-party member of the public who had accessed the Trust's disclosure log on the Trust's internet pages on 17 November 2025. However, the individual that was contacted had been on annual leave and so the email alert was not picked up until 19 November 2025.

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(2) 19 November 2025: On discovery of the reported incident, various actions commenced immediately within the Trust to handle it and liaise with affected individuals. An incident report was submitted on the same day of discovery. The Trust's Head of Information Governance was to prepare an executive briefing paper, so they could be made aware of the incident.

(3) 20 November 2025: The incident was added to Datix, under reference R254194. A review was commenced of all previously disclosed Excel sheets to establish if further incidents had occurred. The investigators understand that the Trust sought to contact the original FOI applicant, to ask that they delete the original response (see further, paragraph **Error! Reference source not found.** above).

(4) 21 November 2025, 14:56: A Data Security and Protection Toolkit Incident Report was made, which is standard for NHS information governance incidents, and automatically makes a referral to the ICO where inbuilt relevant thresholds are met. The incident report noted that changes were being made to the FOI SOP to ensure no future Excel sheets are disclosed without being converted to PDF-type documents. The Trust established a project working group/incident response cell, led by the then Chief Executive, to oversee the response to the incident. The Trust's internal communications team was notified. Contact was also made with the Trust's external legal advisors, for advice on incident reporting and management.

(5) 22 – 23 November 2025 (weekend): The Trust briefed its specialist external communications advisors, to start the process of preparing the communication strategy for notifications to affected staff and incident management.

(6) 25 November 2025: The Trust received confirmation from the ICO, deciding no further action will be taken and the case was closed from their perspective. An executive meeting brief was prepared with a further executive briefing meeting taking place on 27 November 2025.

(7) The Trust developed its initial communication strategy based on a stratification of the staff members concerned and risk associated with the data.

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(8) 28 November 2025: The People Information Unit was asked to start doing historic data sweeps of staff lists and ESR to capture everything (and this work in turn was picked up by People Information Unit (PIU) Service Manager on 1 December 2025). A computer coding script was developed and applied to categorise the severity of sickness information by reason. This was done so that the Trust could seek to identify those with high/very high severity risk sickness information overall, as well as severity for each reason published per person. This was considered important for the appropriate first degree of interaction and support for staff members concerned. The communication strategy was that all staff working for the Trust affected by the incident would be emailed, all-staff briefings would take place via Teams meetings which staff could attend, and a call centre would be set up primarily to deal with the most sensitive cases where direct contact was considered appropriate.

(9) About 1 December 2025: a script was prepared for staff who had been allocated to work in the Trust's incident response call centre to assist with notifications to staff. A rota was drawn up for staff to work in the call centre. Call handlers were briefed on 2 December 2025.

(10) On and around 1 to 3 December 2025: various briefings took place with key organisational stakeholders, including the JCNC staff-side negotiating committee.

(11) 3 December 2025: The Trust call centre went live.

(12) The Trust wrote (initially via email, but also through hard-copy correspondence) to approximately 5000 current staff and 3000 former staff to apologise for the error and explain what had happened.

(13) The Trust provided phone support initially envisaged to be for those identified as having high-sensitivity data within the spreadsheet.

(14) 5 December 2025: The Trust carried out MS Teams Live question and answer sessions with staff which commenced on 5 December 2025 with daytime sessions and one evening session to communicate what had happened. The Trust also created a frequently asked questions page on the Trust's intranet which included a recording of one of the Teams videos, and an update page

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was also set up on its external website, which went live on 15 December 2025. The Trust sought to describe the incident and assure staff that no financial, bank account, national insurance number, address or contact information was breached.

(15) Cornwall IT Service (CITS) carried out an independent review of the FOI portal and found no other breaches of personal data. The Trust also identified an archived copy of the FOI response on a government-hosted web archive, which was taken down on the day it was identified. During interviews, we were advised that no copies of the FOI response had been located on other common archive websites.

(16) The Trust put in place a process to manage complaints from affected individuals.

(17) The Trust responded to a small number of local media enquiries.

Regulatory reporting obligations and consequences

Terms of reference 9

6.10. The legal requirement[5] is that the Trust should report data breaches which meet the relevant statutory threshold within 72 hours of becoming aware of it. If that deadline is missed the response should be accompanied by reasons for the delay. Although there was a slight initial delay in identifying the incident (as it was contained within an email to a staff member who had returned from leave), the incident was reported on 21 November within 72 hours from the email being seen on 19 November, and approximately 96 hours after there was arguably 'corporate knowledge' in terms of the email being sent to the Trust (albeit it was not actually seen and acted upon until approximately two days later).

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[5] Article 33 UK GDPR

6.11. The ICO's response of 25 November to the incident report was to close the case with advice at that stage, namely:

> *"…We advise that in response to the personal data breach you continue to take reasonable steps to contain the incident. We also advise that you consider any steps you can take to mitigate the impact and support the affected individuals.*
>
> *Please check that your policies and procedures are fit for purpose. All staff who handle personal data should receive data protection training regularly and where possible this should be role-specific. If you haven't already done so, consider ensuring that you implement any steps you outlined in your breach report to help prevent a similar breach happening in the future.*
>
> *We also recommend you consider reviewing your process for disclosing information. You should have a robust process to double check that only relevant information is being disclosed. This could include implementing a process for checking for hidden cells or spreadsheets. See our guidance on disclosing documents to the public securely for more information. This guidance includes information on how do we avoid an accidental breach when personal information is hidden in spreadsheets and checklists that can be used when disclosing information in spreadsheets."*

6.12. The steps taken in response to the incident described elsewhere in this report give full effect to the ICO's advice.

6.13. The Trust's second regulatory requirement in reporting the incident is to notify the affected individuals ("data subjects") where an incident is likely to result in a high risk to the rights and freedoms of natural persons. The notification must be given

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in clear and plain language and without undue delay, though no specific timeframe is prescribed. The notifications must at least:

(1) Include the name and contact details of the data protection officer or other contact point where more information can be obtained.

(2) Describe the likely consequences of the personal data breach; and

(3) Describe the measures taken or proposed to be taken by the Trust to address the personal data breach, including, where appropriate, measures to mitigate its possible adverse effects.

6.14. Taken together, we consider that the Trust's notifications complied with these legal requirements.

What lessons can be learned from the way the incident was handled?

Terms of reference 10

Incident response team

6.15. The investigation heard that although no formal critical incident had been declared, the scale and severity of the situation necessitated the rapid formation of an incident response team. The Trust therefore quickly established a project team that included representatives from executive level as well as Information Governance patient experience and communications, to support the organisational response. This response team was chaired by the Chief People Officer and sometimes the Chief Executive, reflecting the seriousness of the incident and ensuring appropriate executive oversight.

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6.16. The investigators heard that regular and frequent meetings were held, and there was a strong sense that responsibilities were well understood across the team. Clear distinctions were maintained between the responsibilities of each individual.

The investigators heard that to ensure robust oversight and accountability, a detailed action log was requested and subsequently developed by the Company Secretary. This facilitated clear tracking of actions, responsibilities, and progress. The Trust also recognised at an early stage the need for external expertise and engaged a specialist consultancy to support the organisational response, which was regarded as beneficial in strengthening the overall approach.

Review of previous FOI responses

6.17. The Trust also took down the link to the FOI website to carry out a check on all FOIs and spreadsheets to ensure there was no other repeat occurrence. This was done by CITS who did not identify any other data breaches within Excel disclosures that had been published. We note that some XLSX files remain on the Trust's 'disclosure log' webpage, in contravention of the various versions of the FOI SOP which says they must be in PDF. The Trust should remove them to reflect the SOP (or update the SOP).

Brief of external support

6.18. A communications and media crisis expert consultancy assisted the Trust executive and communication team. Their work was involved in many aspects of response planning, particularly to review comms, media statements, and assisting executives in relation to staff-wide briefing calls. They reviewed key materials, including video content of the meetings, and provided constructive feedback to support the Trust's approach and improve the approach going forward. This expert input was very well received by executives who worked with the consultancy.

The Trust wrote to approximately 5000 current staff and 3000 former staff to tell them about and apologise for the error.

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6.19. The Trust's Head of Communication, and external expertise worked over the weekend of 22-23 November 2025 to prepare communications and consider the approach to the Trust's response. This began as preparing one letter, however, as it became clear that there were different levels of harm caused, and different organisations whose staff information was accessed, a decision was made to prepare variations. This developed over the following week as the Trust worked through the issue in more detail and gained a clearer understanding of its scope and those affected. As a result, the Trust adapted its communications approach, including updating its messaging, developing a set of frequently asked questions, preparing a media statement for the website, and establishing a dedicated area on the intranet.

6.20. In terms of the letters to affected individuals, the large number of the people that needed to be contacted on a personal level in a short space of time was not something the Trust had had to deal with before. A particular concern of the Trust was ensuring that correspondence was personally addressed to each individual; this required mail merge so that the letters would say *"Dear [name]"* which was not something that had been done before by the Trust. The Trust's comms team therefore had to work with IT colleagues to find a way to do that. This was an example of rapid and collaborative response where colleagues worked together and acted quickly to improve the response to the brief. It also led to a learning for the Trust going forward as it now, as a result of the breach, has this capability. As part of business continuity exercises, the Trust should continue to ensure that a range of mass staff communication scenarios are incorporated, so this knowledge and experience is not lost.

6.21. A further challenge experienced was that the Trust tried to send out the communications all at once and this was blocked by the IT systems, so they had to be sent in batches of around 100. The investigation heard that staff were surprised that the Trust hadn't ever sent (personalised) communications to staff on this scale before, but we anticipate that most such communications are typically

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delivered through systems built for routine mass communications (e.g. payroll) rather than the bespoke communications that was needed here.

6.22. Because of these issues, and because of the extensive information that was coming out about the situation, there was a period of approximately 10 days between the Trust finding out about the breach and starting to notify those affected. The investigation heard that this was difficult for those dealing with the incident during this period, in terms of “holding this knowledge without being able to communicate with staff”. However, the importance of ensuring that the letters were right and communications were drafted appropriately was the priority.

The PIU Lead undertook extensive data analysis to support the incident response.

6.23. On 28 November 2025, the People Information Unit was requested to undertake retrospective data sweeps across staff lists and ESR records to ensure comprehensive capture of all relevant individuals. This request was taken forward by the People Information Service Manager on 1 December 2025 on her return from leave. The Trust was able to identify contact details for those that were still at the Trust; however, as the incident involved datasets which as far back as 2018, there were a large number of individuals who had left the Trust, but who still needed to be contacted. As a result, on 1 December 2025 the PIU service manager properly concluded that reliance on current workforce data alone would significantly underrepresent the affected population. Historic staff lists were therefore obtained and incorporated to maximise identification and matching rates.

6.24. The work undertaken by the PIU service manager during this time was significant. The information was required urgently and there were various significant challenges that were encountered, particularly for pre-ESR Go Live data, where naming conventions within roster systems were inconsistent. Variations included the use of nicknames, middle names, abbreviations, or informal identifiers (e.g.

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"*Rosie*" instead of "*Rosemary*"), reflecting local familiarity rather than formal record standards.

6.25. The PIU Service manager was able to collect the information in course of three days, working over 10 hours a day, and noted it was fortunate that a year previously, they had migrated services on SQL server database to allow for automated matching.

6.26. Approximately 2,000 records could not be matched through automated processes and required manual review. This involved cross-referencing roster departments with historic staff lists to establish likely matches based on contextual information, such as departmental alignment and staffing structures at the time. Through this manual reconciliation exercise, the number of unmatched records was reduced significantly, to approximately 200 cases where definitive identification could not be established. This number included CIC and agency staff as they were not on the Trust's ESR system at any point in time. Subsequent lists were collated for those external staff affected to be shared with those external providers for them to identify and contact their staff/students affected. This reduced the overall unidentifiable staff number to 51 (and those individuals might still have become aware of the incident through internal and external publicity exercises undertaken by the Trust). As mentioned above, during this process distinct categories of individuals were also identified, including agency workers and other non-standard staff groupings, which further informed the classification and handling of records within the investigation.

6.27. Once the information was found, individuals affected were ranked on scale of severity of breach from "very high, high, medium and low". This coding was done by senior staff, who matched each of the sickness reasons in the spreadsheets with a severity score developed by members of the incident response team with the benefit of a clinical background. Each severity score was given a numerical value, so that in SQL the highest value could be located and that number would be marked as the severity of the breach in respect of that individual. For instance,

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if a staff member had absence on three occasions due to headaches and then had been diagnosed with cancer and were on sick leave as a result, the staff member would be counted as “very high sensitivity” because of the seriousness of the cancer diagnosis, and this then had a bearing on approach to communication with them. An issue arose where some staff’s sickness reasons were listed as ‘unclassified or unidentified’. Out of an abundance of caution, these cases were listed as very high sensitivity. However, this significantly increased the number of individuals who required calls, as discussed later on. Seeking to stratify/cohort the staff members affected was a reasonable decision in light of the scale of the incident, although as is described below there was then some confusion among staff members (who did not know what category they were in) because different degrees of interaction had been planned for each cohort (i.e. whether they would be actively called by the Trust) whereas in at least one of the Teams briefings, all attendees were given the impression they would be called.

6.28. Work to categorise affected staff members continued as the call contact centre commenced work, as there was further data matching required each day due to changed addresses and changed surnames since the date of sickness recorded and latest contact information available held by the Trust. The verified and prioritised contact lists were provided to the contact centre to support outgoing and incoming calls. Individuals categorised as high and very high risk were issued letters containing a dedicated contact number, enabling them to make direct contact upon receipt. This formed the basis of the Contact Centre’s workflow, ensuring that incoming queries could be managed alongside proactive outreach.

6.29. Once the contact/call centre became operational, a controlled and centralised approach to data sharing was implemented. A restricted Teams channel was established, containing a live working file of affected individuals (sickness reasons and dates were not shared nor included in the file accessible by the Contact Centre), including high and very high cohorts with associated contact details. All contact centre staff accessed and updated this single dataset to maintain consistency. The file included a series of tracking fields capturing engagement

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outcomes, including whether contact had been successfully established, whether personal details (telephone number, email address, and home address) had been verified, and whether the individual had received their notification letter. Where letters had not been received, preferences for alternative delivery methods were also recorded.

6.30. This dataset became the basis for ongoing data analytics activities. Initially, the file was reviewed daily, before transitioning to a three-day cycle. The purpose of this analysis was to identify individuals who had been successfully contacted but had not received correspondence, and to capture their preferred method of delivery. Based on this, additional distribution lists were generated and shared with the relevant team to facilitate further mail merges, either via email or physical post depending on the individuals' preference (some individuals requested both postal and email).

6.31. This process continued on a sustained basis until mid-February, with the final extraction completed on 11 February. The workload required extended working hours, including early morning and evening review sessions, to ensure timely updates. Each cycle involved detailed interrogation of the dataset to prepare subsequent mail merges and to refine the Contact Centre's working list.

Creation of a guide for staff to find their information

6.32. On 5 December the PIU Service Manager created a *"finding your sickness absence record in ESR"* file report guide that was shared with staff, so that individuals who were working at the Trust could go back and find out what information had been entered at that time, so that they knew what information would have been disclosed. How to access this was put in the Trust wide calls and was put on the Trust's intranet page. This kind of 'self-service' feature is sensible because it significantly reduces the work that is needed by the incident response

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team, and allows affected individuals to understand the incident at their own pace and convenience.

6.33. People outside the organisation would have to email in and have this processed by the Trust's own staff. This is sensible from an information security perspective but then (necessarily) adds to the work for the Trust itself in responding to the incident.

MS Teams Live question and answer sessions with staff

6.34. Executive-led virtual sessions were introduced to communicate what had happened and provide staff with opportunities to ask questions and express concerns. These took place during the day and on one evening. The investigation found mixed responses to these sessions, although the investigators would observe that given the scale of the incident and number of individuals affected, using Teams as a key tool was a reasonable way of trying to maximise opportunities for the largest range of staff (who may be working different shift patterns or on different sites) to find out about the incident and to convey information in as close to real time as possible.

6.35. Senior leadership expressed confidence in the decision to hold staff briefing sessions, recognising that, while some sessions were more challenging than others, maintaining honesty and visibility was essential. They also appreciated that there also acknowledgement of the efforts of operational teams, particularly in managing difficult interactions and responding under pressure. Overall, they wanted there to be clear emphasis on transparency and openness in communications throughout the incident response.

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6.36. However, while the intent behind these sessions was recognised as positive, aiming to demonstrate care, openness, and accountability, the audience perception of the success of their delivery, and their operational impact was mixed. In particular, it was noted that:

(1) There were some discrepancies identified between the information being provided on the Teams calls, in the letters and resources, and on the calls by the call centre. That being said, information sharing evolved as further details became available, and some staff members attended multiple Teams sessions to find out more as the incident unfolded. Updates were incorporated into communications on an ongoing basis, with Frequently Asked Questions (FAQs) maintained as a live document. This resource was continuously updated to reflect emerging queries and intelligence gathered through staff interactions, ensuring a consistent and accessible source of information for those involved in the response.

(2) Due to the need to implement the sessions quickly, initially presenters were selected based on availability rather than consistency or potential suitability/experience to give a credible response. The investigation heard that in hindsight, a smaller, consistent group of well-briefed and confident presenters would likely have improved the quality and consistency of messaging. Variations in delivery style and responses may have contributed to differences in how sessions were received, with some perceived as more challenging or confrontational. In particular, reflections were that the early sessions were (or allowed for feedback which was) angry or unfairly critical of the information governance team, members of which were present at that time. Those presenting asked for feedback from communications specialists on their approach.

(3) There was also feedback regarding perceptions of executive availability. Instances where senior leaders left sessions early due to competing commitments were seen negatively, with some participants interpreting this as a lack of prioritisation. It was recognised that a more measured approach, allowing sufficient time and focus for these engagements, may have improved both perception and effectiveness.

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(4) Certain Executive-led virtual sessions contributed to increased demand on the Contact Centre, with call volumes rising significantly following some events and a noticeable increase in frustration of callers. For example, the first session held on a Thursday led to a notably high volume of calls on the following day.

(5) Further issues were noted regarding session structure and facilitation. High volumes of questions submitted via chat made it difficult to manage discussions effectively, with many questions going unanswered. The investigators also heard that some comments / questions made by staff in the chat could be quite personal and targeted at those they considered should be 'attributed blame'. A more controlled approach, such as prioritising verbal questions or using a moderated "hands-up" format, was identified as a potential opportunity for improvement, and/or using the webinar format on teams or Q&A only would be an option. Some staff members reflected that more Teams sessions, or more extended sessions, may have been beneficial.

(6) Despite these challenges, it was acknowledged that such forums served an important purpose. They allowed staff to voice concerns, particularly given the emotional impact of the incident, and reinforced the organisation's commitment to transparency. It was also noted that senior leaders sharing their own personal connection to the breach helped to build credibility and trust.

6.37. While there was some reflection on whether such open forums should have been held at all, the overall view expressed to the investigators was that they remained important. Avoiding them may have led to increased pressure elsewhere, particularly on Contact Centre and email channels, and could have undermined perceptions of transparency. The investigating team recognises the range of views on this issue, but observes that the question of how to communicate around this kind of incident does not have a perfect answer. The senior leadership team sought. to behave candidly with staff in a timely way, in line with Trust values. In a complex and large organisation, Teams provides a tool which enables a wide reach to be achieved quickly, which overall is advantageous in a dynamic and

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evolving situation. However, the limitations of virtual communications should also be considered. One reflection to the investigation was that if a staff member was on a Teams call at home, they might be more isolated and this could make the experience more distressing than if they were face-to-face with colleagues. The investigators hope that this feedback may be useful if the Trust or another NHS organisation were faced with a similar situation in the future.

Email address for queries

6.38. Early in the incident response process, a dedicated email address was set up with the Information Governance team to manage communications relating to the incident, which was referenced in the notification letters.

6.39. While this was likely an appropriate step, the volume of incoming messages was significantly underestimated. The inbox was initially managed by the Information Governance team, however, the investigation heard that the number of emails received quickly became overwhelming leading to delays in responses (and in turn this may have had a knock-on effect in trust and confidence among some staff).

6.40. To address this, members of the communication team provided additional support and were granted access to the mailbox, assisting with handling enquiries over a period of approximately one to ten days.

The Contact Call Centre

6.41. The Trust set up a call centre in response to the data breach to support affected individuals, particularly those identified as having had information disclosed which was highly sensitive. This was done to make sure that people who had been impacted by this situation had a place to call and get answers to their questions.

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The initial development of this proposal was done very rapidly (within hours), and one member of staff was tasked with bringing people on board and running the centre. The go-live date for the call centre was 3 December, and it was expected to run for around two weeks. It transpired this was a significant underestimate.

6.42. The call centre was operated by the clinical governance team largely independently, with staff keeping the centre active five days a week from 8am to 6pm over a period of 11 weeks, only putting the phone line to voicemail over bank holidays (i.e. Christmas and New Year). During the initial incident response the call centre staff each handled around 60-90 calls a day, with calls varying from a few minutes to potentially taking up to 25 minutes each, both incoming and outgoing calls. The call centre aimed to maintain a minimum of four staff on duty each day. The team proactively contacted individuals categorised as ‘high’ or ‘very high’ risk, whilst receiving incoming calls as well. As is described above, ‘high’ or ‘very high risk’ were people whose information was deemed particularly sensitive in terms of their absence related information. They had the potential to be the most emotionally or psychologically impacted by the disclosure and were most likely to want rapid answers.

6.43. The investigators heard that the clinical governance team were widely praised for the work that they did during the response, particularly in relation to the call centre. They regularly engaged with individuals who have experienced trauma, demonstrating strong empathy, professionalism, and communication skills. Their day-to-day roles required them to respond effectively to sensitive situations, manage complex information, and to provide clear, compassionate support. As such, at a baseline level, they were considered to be the most equipped team, without prior training or discussion to determine if they were in a psychological position to take on the task, to deliver both a rapid and structured response when required efficiently but with empathy and sensitivity.

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6.44. However, the investigation heard some significant challenges that the call handlers faced along the way that are important to recognise and learn from, these included:

(1) While the majority of calls were constructive, and some people were said to have been very kind to the call handlers, there were instances where they experienced challenging behaviours from callers. These were largely expressions of anger or frustration and ended with raised voices or phones being slammed down on the handlers. The investigation also heard of incredibly difficult calls with individuals who were understandably distressed as a result of the severity of the disclosures or were in a position of danger (e.g. because of domestic abuse). The investigators heard these were particularly challenging and the team found that (without any process for the same) they needed to complete safeguarding assessments for some individuals who they considered could be in danger without any training or guidance on approach. Such occurrences of anger or distress were not infrequent, and this reflected the heightened emotions and distress experienced by callers to varying degrees due to the breach. This placed significant emotional burden on individuals working in the contact centre, who were not prepared or provided support on how to deal with those.

(2) There was a very short lead-in period and a degree of uncertainty before call handlers were formally informed that they would need to step up and run the call centre. There were indirect signs over the week prior that something would be happening, such as miscellaneous calendar holds in execs diaries and the creation of a Teams channel for an unknown purpose with ‘random’ invitees. However, there was no clear communication at that stage about what this related to, just a general sense among staff that ‘something big was coming’. The relevant staff members were told on 2 December that they would be manning the call centre, go live was 3 December 2025. This left very limited time to prepare before calls began. It also became apparent during the process that some senior members of the executive team who were themselves affected had already been contacted before the wider calling

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exercise began. The staff working in the call centres had a short training session and then the calls started coming in within minutes of the team being set up. Some staff had not finished reading the pre-prepared script which had arrived only 30 minutes before the centre went live. The Trust's desire to move quickly could have been briefly tempered to ensure that staff felt as 'ready to go' as possible.

(3) Most of the call handlers only became aware that their own data had been affected by the breach while they were actively working in the call centre. In some cases, this occurred when other call handlers identified their names on call lists and let them know. This created an uncomfortable situation; the investigation heard that it was disappointing they had not been told directly prior to call centre starting, especially as others involved in the data breach response had received direct communication beforehand notifying them their information was included. It was particularly hard because those individuals found out they were affected and within minutes had to start talking/taking calls from others who were affected. Though as a general point, the investigation heard that this experience made conversations easier for callers to know that the person they were speaking to was 'in the same boat'.

(4) The investigation heard that other teams were perceived to have a 'choice' in terms of how they participated in the incident response, whereas the clinical governance team working in the call centre felt that it was an instruction. Furthermore, there was no consultation with the handlers to assess whether they were psychologically and emotionally equipped to undertake the task. In any event, irrespective of the capabilities of the clinical governance team, the investigators heard that the nature, scale and scope of the work extended well beyond, and differed fundamentally from, the duties that staff would ordinarily be expected to perform.

(5) Staff were initially told that the call centre work had to take priority, with urgent tasks and existing commitments to be put on hold. This led to cancelled meetings and, in some cases, staff having to let down families as approvals and other work could not be progressed. However, it quickly became apparent that certain other responsibilities still needed to continue, creating an

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expectation that some elements of their usual workload would need to be maintained alongside the demands of the call centre. Staff noted discrepancies in terms of senior staff saying they had to stand everything else down, whilst still asking for things to be completed or for updates. Ensuring that there are appropriate resources for business-as-usual activities to continue, even if a critical/major incident is not prepared, is therefore important.

(6) Staff were required to handle calls in confidence and were instructed not to discuss the work outside of the designated group. However, no appropriate or dedicated workspace was provided to support this requirement. As a result, they were not permitted to work from their usual offices, despite those environments already being used to handle confidential conversations. Staff improvised. They had to find alternative locations, often working from home or in isolated areas within the organisation. This led to staff working in the contact centre feeling physically and professionally isolated, particularly when managing difficult or confrontational calls without immediate support from colleagues nearby. The Netcall system helped mitigate some issues by allowing calls to be made from any device, including personal phones, without displaying or disclosing the user's number. This meant staff could still carry out their roles on their personal phones without compromising personal contact details, despite the lack of designated resources.

(7) Staff received some basic, practical training, but overall support and preparation were limited. In particular, there was no guidance on how to handle difficult or emotional calls, such as dealing with anger or knowing when and how to signpost or escalate concerns. Staff were largely reliant on a single script, which left them uncertain about how to respond to more complex queries. In many cases, they had to record issues and rely on others to follow up later, rather than being able to provide reassurance or answers in the moment.

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(8) The investigation heard that sometimes after the trust-wide FAQ briefings/Teams meetings, calls to the Contact Centre significantly increased and there were discrepancies in what was being told to people in those

meetings compared to elsewhere. For example, in one Teams call staff attending were told they would all receive calls, but the decision had been made that anyone attending the meetings wouldn't receive calls. This point was referenced in the staff survey feedback obtained during the investigation (see paragraph 0 onwards below).

(9) There were discrepancies in staff members being allocated severity lists, some had all "very high risk" while others all "high risk". They also had separate lists, however then found there were difficulties when receiving incoming calls, as they would have to move back to the master document. Staff working in the call centre therefore made changes to the approach to reflect these challenges along the way.

(10) There was also no coaching or preparation around handling crisis communications, despite the sensitive nature of the situation. Staff were expected to begin taking calls almost immediately, while also managing the fact that some were personally affected by the breach. This created a challenging environment, compounded by practical issues such as finding appropriate space to work. Support during calls was limited, with staff often informally listening to each other's conversations to gauge how to handle difficult situations, rather than having structured, real-time guidance available. Daily call centre team checks were attended by an executive lead, and the investigators heard that these did not always feel a psychologically safe space to properly de-brief following challenging calls.

(11) The investigation heard that while the script was helpful at the beginning, there were inaccuracies and inconsistencies that became evident as the response progressed. There were instances of contradictory details, particularly around dates, which made it difficult to provide clear and confident responses to questions. The scripts themselves were lengthy (around 15 pages) and impractical to navigate during live calls, especially when dealing with distressed or angry individuals. While they provided an initial prompt, staff quickly found they relied less on them over time.

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(12) Staff from HR and organisational development were asked to support the call centre due to their prior experience with similar types of conversations. However, the investigation heard that there was a perception of a general reluctance throughout the rest of the organisation to become involved. Individuals from other teams only did short shifts or partial days, often after requests for assistance were escalated due to stress and burn-out within the clinical governance team who were managing the call centre day-to-day. Later in the response timeline, after the team had already completed approximately 4,000 calls, and a backlog of over 1,000 individuals requiring follow-up, additional support was provided by “Kernow Flex” staff. The flex staff were experienced in similar HR call centre work and contributed mainly to evening shifts (6–8pm) when operating hours were extended. Supplementary staff, including those from HR and OD, received informal training covering scripts, call logging, rota management, and reporting requirements. All staff were also required to be trained on how to use Netcall system.

(13) At the outset, the clinical governance team were instructed to receive and manage complaints relating to the incident, despite these involving staff rather than patients and therefore falling outside their usual remit. Although the team raised concerns about this, they initially complied before the position was later revised following continued challenge. By that stage, however, a number of complaints had already been received and required processing. There was no clear guidance on where these complaints should be directed, resulting in uncertainty and delay. Teams were unclear whether responsibility lay with Information Governance, HR, or another function. Complaints were passed between teams, with differing instructions given at different times, and no consistent agreement on ownership. This led to inefficiencies and confusion, with complaints being redirected multiple times. Additionally, these complaints were recorded within the complaints team’s figures despite not relating to patient experience, creating further administrative burden. Staff handling the complaints were also doing so without full context or access to information about the incident, which added to the challenge of managing them appropriately.

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6.45. The call centre was stood down after approximately 11 weeks, with a decision taken to cease active operations at the end of February 2026, and transition to an answerphone facility to manage any further contact.

6.46. During interviews undertaken during the investigation, the call centre team reflected that their ability to work effectively together was a significant strength. Established relationships and familiarity meant they were able to operate smoothly under pressure; however, it was acknowledged that without this existing cohesion, the situation could have been far more challenging. Feedback from service users was very positive, particularly in relation to the compassion and empathy shown by call handlers.

E-Rostering improvements

6.47. After discovery of the incident the E-rostering lead showed significant initiative in investigating the factors that led to the information being disclosed and implementing measures to prevent a similar incident occurring in the future. Within four days of identifying the issue, they had held meetings to explore the risks associated with hidden data in documents and established a structured process within the team. During this session, the team actively tested different methods of handling data, including attempting to identify and remove hidden information and examining how documents could be manipulated through various paste functions (such as pasting as values versus other formats). This enabled them to understand how hidden links and data could persist within documents. They also considered relevant ICO guidance and other resources regarding handling of hidden data. As a result, the team developed a SOP setting out clear guidance on how information should be prepared, what data must be removed, and the correct processes for securely sharing information going forward. This was shared with the PIU Service Manager for input prior to implementation.

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Investigation staff survey

6.48. As part of the investigation process, a survey was shared with all currently employed RCHT staff to provide anonymous feedback on the incident handling process. 484 staff responded. This should be considered in the context of around 8,000 staff members affected by the incident. The feedback given in the staff survey demonstrates that the dominant perception among those that responded was that the Trust handled the incident poorly once identified, with 54% of respondents selecting “Poorly”. 30% selected “Adequately”. Only 16% selected “Well” or “Very Well.”

6.49. Respondents identified some positive features of the Trust’s response. This included the fact that the incident was acknowledged, that some staff were contacted promptly, that the staff working in the Trust call centre were often professional and empathetic, and that opportunities were created to ask questions. However, respondents more frequently emphasised what they believed should have been done differently: earlier notification (albeit it is unclear whether respondents mean that the spreadsheet should have been spotted sooner after it was posted in 2023, or that once the incident had been identified in 2025, notifications should have been given quicker). Respondents also said that they would have wanted more individualised information on what had been disclosed, more consistent and personalised communication, better follow-through on promised actions (e.g. where a call had been promised), better prepared briefings supported by subject-matter experts, and more practical and emotional support for affected staff.

6.50. The survey respondents told us that email was the most commonly experienced communication method regarding the incident. Where staff experienced email-only contact, this was often associated with lower satisfaction. Personal phone contact and multi-channel communication were generally viewed more positively. Teams meetings were valued by some as a beneficial forum for updates and questions,

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but were frequently criticised among survey respondents overall for poor management, inconsistent messaging and providing inadequate answers for attendees.

6.51. From the perspective of staff completing the survey, the principal lessons for the Trust are:

(1) The need for stronger FOI checking and sign-off processes (albeit that the staff who have completed the survey will be unlikely to know those processes in detail).

(2) More effective training and specialist oversight.

(3) A sense that there needs to be equal protection of staff and patient data.

(4) A more personalised and trauma-informed incident response model, and

(5) Clearer visible accountability and learning.

6.52. Common themes in free-text comments included respondents saying they had experienced emotional distress, loss of trust, concern about ongoing misuse of data, perceived inconsistency with Trust values. Unfortunately, the survey evidence indicates that overall, the respondents to it generally perceived the Trust's overall response to the incident as inadequate in empathy, consistency and reassurance, even where some specific actions were recognised as helpful.

6.53. **Recommendation:** The Trust may want to bear the feedback from this survey in mind in any future response exercise, particularly in situations where an early impression is taken by an audience that certain steps will take place, which is different to what then transpires.

6.54. As is set out above, the scale, pace and circumstances of this incident at the Trust were unique. The Trust's existing incident response processes provided a framework (with some adaptation and iteration) for the response and overall the

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Trust was able to communicate information about incident to a very large number of affected current and former staff in a short timeframe, with further support available for an extended period after the incident came to light. All staff involved in the incident response that have contributed to the investigation have provided valuable and contemplative feedback on what worked well, and where the experience was less positive, with a view to ensuring that, should a similar exercise need to be undertaken in the future (whether by the Trust or other parts of the NHS) the experience from this incident is put to good use.

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Summary of findings, areas for improvement and safety actions

SUMMARY OF FINDINGS

6.55. The incident arose from a chain of control failures across the FOI process rather than a single error.

6.56. The immediate cause was publication of an Excel file containing pivot-table functionality that exposed hidden, line-by-line sickness absence data about named staff. This was not in accordance with the Trust's FOI SOP. Contributory factors included:

(1) Allocation of the request to collate data to a team without the strongest workforce-data-wrangling expertise.

(2) Apparent limited awareness of pivot-table and hidden-data risks.

(3) Over-reliance (in the FOI process in force at the time) on Excel inspection tools that do not remove pivot-table source data.

and

(4) The process of converting spreadsheet material before disclosure/publication was not followed or challenged during the creation, checking or data release stage of the workflow. An intrinsic weakness in the FOI process at the time was that any conversion of material into a more secure (PDF) format was the very last step of the procedure and there was no cross-checking following that. If (as here) that step was not done, then there would be an uncontrollable disclosure of any information which was not intended for disclosure.

6.57. As a result of this, sensitive personal data was disclosed inappropriately and outside the scope of the original FOI request.

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6.58. Over the last three years, the Trust has updated its FOI management processes in a way which provide additional human controls to avoid the release of similar information. The main areas for potential improvement to avoid similar incidents happening in the future are:

(1) To ensure that further organisational controls for checking spreadsheets and datasets are incorporated into the FOI SOP, in particular ensuring that the FOI response process is updated to require that data files are converted to CSV wherever possible before disclosure, and incorporating other recent elements of the ICO guidance into the Trust's FOI processes.

(2) Embedding clearer guidance on pivot tables and hidden data risks into FOI procedures, particularly for information holders, while recognising that this recommendation is also applicable to other disclosures.

(3) Maintaining the second-stage review of disclosure material.

(4) Increasing the use of SharePoint or other file-sharing mechanisms, rather than email, which allow access to disclosed data to be turned off if it is shared in error, and exploring other technical data loss prevention tools.

(5) To ensure that there is clear accountability and capability across staff working in FOI and wider data-sharing processes to identify the potential risks from large volumes of sensitive information being shared, as the nature of the incident here is unlikely to be solely FOI-specific.

(6) To explore whether additional technical controls can be put in place to guard against inadvertent loss of data under FOIA (and to limit its exposure if it is disclosed). This recommendation is applicable to wider scenarios where data loss prevention may be desirable (beyond FOIA), but the Trust will need to balance this with the general need of the Trust and stakeholders to ensure the timely and right-touch levels of security to promote the efficient exchange of information.

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6.59. Once the breach was identified in November 2025, the Trust acted promptly and in good faith to remove the material, report the incident, notify affected individuals and strengthen safeguards. On the evidence reviewed, the Trust met its core reporting obligations and implemented the Information Commissioner's advice in these regards.

6.60. The Trust was able to notify a very large number of staff about the incident and did so promptly. Staff worked collegiately, with candour and at pace to try to ensure that there was assurance that incident was isolated, and that everyone was told about it as quickly and comprehensively as possible.

6.61. However, the response highlighted important lessons on aspects of preparedness (which is reflective of the unprecedented nature and scale of the incident within the Trust), including communications, business continuity, staff support and the operational burden of managing a large-scale data breach.

6.62. Affected staff described distress, loss of trust and concern about misuse of their personal information. Staff supporting the response, particularly in the contact centre and incident team, also experienced significant emotional and operational pressure, often with limited preparation, workspace or structured support.

6.63. Recommendations for the Trust in this regard are:

(1) Widening role-specific training on data handling across the organisation, not limited to the FOI context, but for all staff routinely involved in data analytics where large datasets may be shared externally or with large audiences in their work.

(2) Ensuring there is an appropriate level of support and resources for staff managing high-volume contact operations.

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(3) Ensuring there are effective deputisation and knowledge-sharing arrangements so that the Trust is not over-reliant on single members of staff to coordinate or deliver key steps in incident responses.

(4) Integrating the data breach process into Emergency Planning and Resilience Response processes more generally, with incident planning factoring in data loss events as well as cyber-attacks, recalls or other large-scale staff or patient contact exercises (and to incorporate into the data breach policy the possibility that a data breach may affect large numbers of people; it seemed to the investigators that it was geared more towards smaller incidents).

(5) To ensure that (in so far as possible) that prior to going live with a recall or mass contact exercise, those that are engaged in the exercise have had sufficient time to prepare.

(6) To ensure that (as far as possible) there are appropriate practical resources available to the incident response team both in the course of the incident, even if a critical- or major incident is not prepared.

(7) To carefully consider (particularly if a critical- or major- incident is not declared) the balancing of resources which are needed for the incident response with other caseloads.

(8) Ensuring that future engagement with affected individuals in any incident continues to be timely, consistent and trauma-informed.

(9) Continuing to debrief staff involved in the incident response and to take account of feedback from affected staff to help inform any response to similar incidents in future.

6.64. The safety actions contained in the associated action plan are intended to reduce recurrence risk, strengthen assurance over appropriate disclosures, and improve resilience in future responses. Other recommendations may be found in the body of the report.

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References

Legislation

- Data Protection Act 2018.
- Freedom of Information Act 2000.
- UK General Data Protection Regulation.

Guidance

- Information Commissioner's Office, *"Means of communicating information (section 11)"* *Means of communicating information (section 11) | ICO*
- Information Commissioner's Office, "*How to disclose information safely: Removing personal data from information requests and datasets"* *How to disclose information safely*
- Information Commissioner's Office, "*Advisory note to public authorities"* *Information Commissioner's Office - Advisory note to public authorities | ICO*
- Information Commissioner's Office, *"Disclosing documents to the public securely: hidden personal information and how to avoid an accidental breach"* *Disclosing documents to the public securely: hidden personal information and how to avoid an accidental breach | ICO*
- Information Commissioner's Office, *"Checklist and sign off for public authorities to use for the safe disclosure of information from Excel"* *disclosure-checklist-v1_0.docx*
- Cabinet Office, *"Freedom of Information Guidance: Communication by Spreadsheet"* Freedom of Information Guidance: Communication by Spreadsheet - GOV.UK
- Royal Cornwall Hospitals NHS Trust, *"Freedom of information Guidance for Information Holders"* *Freedom of information Guidance for Information Holders v1.docx*

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Policies and Procedures:

- Royal Cornwall Hospitals NHS Trust, "*Information Use Framework Policy*", November 2022.
- Royal Cornwall Hospitals NHS Trust, *"Data Breach Policy"*, December 2023.
- Royal Cornwall Hospitals NHS Trust, *"Management of Information, Records and Data Quality Policy"*, May 2024.
- Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust, *"Acceptable Use Policy",* July 2024.
- Royal Cornwall Hospitals NHS Trust, "*Information Security Policy"*, August 2024.
- Royal Cornwall Hospitals NHS Trust, "*Information Use Framework Policy"*, October 2025.
- Royal Cornwall Hospitals NHS Trust, "*Information Use Framework Policy"*, November 2025.
- Royal Cornwall Hospitals NHS Trust, "*Standard Operating Procedures*", March 2021, v. 21.
- Royal Cornwall Hospitals NHS Trust, "*Standard Operating Procedures*", September 2023 v. 24.
- Royal Cornwall Hospitals NHS Trust, "*Standard Operating Procedures*", February 2026, v. 26.
- Royal Cornwall Hospitals NHS Trust, *"Confidentiality Audit Procedure"*, August 2024.
- Royal Cornwall Hospitals NHS Trust, *"Emergency Preparedness, Resilience and Response (EPRR) Strategy"*, January 2026.
- Royal Cornwall Hospitals NHS Trust, *"Data sharing tips, tricks and pitfalls".*

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Email Correspondence and Other Documents, including:

- Email chain regarding the initial report of a data breach to the Information Governance Team, subsequently forwarded to senior management, 17 November 2025 and 19 November 2025.
- Data Security and Protection Toolkit, dated 21 November 2025, in relation to the reported incident.
- Email from the Information Governance Team concerning sending spreadsheets, 25 November 2025.
- Monday Executive Meeting regarding the FOIA breach, 25 November 2025.
- Frequently Asked Questions page set up on the Trust's intranet.
- A computer coding script developed and applied to categorise the severity of sickness information by reason.
- Royal Cornwall Hospitals NHS Trust FOI Incident Call Handler Scripts and FAQs, 01 December 2025.
- NetCall Cover Rota for staff working in the call centre.

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Unique ID	Recommendation ID	Recommendations and advisories	Recommendation Theme	Safety Action	Patient Safety Action Hierachy Rating	Pathway Impact	Problem Being Solved	Steps to Success	Owner	Supporting Teams	Interdependencies	Actions	Risks to Delivery	Mitigation Plan	Implementation Date	Milestone Dates	Progress Status	Evidence of Completion	Outcome Measure	Review Frequency	Safety Oversight
1	R1: Widening role-specific training on data handling across the organisation, not limited to the FOI context, but for all staff routinely involved in data analytics where large datasets may be shared externally or with large audiences in their work.	Within 3 months, revise the FOI SOP and Information Holder guidance to require CSV conversion where practicable, hidden-data checks, independent second review and publication only in the approved format.	Safer preparation, checking and disclosure of spreadsheets and datasets	Revise and ratify FOI SOP and Information Holder guidance requiring CSV conversion where practicable, hidden-data checks, independent second-person review, and publication only in approved formats.	Moderate - Rules, policies and procedures	Information disclosure process	Risk of inadvertent disclosure of hidden spreadsheet data during FOI responses.	1. Draft revised SOP 2. Consultation and approval 3. Communicate changes 4. Implement compliance monitoring	Head of Information Governance	Information Governance Team	1. IG Team capacity 2. Approval through the Information Governance Group 3. Alignment with the FOI SOP, disclosure checklist and approved publication formats.	1. Finalise the revised FOI SOP and Information Holder guidance. 2. Define when CSV, PDF or Excel may be used and document exceptions. 3. Introduce a mandatory hidden-data check and independent second-person review. 4. Table through the Information Governance Group for approval. 5. Communicate the changes to Information Holders and FOI officer. 6. Implement monthly compliance sampling and report exceptions.	None	The guidance provided will be clear that unelss stated no excel sheets should be provided to the FOI function, they should be converted to pdf prior to submission	10/09/2026	none	completed	Ratified SOP and guidance	100% sampled disclosures demonstrate compliance	Monthly checks will be undertaken to ensure authorisation for exec sheets to be sent has been obtained.	Information Governance Group / SIRO
2	R1: Widening role-specific training on data handling across the organisation, not limited to the FOI context, but for all staff routinely involved in data analytics where large datasets may be shared externally or with large audiences in their work.	Evaluate FOI files to establish if new processing is effective	Safer preparation, checking and disclosure of spreadsheets and datasets	Audit of sampled FOI files for evidence of CSV conversion and second-person review	Moderate -Monitoring and checking	Information disclosure process	Lack of assurance that revised controls are consistently applied.	1. Audit FOI responses to establish if new processes has been implemented and followed	Head of Information Governance	Information Governance Team	1. Completion and approval of the revised FOI SOP under Action 1 2. IG Team capacity	1. Develop an audit methodology and sample criteria. 2. Audit evidence of format conversion, hidden-data checks and second-person review. 3. Escalate repeated exceptions to the Information Governance Group 4. Repeat the audit monthly until sustained compliance is demonstrated.	IG capacity to undertake regular reviews	Where gaps are identified further training and documented support will be provided to those teams who are responsible for data analytics.	30/11/2026	31/10/2026	Started	Confirmaton of current practices along with any supporting documentation	Audit compliance rate		Information Governance Group
3	R1: Widening role-specific training on data handling across the organisation, not limited to the FOI context, but for all staff routinely involved in data analytics where large datasets may be shared externally or with large audiences in their work.	Complete a training needs analysis for all those undertaking data handling on pivot tables, hidden data, document inspection limits, and lawful disclosure.	Safer preparation, checking and disclosure of spreadsheets and datasets	Complete a training needs analysis for staff undertaking data handling activities.	Low-Training and education	Workforce capability	Knowledge gaps relating to spreadsheet risks and lawful disclosure.	1. Identify staff groups 2. Assess competencies 3. Define training requirements	Head of BIU eRoster Manager Finance Manager Head of IG	Learning & Development, CITS	1. Timely input from BIU, Finance, eRoster, CITS, Learning and Development and Head of IG 2. Access to existing SOPs and training records identification of all staff groups handling large datasets.	1. Identify teams and roles routinely creating, analysing or externally sharing datasets. 2. Gather existing SOPs, guidance, training materials and competency records. 3. Assess current knowledge of pivot tables, hidden data, document inspection and lawful disclosure. 4. Identify role-specific competency gaps and priority groups. 5. Agree required learning outcomes with Learning and Development/CITS. 6. Produce and approve a documented training needs analysis and delivery plan.	Difficulty identifying all relevant staff groups and data-handling activities delayed or incomplete responses from BIU, Finance, eRoster and other teams inconsistent competency information insufficient Learning and Development capacity.		31/12/2026	30/11/2026	Started	Completed TNA report	Training needs analysis approved		Information Governance Group / Workforce Committee
4	R1: Widening role-specific training on data handling across the organisation, not limited to the FOI context, but for all staff routinely involved in data analytics where large datasets may be shared externally or with large audiences in their work.	Deliver role-specific training on	Safer preparation, checking and disclosure of spreadsheets and datasets	Deliver role-specific training on pivot tables, hidden data, document inspection limitations and lawful disclsure.	Low-Training and education	Workforce capability	Staff may not recognise hidden-data risks in spreadsheets.	1. Develop materials 2. Deliver training 3. Assess competence 4. monitor compliance	SIRO	Learning & Development, CITS	1. Completion of the training needs analysis under Action 3 2. Availability of subject-matter experts 3. Learning and Development/CITS capacity 4. Manager support for staff release 5. Access to a training platform and competency assessment method.	1. Develop role-specific materials based on the approved training needs analysis. 2. Include practical examples covering hidden data, pivot tables, metadata, document inspection limits and secure disclosure. 3. Pilot the training with BIU, Finance and eRoster staff. 4. Refine materials following feedback. 5. Deliver mandatory training to priority groups and assess practical competence. 6. Establish completion monitoring, refresher training and escalation for non-compliance.	Difficulty identifying all relevant staff groups and data-handling activities delayed or incomplete responses from BIU, Finance, eRoster and other teams inconsistent competency information insufficient Learning and Development capacity.	The three main contributors of excel files have been identified. The guidance has been updated to ensure no excel sheets are submitted without appropraite checks or need.	31/01/2027		Started	Training attendance and competency records	Training completion rate and knowledge improvement		Workforce Committee
5	R1: Widening role-specific training on data handling across the organisation, not limited to the FOI context, but for all staff routinely involved in data analytics where large datasets may be shared externally or with large audiences in their work.	Incident review of data handling errors to look for patterns and themes	Safer preparation, checking and disclosure of spreadsheets and datasets	Implement routine incident review process for data handling errors to identify patterns, themes and learning.	Moderate -Monitoring and checking	Organisational learning	Repeated errors may occur without systematic review and learning.	1. Review incidents 2. identify themes 3. share learning 4. track actions	Head of Information Governance		2. Consistent incident coding and reporting access to historic Datix records 3. Input from IG, Patient Safety and relevant service leads	1. Define search terms and incident categories for data-handling errors and near misses. 2. Review relevant Datix incidents for the agreed look-back period. 3. Analyse root causes, contributory factors, controls and recurring themes. 4. Confirm action owners and due dates for identified improvements. 5. Share learning with affected teams and incorporate themes into training and guidance. 6. Report findings and overdue actions to the Digital Governance Board/SIRO.	Data-handling incidents and near misses are under-reported or inconsistently categorised insufficient capacity for thematic review unclear ownership of resulting actions learning is not shared or embedded across relevant services.	We will review the outcome of the Datix review to determine mitigations.	30/11/2026		Not Started	Incident review reports	Reduction in spreadsheet-related incidents and near misses		Digital Governance Board / SIRO
	R2:Ensuring there is an appropriate level of support and resources for staff managing high-volume contact operations	Assess the exisitance of proportionate technical controls. Investigate the benefits of implementing secure file sharing, and data-loss prevention tools, to support high-risk disclosures.EPP	Safer preparation, checking and disclosure of spreadsheets and datasets	Provide summary of options	High	Digital information governance	Reliance on human controls without technical safeguards.	1. Assess options 2. Produce business case if additional software is identified as adding benefit 3. Approve solution implemented	Head of Information Governance/CITS	CITS	CITS, Cyber Security, Information Governance, Procurement, Finance and Information Asset Owner input	1 Evaluate available technical and procedural options, including costs and limitations. 2 Produce an options appraisal and business case with a recommended implementation plan.	Benefits and proportionality are difficult to evidence	Continue to use current technical solutions with enahanced controls.	30/11/2026						
7	R3: Ensuring there are effective deputisation and knowledge-sharing arrangements so that the Trust is not over-reliant on single members of staff to coordinate or deliver key steps in incident responses	Update the Data Breach Policy and related continuity/EPPR plans to include crossover management for mass data-loss events.	Preparedness, staff support and governance in large-scale data breach response	Implement a formal deputisation and knowledge-transfer framework for all key Information Governance and incident management roles.	Moderate -Standardisation and Simplification	Workforce capability	Over-reliance on key individuals can reduce resilience during incident response.	1. Identify critical roles 2. Nominate deputies 3. Create handover documentation 4. Test through exercises	EPPL		1. EPRR Lead involvement 2. Agreement of critical IG and incident-management roles 3. Availability and competence of nominated deputies 4. HR/workforce support 5. Protected time for knowledge transfer 6. Alignment with business continuity plans.	1. Identify all critical roles and single points of failure in major information incident response. 2. Nominate primary and secondary deputies for each role. 3. Document minimum competencies, authority levels, escalation routes and contact details. 4. Create role packs, handover notes and accessible response checklists. 5. Provide shadowing and scenario-based training for deputies. 6. Test arrangements through an exercise and address identified gaps. 7. Review the framework at least annually and after staffing or process changes.	Suitable deputies cannot be identified because of limited capacity or specialist knowledge protected time for knowledge transfer is unavailable handover documentation becomes outdated arrangements are not tested or maintained following staff changes.		31/01/2027		Not Started	Drop down escalation list of suitable informed and trained managers	100% of critical roles have documented deputy arrangements		Information Governance Group
8	R4Integrating the data breach process into Emergency Planning and Resilience Response processes more generally, with incident planning factoring in data loss events as well as cyber-attacks, recalls or other large-scale staff or patient contact exercises (and to incorporate into the data breach policy the possibility that a data breach may affect large numbers of people it seemed to the investigators that it was geared more towards smaller incidents)	Introduce a staff-support standard for major information incidents, covering briefing, escalation, debrief, psychological support, workspace and workload management.	Preparedness, staff support and governance in large-scale data breach response	Update Data Breach Policy, EPRR plans and business continuity arrangements to ensure major information incidents are managed through established emergency response arrangements.	Moderate - Rules, policies and procedures	Emergency planning and business continuity	Large-scale information incidents may not receive a coordinated emergency response.	1. Review policies 2. Update plans 3. Complete tabletop exercise 4. Implement learning	TRIM lead / EPRR Lead / SIRO		1. Joint ownership across IG, EPRR, TRIM led, Communications, CITS/Cyber and business continuity leads 2. Agreement on incident thresholds and command structure 4. Policy approval timetable 5. Exercise capacity 6. Executive Leadership Team oversight.	1. Review the Data Breach Policy, EPRR plans and business continuity arrangements for gaps relating to mass data-loss events. 2. Define thresholds for declaring and escalating a major information incident. 3. Align command, control, communications, decision logging and reporting arrangements. 4. Include scenarios affecting large numbers of patients or staff. 5. Obtain approval through the relevant governance routes. 6. Complete a multi-agency tabletop exercise. 7. Record, assign and track exercise actions to completion.	Misalignment between IG, EPRR and business continuity procedures limited availability of subject-matter experts and approval forums disagreement over incident thresholds and command arrangements tabletop exercises are delayed or identified actions remain unresolved.		28/02/2027		Not Started	Updated policy and completed exercise	Successful exercise and closure of actions		Executive Leadership Team / Audit and Risk Committee
9	R5:To ensure that (in so far as possible) that prior to going live with a recall or mass contact exercise, those that are engaged in the exercise have had sufficient time to prepare	Introduce a staff-support standard for major information incidents, covering briefing, escalation, debrief, psychological support, workspace and workload management.	Preparedness, staff support and governance in large-scale data breach response	Introduce a mandatory readiness assessment and planning checklist before any large-scale recall or patient-contact exercise.	Moderate -Standardisation and Simplification	Emergency planning and business continuity	Mass-contact exercises may commence without adequate preparation.	1. Develop checklist 2. Agree approval process 3. Implement 4. Audit compliance	Chief People Officer	People & OD	1. Alignment with the updated EPRR and Data Breach arrangements under Action 8 2. Operational, clinical, communications, IG, patient experience and administrative input 3. Agreed approval authority	1. Develop a mandatory readiness checklist for mass-contact exercises. 2. Include scope, affected cohort, data quality, lawful use, communication routes, staffing, scripts, escalation, welfare and contingency arrangements. 3. Define minimum lead times and an exception process for urgent cases. 4. Assign a senior officer to approve readiness before launch. 5. Pilot the checklist through an exercise or planned contact activity. 6. Audit compliance and report exceptions to the Operational Governance Group.	Operational teams bypass the readiness assessment because of urgent timescales checklist ownership and approval authority are unclear insufficient planning information is available before launch compliance monitoring is not established.		31/03/2027		Not Started	Estabilsed and accessible mandatory readiness assessment and planning checklist	100% compliance with readiness assessment process		?
10	R6:To ensure that (as far as possible) there are appropriate practical resources available to the incident response team both in the course of the incident, even if a critical- or major incident is not prepared	Introduce a staff-support standard for major information incidents, covering briefing, escalation, debrief, psychological support, workspace and workload management.	Preparedness, staff support and governance in large-scale data breach response	Develop and maintain an incident-response resource plan covering workspace, equipment, administrative support and wellbeing support.	Moderate -Administrative Controls	Emergency planning and business continuity	Response teams may lack resources required for sustained incident management.	1. Define resource requirements 2. Create deployment arrangements 3. Test via exercise 4. Review after incidents	Chief Operating Officer	EPRR Lead	1. EPRR and business continuity planning 2. workspace availability, 3. CITS, telephony, administrative, communications, HR and wellbeing support	1. Define the staff, workspace, equipment, system, telephony, administrative and wellbeing resources required for a sustained response. 2. Identify named resource providers, activation routes and out-of-hours contacts. 3. Establish arrangements for rapid system access, equipment deployment and secure working. 4. Document contingency arrangements for prolonged or concurrent incidents. 5. Test the resource plan through an exercise. 6. Review resource availability after exercises and incidents and update the plan.	Required workspace, equipment, administrative support or wellbeing resources are unavailable during a major incident resource assumptions are not funded or maintained competing incidents create simultaneous demand deployment arrangements are not exercised.		31/03/2027		Not Started	Incident-response resource plan	Post-incident reviews confirm resource availability		Executive Leadership Team
11	R6:To ensure that (as far as possible) there are appropriate practical resources available to the incident response team both in the course of the incident, even if a critical- or major incident is not prepared	Introduce a staff-support standard for major information incidents, covering briefing, escalation, debrief, psychological support, workspace and workload management.	Preparedness, staff support and governance in large-scale data breach response	Implement staff-support standards including briefing, escalation, debrief, psychological support and workload management following major incidents.	Moderate -Administrative Controls	Workforce wellbeing	Staff wellbeing impacts may not be recognised or managed during prolonged incidents.	1. Develop support standard 2. Communicate 3. Implement 4. Review uptake	Chief People Officer	People & OD	1. People and Culture, Occupational Health, staff wellbeing services, line managers, EPRR and incident commanders 2. Alignment with Action 10 resource planning access to confidential and out-of-hours support staff communications channels.	1. Develop a staff-support standard for major information incidents. 2. Define requirements for briefings, shift management, rest breaks, escalation, debriefing and psychological support. 3. Clarify manager responsibilities and referral routes. 4. Ensure confidential and out-of-hours support options are available. 5. Communicate the standard and include it in incident response documentation. 6. Test the arrangements through an exercise and review after each major incident.	Staff-support standards are not consistently applied across services managers are unaware of escalation routes or available support operational pressures prevent staff from accessing support or debriefs confidentiality concerns reduce uptake.		31/03/2027		Not Started	Published staff-support standard for major information incidents	Uptake of support offers and positive staff feedback		People Committee
12	R6:To ensure that (as far as possible) there are appropriate practical resources available to the incident response team both in the course of the incident, even if a critical- or major incident is not prepared	Introduce a staff-support standard for major information incidents, covering briefing, escalation, debrief, psychological support, workspace and workload management.	Preparedness, staff support and governance in large-scale data breach response	Monitor uptake of wellbeing and support services following major incidents and use findings to improve support provision.	Moderate -Monitoring and checking	Workforce wellbeing	Lack of feedback may prevent improvement of support arrangements.	1. Collect data 2. Analyse themes 3. Report findings 4. Implement improvements	Chief People Officer		1. Implementation of the staff-support standard under Action 11 2.Reliable and appropriately anonymised monitoring data 3. Occupational Health and wellbeing service input	1. Agree proportionate measures of support uptake, timeliness, accessibility and perceived effectiveness. 2. Establish confidential feedback methods that minimise identification risk. 3. Collect information following exercises and qualifying incidents. 4. Analyse themes by service and support type without identifying individuals. 5. Report findings and recommendations to the People Committee. 6. Assign and track improvements to support provision. 7. Review whether changes have improved staff experience.	Low uptake or incomplete data produces an unreliable assessment of need confidentiality and staff trust concerns limit feedback measures focus on activity rather than effectiveness findings are not translated into service improvements.		31/03/2027		Not Started	Staff awareness of staff-support standard for major information incidents	Improved utilisation and staff satisfaction		?

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13	R7: To carefully consider (particularly if a critical- or major- incident is not declared) the balancing of resources which are needed for the incident response with other caseloads	Introduce a staff-support standard for major information incidents, covering briefing, escalation, debrief, psychological support, workspace and workload management.	Preparedness, staff support and governance in large-scale data breach response	Implement a workforce escalation framework supporting redeployment, prioritisation and suspension of non-critical work during major incidents.	Moderate -Administrative Controls	Operational resilience	Competing operational demands can hinder effective incident response.	1. Define triggers 2. Develop framework 3. Approval 4. Test via exercise	Chief Operating Officer / Chief People Officer	EPRR Lead	1. Agreement between Chief Operating Officer and Chief People Officer 2. Input from EPRR, HR, service leads and finance 3. workforce availability and competence data 4. union/professional requirements 5. alignment with business continuity and critical service priorities.	1. Define incident severity and capacity triggers for workforce escalation. 2. Identify activities that may be deferred, reduced or suspended and those that must continue. 3. Establish decision rights, accountability, documentation and review requirements. 4. Create a register of staff who may be redeployed and the competencies/access they require. 5. Include fatigue, welfare, handover and backlog-recovery arrangements. 6. Review and update it following exercises or incidents.	Insufficient staff are available for redeployment business-critical activity is incorrectly suspended or prioritised roles, triggers and decision rights are unclear workforce or professional constraints delay reassignment prolonged incidents create fatigue and backlogs.	There will be a flexible framework designed to cover any type of breach or recall regardless of scale and impact that will be built on the existing Strategic, Tactical and Operational Incident Response principles. It will enable the level and type of resources required to be determined proportionately according to the circumstances of the incident. From the framework a specific incident response plan can be produced to address the various requirements, the main one being resources. These resources should be drawn from across the organisation to provide sufficient resilience and capacity, while ensuring that no single team or department is disproportionately affected by the response.	31/03/2027		Not Started	Published workforce escalation framework	Evidence of workforce review during incidents		Executive Leadership Team
14	R8: Ensuring that future engagement with affected individuals in any incident continues to be timely, consistent and trauma-informed	Establish a formal post-incident learning review process with debriefs, review of communications and complaints themes, and reporting of lessons and action completion.	Preparedness, staff support and governance in large-scale data breach response	Develop and implement a trauma-informed communication standard for affected patients, families and staff during major information incidents.	Moderate -Administrative Controls	Patient and staff experience	Communication may be inconsistent and not meet the needs of affected individuals.	1. Develop standard 2. Train staff 3. Embed in procedures 4. Monitor feedback	Head of Communications	Head of Communications	1. Communications, Patient Experience, PALS/Complaints, clinical teams, IG/DPO, Legal Services and accessibility/translation services 2.input from those affected 3. alignment with incident command and approval processes.	1. Develop a trauma-informed communication standard for patients, families and staff. 2. Define principles for timeliness, clarity, empathy, candour, accessibility and consistency. 3. Create approved templates and scripts for initial notification, updates, apology, support and closure. 4. Establish legal, clinical, IG and communications review routes that support urgent release. 5. Train staff who may communicate with affected individuals. 6. Test materials with Patient Experience and accessibility representatives. 7. Monitor complaints and feedback and update the standard accordingly.	Limited access to trauma-informed communications expertise and training inconsistent messages across channels or teams urgent communications are issued before appropriate review accessibility and individual communication needs are not fully addressed legal, clinical and reputational considerations delay approval.		31/03/2027		Not Started	Creation and implementation of a trauma-informed communication standard	Reduced communication-related complaints		?
15	R8: Ensuring that future engagement with affected individuals in any incident continues to be timely, consistent and trauma-informed	Establish a formal post-incident learning review process with debriefs, review of communications and complaints themes, and reporting of lessons and action completion.	Preparedness, staff support and governance in large-scale data breach response	Implement a structured post-incident learning programme including debriefs, thematic analysis, action tracking and board oversight.	Moderate - Monitoring, Feedback and Learning	Organisational learning	Learning from incidents may not be consistently captured or implemented.	1. Establish debrief process 2. Use standard template 3. Track actions 4. Board reporting	Associate Director of Quality Governance / Patient Safety Specialist	Associate Director of Quality Governance / Patient Safety Specialist	1. Incident debrief process 2. Datix and complaints information 3. Participaton from IG, Patient Safety, Communications, People and operational leads 4. Action-tracking system 5. Governance capacity at Audit and Risk Committee 6. linkage with Action 16.	1. Define which incidents require a formal post-incident review and the required timescale. 2. Introduce a standard debrief and learning-review template. 3. Include incident chronology, decisions, communications, staff feedback, complaints, controls and root causes. 4. Assign each improvement action an owner, deadline, evidence requirement and outcome measure. 5. Maintain a central action tracker with escalation for overdue actions. 6. Report themes and progress to the Audit and Risk Committee. 7. Verify that completed actions have reduced the identified risk.	Debriefs are delayed or poorly attended staff are reluctant to provide candid feedback actions lack clear owners, deadlines or resources learning is not shared across governance forums board oversight does not result in timely closure of actions.		31/03/2027		Not Started	Creation and implement a structured post-incident learning programme	100% of qualifying incidents receive formal debrief		Audit and Risk Committee
16	Ensure there is a documented and approved disaster recovery plan cover Information Governance acitivites following an incident.	Develop, approve and test a disaster recovery plan covering Information Governance activities following a major incident or service disruption.	Information governance resilience and continuity	Develop and maintain an approved Information Governance disaster recovery plan with defined recovery priorities, roles, dependencies and testing arrangements.	Moderate - Rules, policies and procedures	Business continuity and information governance	Information Governance services may not be restored consistently or promptly following a major incident.	1. Identify critical IG activities 2. Define recovery arrangements 3. Approve the plan 4. Test and improve	Head of Information Governance	EPRR, Business Continuity, CITS, Cyber Security, DPO, Records Management, Communications and operational service leads	1. Alignment with organisational business continuity and disaster recovery arrangements 2. Identification of critical IG processes, systems, records and suppliers 3. Availability of recovery locations, systems and trained deputies 4. Approval through the Information Governance Group and relevant resilience forum	1. Identify critical Information Governance activities, systems, records, suppliers and maximum tolerable periods of disruption. 2. Define recovery priorities, minimum staffing, deputy arrangements, manual workarounds and alternative communication routes. 3. Document dependencies on CITS, Cyber Security, EPRR, suppliers and operational services. 4. Establish activation, escalation, decision-logging and return-to-normal arrangements. 5. Obtain formal approval and make the plan accessible to authorised staff during an outage. 6. Test the plan through a tabletop exercise and record improvement actions. 7. Review the plan annually and after incidents, exercises or material service changes.	Critical dependencies or recovery requirements are not fully identified; key staff or systems are unavailable during disruption; the plan becomes outdated; testing is delayed or actions remain unresolved.	Use the corporate business continuity framework, maintain offline access to essential contacts and procedures, nominate deputies, and track exercise actions through the Information Governance Group.	31/03/2027	31/01/2027	Not Started	Approved Information Governance disaster recovery plan and completed exercise report with tracked actions	100% of critical IG activities have documented recovery arrangements and all high-priority exercise actions are closed by due date	Annual and after each qualifying incident, exercise or material change	Information Governance Group / Digital Governance Board
17	Ensure the organisation is aware of all transfers of information realting to staff, patients and service users.	Establish and maintain an organisation-wide record of transfers of personal information relating to staff, patients and service users.	Transparency and control of information sharing	Update Record of Processing Activity covering routine and ad hoc transfers, lawful basis, recipients, methods, safeguards and review dates.	Moderate - Standardisation and Simplification	Information sharing and data governance	The organisation may not have complete oversight of where personal information is sent, why it is transferred or whether appropriate safeguards are in place.	1. Define scope and standard 2. Map current transfers 3. Create central register 4. Validate and review	Data Protection Officer / Head of Information Governance	Information Asset Owners, Information Asset Administrators, CITS, Cyber Security, HR, Finance, Procurement, Research, clinical and operational services	1. Complete and accurate input from all services and Information Asset Owners 2. Alignment with the Record of Processing Activities, data-flow maps, contracts and Data Protection Impact Assessments 3. Agreed ownership and system for maintaining the register 4. Procurement and supplier information	1. Define which internal, external, routine and ad hoc information transfers must be recorded. 2. Create a standard register capturing data subjects, data categories, purpose, lawful basis, source, recipient, frequency, transfer method, location, retention and safeguards. 3. Require each service and Information Asset Owner to identify and validate current transfers. 4. Reconcile the register with the Record of Processing Activities, contracts, DPIAs, data-flow maps and supplier records. 5. Assess high-risk, international or insecure transfers and assign remedial actions. 6. Establish approval and notification processes for new or changed transfers. 7. Review the register quarterly and report gaps or overdue actions to the Information Governance Group.	Services fail to identify informal or historic transfers; register information becomes outdated; ownership is unclear; supplier and international transfer details are incomplete; remediation is delayed.	Issue mandatory guidance and a standard template, obtain senior owner attestation, reconcile against existing governance records, prioritise high-risk transfers and escalate non-responses or overdue actions.	01/03/2027	31/01/2027	Not Started	Approved central information-transfer register with service-level attestations and remediation log	100% of services submit and attest their transfers; 100% of identified high-risk transfers have documented safeguards or an approved remediation plan	Quarterly and whenever a transfer is introduced or materially changed	Information Governance Group / SIRO

Neave,Lynsey
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Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 09

Title of Report: Urgent Care Update and Ending Corridor Care

Executive Director Lead: Robin Jones, Chief Operating Officer and Acting Deputy Chief Executive, Merry Kane, Chief Medical Officer, Bernadette George, Acting Chief Nurse

Author and Job Title: Robin Jones, Chief Operating Officer and Acting Deputy Chief Executive, Merry Kane, Chief Medical Officer, Bernadette George, Acting Chief Nurse, Liz Trew, Deputy Chief Operating Officer (Clinical)

Email Address: robin.jones2@nhs.net

Purpose of the Report:

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

To provide the Committee with the actions to end Corridor Care and provide assurance on performance on the Urgent and Emergency Care against the recovery plan and agreed trajectories submitted to NHSE in August to being us back to the Trusts 2026 /2027 Annual Operating plan requirements.

Consultation:

This report summarises actions being taken across a wide range of specialties, primarily by the Medicine Division leadership team and colleagues across the Trust.

Urgent Care actions are also supported by partners across Cornwall and the Isles of Scilly health and social care system, including voluntary sector providers.

The report has been written to draw together reports from a range of sources and represent the actions being taken across the four Divisions. The report is a specific report for the committee and consultation is achieved through the coordination of the Clinical Vision of Flow.

The report complements the weekly updates from the Chief Executive Officer to Trust Board Members.

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The report was discussed in detail at the October Quality Assurance Committee.

This report contains updated data from the review by the Quality Assurance Committee but has not been materially updated in the interests of providing the update for the benefit of the Public Board and transparency of the overall focus of the Trust.

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 wellbeing, and the quality of care for all patients and staff.
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 inequalities in benefits from those services	N/A
Sustainable and efficient	N/A

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Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
use of NHS resources by RCHT	

Recommendation(s):

The Board is recommended to:

- **Discuss for assurance** we are not meeting the current UEC recovery trajectories and additional actions being taken to bring us back to the improvement trajectories
- **Note** progress to date on the GIRFT 11 Point Recovery Plan (Appendix A)
- **Note** the Chief Operating Officer's escalation of No Criteria to Reside and **support** continued action with system partners to reduce delays and deliver agreed trajectory; and
- **Take assurance** from the marked reduction in ward area corridor care since 29 September 2026, recognising that Emergency Department corridor care has not been fully eliminated, and the improvement is not yet proven to be sustained.

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Urgent Care Update and Ending Corridor Care

1. Executive Summary

Urgent and Emergency Care (UEC) performance remains under significant pressure and is currently behind the agreed trajectories. For the month to 27 October 2026, Type 1 four-hour performance was 51.3% against a trajectory of 62.54% (September performance 47.17%) and 17.15% of patients spent more than 12 hours in the Emergency Department (ED) against a trajectory of 10.5% (September performance 14.31%). Average ambulance handover times 28 minutes (September performance 45 minutes).

The Trust is therefore not currently meeting the agreed UEC recovery trajectories. ED crowding, prolonged waits, escalation capacity and corridor care therefore remain material quality, safety, patient experience, workforce and regulatory risks. Risk 9048, ED Overcrowding, remains the Trust's highest-scored risk at 25.

The Trust continues to deliver the recovery actions through the weekly Clinical Vision of Flow (CVoF) meetings, which provide oversight of the GIRFT Action Plan set out in Appendix A. The approach combines daily operational grip, clinical leadership, specialty ownership, discharge optimisation, timely diagnostics and therapy, and work with system partners to reduce Pathway 2 and 3 delays.

A marked reduction in corridor care followed the instruction to cease ward-based corridor spaces from 29 September 2026. The Trust is not currently using ward corridor care spaces which has been the case for most of the month of October. The Trust ambition is to have ended corridor care use by the end of October and as of 28 October the remaining use was in ED, although reduced from earlier in the month, with final focused actions to end the corridor care use continuing.

The Board can take assurance from the substantial reduction in corridor care occupancy, hours and breaches compared with previous weeks, and from the continued alignment of divisional actions with GIRFT recommendations. Assurance can also be taken in relation to delivery of THP 45, though the Trust remains behind plan on 12hr and 4 hr performance.

This assurance is qualified: corridor care has not been fully eliminated, two relevant patient-safety incidents were reported, and a longer period of monitoring is required to demonstrate that the improvement is sustained.

2. Background

The August Trust Board approved the 11-point action plan intended to recover the Urgent and Emergency Care performance as a result of the visit from the Getting It Right First Time (GIRFT) team and National Discharge Lead (Lesley Watts) on 17 July 2026.

Steve Lyttle
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The Trust is currently behind plan on delivery of 4-hour and 12-hour emergency care access standards but has seen a reduction over recent weeks in Corridor Care Spaces.

The mean handover time in August was 90 minutes noting the need for the Trust to deliver a maximum handover of 45 minutes. This has now improved to the September mean of 44.9 minutes.

The current operational trajectory is monitored through weekly UEC metrics, daily dashboards and the CVoF weekly meetings. As at 15 October 2026, performance remains below the required standards and sustained improvement is needed across four-hour performance, 12-hour stays, ambulance handover and discharge.

3. Assessment

Current Performance:

performance to 27 October 2026 shows:

- Type 1 four-hour performance of 51.3% month to date against a 62.54% trajectory,
- 17.15% of patients spending more than 12 hours in ED against a 10.50% trajectory.
- Ambulance handover time averaged 28 minutes
- Performance against the 30% discharges before midday and 80% before 1700 is 16.8% and 69.9% respectively.
- Corridor care reduced substantially following all ward-based corridor spaces closing on 29 September 2026 with any opening now requiring COO/ CNO or CMO authorisation.
- ED Corridor Care Spaces remain open with the exception of the three majors area escalation spaces which now require COO / CNO or CMO authorisation

Current Operational Focus and Remedial Actions To Improve 4hr and 12hr performance:

- Ensure no patient remains in a corridor care or ambulance handover space for more than 45 minutes, with escalation to divisional leadership at 40 minutes and executive intervention at 60 minutes;
- Escalate patients at risk of a 10-hour ED stay to the responsible division, with executive escalation by 11 hours 30 minutes;
- Cease overnight use and staffing of the discharge lounge as an escalation area;
- Deliver the Operational Pressure Escalation Level (OPEL) 2 actions in full, supported by clear evidence of completion and automated escalation through the OPEL dashboard, which is currently in PDSA testing;
- Stream patients promptly to the most appropriate service, including direct access to specialty assessment areas, and avoid ED attendance for expected patients unless ED-specific care is required;
- Identify patients whose needs can safely be met through community or out-of-hospital services and redirect them in real time; and

Neave,Lynsey
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- Align specialty, diagnostic and discharge capacity more closely with the daily demand profile, particularly after 16:00.

Progress and exceptions will be reviewed through daily operational oversight, with named divisional ownership of unresolved delays. This strengthened approach is intended to move the Trust away from transferring risk into temporary escalation spaces and towards providing care in the right place, by the right team and at the right time.

GIRFT UEC 11-Point Plan

The Urgent and Emergency Care recovery plan shows progress in implementing several flow initiatives, including the Discharge Ready Unit, the West Cornwall SDEC, pharmacy supported TTO completion and weekday streaming to the Same Day Medical Assessment. However, the plan does not yet demonstrate consistent improvement in operational outcomes, and the latest recorded position is dated 30 September 2026.

Plans for an expanded Same Day Emergency Care unit remain on track for early November, with specialty hot clinics planned in tandem.

The Waiting to Be Seen (WTBS) time in ED remains the principal area of concern, with no material overall improvement in overnight performance. Assurance is required that the agreed staffing, streaming, redirection and clinical oversight actions are fully implemented and delivering improvement.

Criteria Led Discharge (CLD) implementation is progressing, supported by an updated SOP, training and senior clinical engagement. Some areas are showing good levels of engagement with CLD and full assurance will be available once CLD is consistently used across relevant wards and evidence shows that it is improving discharge performance.

Performance against the GIRFT Clinical Operational Standards is being tracked and reviewed daily

A Community Care Framework workshop held on 13 October with system partners, including the voluntary sector and SWAST, identified 4 patient pathways that can be shaped at pace to ensure only patients requiring secondary care input present to RCHT; Patients with transient loss of consciousness, Frail patients with signs of infection, Frail patients with heart failure and Frail patients with delirium. Actions will now be progressed and tracked, with join CFT DCMO / RCHT CMO oversight.

Enhanced RCH Same Day Emergency Care

Enhanced RCH Same Day Emergency Care is due to open in early November, although the exact date requires confirmation. It offers the main opportunity to reduce admissions and ED pressure and whilst weekday streaming is established and control of the medical take has been strengthened; specialty pathways must be ready before go-live to deliver the intended 30% reduction in admissions. Gastroenterology hot-clinic capacity is operational, while respiratory and cardiology pathways remain in development.

No Criteria To Reside

Navigate Insight
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The Chief Operating Officer has escalated No Criterial To Reside (NCTR) as a key Trust and system flow priority, with performance remaining above the operational plan requirement of no more than 42 NCTR patients. System partners are being challenged to maximise Pathway 1–3 and out-of-hospital capacity, with unresolved Pathway 2 and 3 delays escalated through system arrangements. Internally, daily review and named ownership of discharge barriers are supported by earlier discharge planning, strengthened patient “pull”, Criteria-Led Discharge, pharmacy support, the Discharge Ready Unit and increased use of community alternatives. The Discharge Ready Unit has supported a reduction in NCTR; however, sustained delivery remains dependent on timely system capacity and measurable improvement against the agreed trajectory. Progress and exceptions are monitored through daily operational oversight and the Clinical Vision of Flow.

4. Risk

The principal risks are captured in Board Assurance Framework 1 and risk 9048, ED Overcrowding, scored at 25. Risks include prolonged ED waits, delayed ambulance handovers, non-standard care environments, and delays to specialty review, admission and discharge.

Failure to deliver planned improvements in four- and 12-hour performance, ambulance handover, escalation use and corridor care presents reputational and regulatory risk. Strengthened executive and clinical oversight is in place, with the Chief Medical Officer-chaired Clinical Vision of Flow driving sustained improvement.

Key risks for Committee assurance are:

- Quality and safety risks from crowding, delays and care in non-standard environments.
- Patient experience risks to privacy, dignity, communication, confidence and timely access to appropriate care.
- Workforce, reputational, financial and regulatory risks if recovery trajectories and corridor care reductions are not sustained.

5. Accountability

The Chief Operating Officer retains executive accountability for operational performance and delivery of urgent and emergency care recovery.

The Chief Medical Officer is accountable for the Clinical Vision of Flow and for strengthening clinical leadership of the GIRFT Clinical Operational Standards.

The Acting Chief Nursing Officer provides executive leadership for nursing quality, patient experience, safety and the reduction of harm associated with crowding and corridor care.

Stacey Linsey 30/1/2026 09:31:19

Delivery will require active ownership by Divisional leadership teams, clinical directors, specialty teams, site management, corporate support services and system partners.

6. Recommendations

- **Discuss for assurance** we are not meeting the current UEC recovery trajectories and additional actions being taken to bring us back to the improvement trajectories
- **Note** progress to date on the GIRFT 11 Point Recovery Plan (Appendix A)
- **Note** the Chief Operating Officer's escalation of No Criteria to Reside and **support** continued action with system partners to reduce delays and deliver agreed trajectory; and
- **Take assurance** from the marked reduction in ward area corridor care since 29 September 2026, recognising that Emergency Department corridor care has not been fully eliminated, and the improvement is not yet proven to be sustained.

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LINE	ACTION	OPERATIONAL LEAD	DIVISION	EXECUTIVE LEAD (s)	OUTCOME	ACTIONS TO ACHIEVE OUTCOME	GOVERNANCE AND ACCOUNTABILITY	QUALITY AND PATIENT SAFETY RISKS	OPERATIONAL AND FINANCIAL RECOVERY	CURRENT STATUS	PROGRESS SINCE JULY SUBMISSION AND IMPACT ON DELIVERY	DIRECT CONTROL / ICB OR SYSTEM ACTION	COMPLETION DATE	MILESTONES AND TRAJECTORIES	RAG
1	Delivery of Clinical Operational Standards (COS) (consistently with reporting) 7 days a week	AMD for UEC Deputy Divisional Director for Medicine	All	Chief Operating Officer	Consistent delivery of the GIRFT Clincial Operational standards to contribute to ending Corridor Care, delivery of THP45 and no 12 hour ED stay	Trust wide publication of the standards Tracking tool to map delivery and improved performance Tracking tool used with recovery actions Trend breech analysis of the responses to QR codes	Reported in the Clinical Vision of Flow weekly meetings with data sets	Contribution to reducing Aggregated Patent Delay which is tracked to the ED Crowding Risk 9048 Corporate Risk Register which is currently scored at 25.	£300K per month in escalation costs will be avoided. Supports the delivery of the Annual Operating plan requirements in dleivery of 4 and 12 hour UEC standards.	Tracking tool created and being added to daily drumbeat to drive delivery as impact not being seen QR codes across the Trust for use with a tracking tool **Update 23.09.26**: Review held by COO and Divisional Chair for Medicine to further embed COS across the organisation. Agreed current posters would be updated to included verbatim standards across the Trust. **Update 30.09.26:** Daily 4pm meeting held. Tracker to be shared with divisions. Themes to be identified and shared	QR code used to gain intelligence from across the Trust which is reviewed in the weekly clinical vision of flow meeting. Tracking GIRFT delay analysis reports for trend analysis of reported breaches and themes for agreeing actions. All Divisions present. Updating this process for line by line assurance of each of the standards. since the launch the QR code has been used 307 times and analysed. Further work is required with the BI Team to develop the ability to track reported compliance against each standard.	Direct Control	Initial milestone of 20th July met with launch of the standards Action kept open as ongoing work to embed it to just become 'normal operating delivery' estimated 31 March 2027	10th September launch daily line by line Clinical Standards detail tracker Weekly review in Clinical Vision of Flow	
2a	To Take Out (TTO) Pilot on AMU and Roskear	Chief Pharmacist	All	Deputy Chief Medical Officer	Increase morning discharge and reduce LOS by decreasing turnaround time for TTO	1. Roll out AMU 2. Roll out Roskear Ward 3. Evaluate impact for sustainability case.	Clinical Vision For Flow	None identified	Direct link to Annual Operating Plan of delivery of 4 hour and 12 hour performance. Increase in 30% of discharges before 12md and 80% discharges before 1700	Roll out programme developed and operationalising in practice in both areas. **Update 23.09.26**:Practice embedded with plan to expand to Wellington ward. Good feedback received from divisions. Further work required to identify operational space. **Update 30.09.26** Working continuing. Evaluation planned 30.11.26	Rolled out to Acute Medical Unit and Roskear Ward. Recruitment completed for next technician and rollout to 3 further wards to be confirmed.	Direct Control	Initial rollout complete. 31st November, evaluation to be complete.	31st November complete evaluation of impact for sustainability role out	
2b	Criteria-led Discharge (CLD) dedicated workstream (noting link to the COS)	Head of Nursing for Medicine	All	CNO /CMO	Increase number of patients leaving the wards on criteria led discharge	Review current system for CLD against West Hertfordshire model including SOP and training model and then develop divisional delivery plans whiich will be tracked against ward daily dashboard	Ward daily dashboard and whole hospital review process. Reported through to CVoF	Delivers improved patient experience, reduces Aggregated patient delay in ED and directly links to reducing ED Crowding Risk 9048. Current risk score 9048.	Direct link to Annual Operating Plan in relation to delivery of 4 hour and 12 hour UEC standards and erradicating corridor care. Direct link to meeting requirements for >30% discharges before 12 md and 80% discharges before 1700. Direct link to current 300k per month eslcation space costs	Still in scoping phase and using current system of CLD. **Update 23.09.26:** Work taking place across the ward to ensure correct data is uploaded to nervecentre. Training to be given to resident doctors and nurses from w/c 28 Sept **Update 30.09.26:** Training package proposal to be circulated for review /feedback once completed. Will require support from clinicians to implement. TS/EB to discuss further	Limited progress since July submission due to other areas of focus in delivery co-located UTC , West Cornwall SDEC and streaming. Focused work to continue through September to delivery training material and refresh programme.	Direct Control	31st October	Clinician engagement and data sharing during September End of September complete gap analysis agaisnt West Herts model Early October individual Divisional level delivery plans	
3	Make a space somewhere in the hospital to function as a UTC (UTC model to be operational in August) noting need for the capital build to deliver sustainable model	Divisional Director for Medicine	Medicine	COO/CNO/CMO	Create a tempoary UTC within ED footprint	Find designated location in the ED Operationalise the new location with staff	ED Business and Governance meeting through to Divisional Board Sign off by Director of Estates and IPAC CNO/CMO sign off of the clinical model and staffing numbers	Potential for unexpected deterioation of ambulatory patients managed by the SOP and appropriate escalation. Direct link to reducing ED Crowding Risk 9048	Supports non admitted 4-hour performance in Annual Operating Plan.	New unit opened on 11th August as the Quasi UTC **Update 23.09.26:** Area is open, using current staffing. THP offleads have increased patients who should not be in the waiting room. Recent visit to Royal Bournemouth Hospital has offered insight. Awating progression of funding for digital front door **Update 30.09.26:** This area remains a challenge. Space is still required. Nursing team are being pulled to care for patients. Discussed ED corridor care - regular 16 patients in these areas	Unit opened	Direct control	11/08/2026	Optimising delivery over the next 8 weeks (end of October)	
4	Better drive for the use of our own Same Day Emergency Care (SDEC) space at RCH	Clinical Lead for Acute Medicine	Medicine Division	COO/CNO/CMO	30% reduction in admissions	1. Streaming pull by SDMA team (Monday to Friday) 2. Medical Registra controlling medical take 3. Move the current SDMA unit to an enhanced space with more capacity in the Tremenol Unit where links to below action hot clinics for repsiratory, cardiology and others can be delivered. 4. Create SDEC space at WCH	Clinical Vision of Flow	None identified - improving clinically led streaming and creating positive patient experience.	Direct link to Annual Operating Plan and improvement in 4 and 12 hour UEC performance.	1. SDMA streaming delivered Monday to Friday and working up plan for weekend delivery 2. Medical Registrar control of the medical take pilot commenced on 7th September 2026 3. Estates work has been specified, survey ongoing and allocation of the contractor who will commence works in November to enable unit to go live **Update 23.09.26:** Work progressing **Update 30.09.26:** Work progressing to plan. Gym now moved to St Mawes as part of the enabling works. Staff are engaged. No additional support required at this stage	1. SDMA streaming delivered mon-fri from SDMA 2. Estates quotes and contractor appointed to delivered enabling works on SDMA to return to being in-patient ward and SDMA to move to enlarged template. Currently on plan to deliver change 2nd week november. 4. SDEC opened WCH	Direct control	7th November	Completed - nurse (ACP) control of take to SDMA Contractor to be appointed in September 2026 to commence work in November	
5	Holiday planning for August	Divisional Directors	All	Chief Operating Officer	Performance improvement in August	Use weekend planning tool to track capacity	Weekend planning meetings Divisional staffing reviews (held by the Divisions)	Aligning staffing where possible to demand profiles noting financial challenges. Included parameters for divisional teams	Supporting consistant delivery of operational standards	complete **Update 23.09.26:** Requested first review of October half term, Christmas and February 2027 half term holiday plans at the meeting on 30 Sept **Update 30.09.26:** this will be discussed on 7 October	minimal additional resource secured	Direct control	31-Aug-26	completed	

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LINE	ACTION	OPERATIONAL LEAD	DIVISION	EXECUTIVE LEAD (s)	OUTCOME	ACTIONS TO ACHIEVE OUTCOME	GOVERNANCE AND ACCOUNTABILITY	QUALITY AND PATIENT SAFETY RISKS	OPERATIONAL AND FINANCIAL RECOVERY	CURRENT STATUS	PROGRESS SINCE JULY SUBMISSION AND IMPACT ON DELIVERY	DIRECT CONTROL / ICB OR SYSTEM ACTION	COMPLETION DATE	MILESTONES AND TRAJECTORIES	RAG
6	Waiting To Be Seen (WTBS) project in ED (noting link to the COS	Clinical Director Emergency Department	Medicine	Chief Medical Officer	Delivering the operational standard for WTBS 24/7	No material shift in performance to date. so further reivew undertaken by clinical director for emergency department	Clinical Vision of Flow / IPR	Key patient experience indicator, linked to risk 9048, proxy for safety	Supports 4-hour and 12-hour delivery in ED and requirements of Annual Operating Plan.	Actions taken to date have not improved overnight performance. Additional actions agreed on 9th September. **Update 23.09.26:** Processes amended to reduce WTBS and make system more efficient. SOP has been written and will link to digital front door process before publishing. Feedback / escalation required if ENP's (emergency nurse practioners) are not ringfenced as previously agreed **Update 30.09.26:** Continues to be a challenge. Discussions held to review processess with consultation process to commence. Additional actions update 1 - EOI for Band 6 to act up to Band 7. 2 - Overnight SOP - confirmation received of funding for digital front door (NHSE funding by March 2027). Interim procedures to be worked through. 3 - Overnight redirection to be worked through with MIUs. Support required from Comms and creation of patient leaflet. Good	Additional actions agreed 9th September 2026. 1. Streaming 24/7 band 7 by 5th October 2026. 2. development of SOP to support the role 3. Overnight re-direction, SOP to be developed for suitable patients to be booked into next day ENP OPD by 28th September. 4. Ringfencing ENP shifts now complete. 5. Leadership: all patients to be discussed with ED Consultant 0800-1900 and all desciions to admit to be discussed with ED Consultant as of 9th september 2026. 6. Review of substantive overnight middle grade cover with interim additional 3rd middle grade in place currently , Case to be reviewed within 2 weeks .	Direct control	5th October 2026	See progress update.	
7	Accelerate the AI supported discharge summary process	Consultant Gastroenterologist	All	Chief Information Officer	Faster discharge summaries and freeing up clinical resource – reduce LOS	1. Task and Finish Group set up 2. Pilot in one area with current liscenes the Trust has. 3. Trust to submit national bid in October if successful money draw down in November to support Trust roll-out.	Digital Board	improvement project,	reduce length of stay and increases morning discharge	pilot project **Update 23.09.26:** Awaiting confirmation (and outcome) that the AI bid has been submitted. **Update 30.09.26** Awaiting confirmation of funding allocation. BG/RJ to progress this on 05.10.26. TS to speak with KH in regard of the AI offer and incorporation into WTBS	CITS development of bid for funding to increase licences	Direct control	TBC	October bid submission. Drawdown of funding November for increased licences	
8	Expand Acute Care at home – with linkage to Virtual ward elements	Various	All	Chief Medical Officer(RCHT), Deputy CMO (CFT)	Reduce LOS, admission avoidance, patient right place, care closer to home / within neighbourhood	Agreed framework within both Executive teams(RCHT/CFT), workshop planned to further define the model implementation - initial clinical pathways for key focus and to identify any resource gaps	CFT/RCHT Hospital at home stakeholder group chaired by COO (CFT). RCHT reporting via CVoF and QAC	Avoiding deconditioning and reduces ED crowding risk 9048, reduces aggregated patient delay. Will support increase in 30% discharges before 12 midday and 80% discharges before 1700.	contributes to the 4-hr and 12-hr delivery	Not currently operationalised. **Update 23.09.26** Initial call held between RCHT/CFT. Planned system workshop on 13 October bringing all system partners together to produce action plan, map pathways and mobilise. **Update 30.09.26** Workshop Invites sent with good engagement.	High level proposal on future model agreed by RCHT& CFT Executives teams. Workshop set up for 13th October for keystakeholders to agree delivery and timescales.	System action	31-Oct-26	During September finalise agreements for the new model Comence the new model by the end of September	
9	An interim electronic solution for real time data relating to the medical take					this was paused as unable to be delivered until after the eCare launch				paused	Reviewed and noted as needing to wait for eCare completion	Direct control	n/a		
10	Maximise hot clinics priority for Respiratory, Cardiology and Gastro and an assessment of how to use more community capacity	Divisional Director for Medicine	Medicine Division	Chief Medical Officer	To have 5 day hot clinics in respiratory, cardiology and gatroenterology moving to7 day to support enlarged SDEC area	Delivery plan for each service for 5 day hot clinic service moving to 7 day service	Medical Services Division. CVoF	Direct link to reducing ED Crowding risk 9048 current risk score 25	Direct link with 4 and 12 performance requirements of Annual Operating Plan	Gastroenterology currently have 6 day GI bleed discharge and return day . No service for cardiology other than RACPAC or respiratory. **Update 23.09.26:** Gastroenterology now working 5 days per week. Cardiology is in progress with anticipated delivery time of approx 2 months. Respiratory to commence circa November 2026 (pending SDEC opening). **Update 30.09.26:** Plan to offer an MOT/hotline for approx. 120 respiratory patients who are regular attenders	Gastro 2 clinic slots a day (Mon - Fri) for ac	Direct control	31st November 2026	Gastro 2 clinic slots a day (Mon - Fri) for acute medicing commence 14th Sept Phased delivery plans for the 'more challenging specialities' to be completed by end of September to commence delivery	
11	Update resident doctor staffing numbers reviewing across the 24/7 period to include H@Night modelling	Clinical Lead for Eldercare and Eldercare Consultant	All divisions	Chief Medical Officer	to ensure safe medical staffing and skill mix across the organisation appropriate for acuity and bed numbers	Base line to be ascertained. Regional workforce planner consulted with further work to link model to capacity,demand and RCHT footprint	ELT, QAC, Trust Board with visibility through PCC	maintaining professional standards 24/7	Supporting consistent delivery of operational standards 24/7 and 7 day working.	See over. No update 23.09.26 **Update 30.09.26:** called planned to progress staffing model. Will require more uplift on senior nurses for triage.	adhoc additional out of hours staffing to support obvious capacity gaps. Additional resident doctor to support FAST front door Stroke team . Additional consultant to support HASU team. Established resident doctor staffing baseline	Direct control	Mar-27	Modeling to be complete to inform the delivery plan	
12	Discharge Ready Unit (DRU)	Divisional Director for Medicine	Medicine	Chief Operating Officer	Open Unit - operational	Develop clinical model, sign off staffing model and SOP	CVoF	reduces deconditioning,increased P1 discharge, reduce LOS	Delivery of 4-hr and 12-hr standard. Reduction in NCTR, reduce corridor care	**Update 23.09.26:** Going well from a discharge perpective. Further work required with all wards in regard of 'patient pull'. Ward leader to link with Chelsea and Westminister hospital ward leader for peer advice/support **Update 30.09.26:** work completed. Work is required to monitor the reduction. High turnover of patients. Voluntary services have been able to offer holistic support. Awaiting engagement from military veterans	Unit opened. NCTR has reduced	Direct control	completed 17 August 2026	completed	

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 10

Title of Report: Bi-annual Strategy Implementation Report

Executive Director Lead: Ella Stracey, Chief Strategy Officer

Author and Job Title: Nathalie Purchase, Head of Strategic Development

Email Address: Nathalie.purchase@nhs.net

Purpose of the Report:

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

For Board to consider progress against the Trust Strategy since approval in January.

Consultation:

The strategy was developed following engagement both within the organisation and with strategic partners. This report has been considered at ELT and Committees ahead of Trust Board.

Feedback from Committee noted the encouraging early progress against delivery of the Trust's 2026-2035 Strategy, including implementation of the new operating model, launch of the culture programme, commencement of robotic-assisted surgery, progress in neighbourhood development and approval of the Commercial Strategy. Recognised that delivery remained uneven and that operational performance, RTT recovery and financial sustainability continued to present significant risks to achievement of strategic objectives.

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	This was completed against the strategy itself in January 2026.
Quality Impact Assessment completed?			x	This was completed against the strategy itself in January 2026.
Data Protection Impact Assessment completed?			X	Not required.

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	Addressing the health and wellbeing of the population is a thread throughout our Trust Strategy. We describe a specific principle setting our ambition to 'drive improvements to population health and reduce health inequalities'.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Safe high-quality care remains a strategic objective of the Trust Strategy. The strategy considers action which support this objective across each area of our clinical focus. In addition, the strategy proposes a new enabling strategy, focused on quality and safety- recognising the additional focus this is being given nationally.
Sustainable and efficient use of NHS resources by RCHT	A key consideration within the strategy is our ambition to achieve financial sustainability, with a specific principle describing our ambition to adopt a sustainable approach to all that we do – for our people, our finances and our environment.

Recommendation(s):

The Board **is recommended to:**

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- **Note** the progress in delivery of the Trust Strategy Year 1 milestones and ongoing strategic development across all areas of clinical focus.

Bi-Annual Strategy Implementation Report

1. Situation / Executive Summary

Trust Board approved the new Trust Strategy 2026-2035 in January 2026. The Strategy was formally launched internally in June. Note, the delay in launching the strategy was agreed with Board owing to the ongoing organisational change underway within the Trust during early 2026 and the need to sensitively handle communications during this period. However, work has remained ongoing to develop and deliver the strategic priorities identified within the strategy itself.

Since approval, the Trust has made good progress in implementing early milestones described within the strategy, with 3 completed in full and 4 areas on track to deliver. There has been a minor delay in one area (re-location of cardiac services), although this is expected to complete in-year; and an agreed delay to go live of our electronic patient record, eCare. There are also some delays in fully implementing the organisational change. RTT 52 week performance remains the most significantly off-track strategic milestone for the Trust, with there also being challenges in delivery of financial sustainability schemes although the infrastructure is now in place. A full break down is provided in section 3.1 of this report. It should be noted that Urgent and Emergency Care is a clearly stated Trust priority in the strategy however for the purposes of measuring implementation, there are no milestones stated in the published strategy this year. However, alongside the described milestones; there has been ongoing development of services within the Trust against our described areas of clinical focus – while these do not yet have agreed milestones, this report highlights some of the key achievements and work underway to date – this is further described in section 3.2 of this report.

Key highlights to date, include:

- Launch of the strategy internally by our CEO, with a video featuring our staff talking about the priorities.
- Implementation of new leadership structures across operational and corporate teams.
- Launch of the We are RCHT culture transformation.
- Continued delivery of eCare for an April 4th go live.
- Launch of the Trust's robotic surgery programme.
- Appointment of a Sustainability Manager to drive delivery of the Green Plan and support Net Zero Carbon reduction requirements.

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Continued strategy implementation priorities for the remainder of the year, include:

- Maintaining a focus on reducing 52 week waits – this at present represents the

biggest risk to strategy delivery this year. This is closely reported through the Trust's performance monitoring structures and reported in the Integrated Performance Report.

- Completion of the Outline Business Case for the Women & Children's Hospital.
- Preparing for the implementation of our electronic patient record, eCare, in April 2026.
- Continued delivery across key strategic programmes including Financial Sustainability Programme, Culture Programme, and Clinical Vision of Flow.
- With our partners across health and social care, continue to develop new neighbourhood-based models of care across both Cornwall and the Isles of Scilly.
- Continue to work with academic partners in support of our ambitions for University Hospital Status. Recent review of the revised University Hospital Association criteria confirms priorities remain increasing the Trust's proportion of joint clinical-academic appointments over the next three years to a minimum of 20, and increasing the Trust's average Research Capability Funding income to an average above £200k over two years. A plan for achieving University Hospital Status is now in development, and will be supported by a new Steering Group. The roadmap for achieving University Hospital Status will be included within the next report.

Additionally, the Trust has approved a Digital Strategy and Medium Term Financial Plan, which are key enablers to the strategy. A Medium-Term workforce plan has been developed which continues to be refined. Further key enablers to be completed are the development of a clinical site strategy and reviewing the Trust's Quality and Safety Strategy in light of the new national strategy.

2. Background

As part of the new strategy, the Trust retained its vision of Outstanding Care for One and All; meaning ultimately delivery of the ambitions described within our strategy should support the Trust to reach this position. The Trust values of Respect, Compassion, Honesty and Teamwork were also retained, reflecting they are well recognised and embedded within the Trust. The overarching strategic objectives are:

- Safe, high quality care
- Supported and valued people
- Improving together
- Partnering with purpose.

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3. Assessment

3.1 Progress against Strategic Milestones for Year 1

The key strategic ambitions set out in the strategy for year 1 are set out below, with an update on delivery progress:

Strategic Priority	Intended Strategic Impact	Alignment to Strategic Objectives	Current Position	Update
Implementation of our new organisational structures.	Increase our patient focus to ensure clinical effectiveness and excellence in both patient outcome and patient experience with increased operational focus to improve quality, capacity, throughout and to reduce waste.	Supported and valued people	Delivery ongoing with some delay	Operational and Corporate teams organisational change is now approaching conclusion, with the new Operating Model now in place and changes in practice now embedding. There remain some key vacancies within the Divisions, with recruitment now underway. Clinical Administration Review remains in progress, with phase 2 of the staff consultation expected to commence 8th September 2026.
Neighbourhood Care Blueprint agreed with system partners.	The local Cornwall and Isles of Scilly System is able to define shared ambitions for realising neighbourhood based models of care, in support of the national 10 Year Plan ambition of shifting care from hospital into the community.	Partnering with purpose	In progress, on track to deliver	The Trust is a key partner within the Neighbourhood Innovation Delivery Team, which is leading delivery of the strategic approach to neighbourhood care across Cornwall and Isles of Scilly. A public facing blueprint is in development and will be considered through Trust governance structures ahead of approval. A pan organisation Neighbourhood Delivery Team is place with RCHT membership – this group provides system wide strategic and delivery capability to the

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Strategic Priority	Intended Strategic Impact	Alignment to Strategic Objectives	Current Position	Update
				implementation of Neighbourhood Care.
52 week waits eliminated.	Reducing the number of people waiting longer than a year for appointments is a national planning ambition for 2026/27, leading to an improved patient experience.	Safe, high quality care	Delivery at risk	52 week waits have increased in year – this is being managed through the Trust's performance framework with Divisions, and the Clinical Vision for Planned Care. Progress is reported through the Integrated Performance Report. In the main the over 52 week wait patients require surgery and a '100 day' plan is being implemented from 14 September to increase theatre activity which will support income from an FSP perspective and increase capacity for clock stops, including those over 52 weeks.
Our electronic patient record, eCare goes live (*note this has been deferred from June 2026* in agreement with Board).	This directly supports the national ambition to move from analogue to digital, enabling significant improvements to patient care through introducing a new, electronic patient record.	Digital transformation (enabler).	Delivery delayed but expected to complete in April 2027.	Delivery delayed into April 2027 in agreement with Trust Board (previously June 2026). New go-live date agreed for April, with significant planning now underway to enable this.
Business case for new Women and Children's Hospital submitted.	Outline Business Case approved to enable progress to Full Business Case stage.	Estates transformation (enabler).	In progress as planned	Outline Business Case is programmed for completion in March 2027 in agreement with New Hospital Programme. This will be challenging but is expected to deliver; business case leads identified. Progress is monitored through the Women & Children's Hospital Programme Board. The contract with Wilmot Dixon marks a significant achievement within the Programme.
Launch of a new Culture	Building a culture where everyone feels cared for,	Supported and valued people	In progress as planned	The Trust's Culture Programme is now in place, with reporting established through to People and

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Strategic Priority	Intended Strategic Impact	Alignment to Strategic Objectives	Current Position	Update
Improvement Plan.	listened to and makes a difference – ultimately improving staff experience at work.			Culture Committee. Recent pulse survey indicates a small improvement in the number of people recommending the Trust as a place to work.
CRDC-funded research hub opens.	Build a delivery model capable of opening, recruiting to and delivering commercial studies efficiently and at scale, expanding access to commercial research through secondary care, primary care and community settings.	Partnering with purpose	On track to deliver against strategic priorities in the programme.	The CRDC has successfully moved from establishment into operational delivery and is demonstrating strong performance against most strategic priorities. Key achievements include rapid study set-up, exceeding recruitment targets, expansion into primary care and community settings, and strong partnership development. The main area where delivery is not yet fully realised is workforce establishment and longer-term financial maturity, both of which reflect the CRDC's early stage of development rather than a failure to deliver. Overall, the programme appears on track.
A refreshed Memorandum of Understanding (MoU) with University of Plymouth agreed.	To continue to develop our relationship with the University, in support of our broader University Hospital Status ambitions.	Partnering with purpose	Some progress.	Initial discussions held with the university- recognising the need to be clear on the intended outcomes of the partnership if a new MoU is to be agreed. Further discussions planned for September and October 2026.
Cardiac services re-location.	Re-location of cardiac services is a key enabler of the Women & Children's Programme	Estates transformation (enabler).	Minor delay but expected to deliver in year	Work is now underway to relocate the service into the Outpatient department within Trelawney wing; estate enabling works are underway and are expected to be completed in December after a minor delay with the contractor (original plan was September).
Appoint a specialist	To lead delivery of the Trust's Green Plan, enabling	Improving together	Completed	Substantive Trust Sustainability Manager commenced in post in May 2026. Priority now is to

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Strategic Priority	Intended Strategic Impact	Alignment to Strategic Objectives	Current Position	Update
Sustainability Lead.	the Trust to meet Net Zero Carbon reduction.			lead delivery of the Trust's Green Plan.
Introduction of robotic assisted surgery.	To reduce a local acute health inequality by enabling local access to modern, surgical procedures associated with improved patient outcomes.	Safe, high quality care	Completed	Following delivery of the robot in the spring, the first patients were treated in July m2026 following an extensive training programme for the clinical teams involved. Expansion of the robotic surgery programme is now being led through the surgical division.
Launch of the new Financial Sustainability Programme.	To develop a new approach to achieving longer term financial sustainability for the Trust with supporting infrastructure to facilitate delivery of identified savings schemes in year.	Improving together	New approach launched but challenges with delivery of required savings.	A new Financial Sustainability Team is in place to drive delivery within the Trust. Financial Sustainability Programme established with named leads for individual workstreams. This reports through to the Financial Sustainability Programme Board; and Finance & Performance Committee.
Develop a Commercial Strategy for the Trust	In support of longer-term financial sustainability, the Trust needs an agreed approach to grow commercial income.	Improving together	Completed	The Trust's Commercial Strategy was approved by Board in July 2026; work is now underway to implement this through a dedicated workstream within the Financial Sustainability Programme.

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3.2 Ongoing strategic development against our areas of clinical focus

Area of Clinical Focus	Overarching Strategic Ambition	Areas of Strategic Development
Urgent and Emergency Care	Together with our partners, we will optimise our urgent and emergency care pathways across Cornwall and Isles of Scilly, enabling us to deliver our clinical vision of flow.	• While operational performance remains challenged across UEC as described in the Integrated Performance Report; the Trust continues to strive towards improving and sustaining performance across all urgent care pathways both through introducing local improvements and through working with strategic partners to support reducing demand for our services. • The Clinical Vision of Flow Programme remains active and is the delivery vehicle for planning and implementing changes in this area. • The new Discharge Ready Unit is supporting timely discharge and flow through our beds. • Development of the Urgent Treatment Centre (UTC) model for Truro, co-located with ED marks a significant change; this is both an ambition of the strategy and a national requirement. An interim UTC offering has been created within the existing footprint while the capital scheme is progress • Participation in recent Getting it Right First Time visits to drive local improvement in line with national best practice and agreeing 11 point recovery plan. • There have been a number of moves of services since the GIRFT visit at the end of July with the next significant change being an increase in footprint of the Same Day Medical Assessment area • Working with system partners to identify opportunity to deliver models of care differently as mitigation to the forecast occupancy by achieving more care and pathways provided in out of hospital setting
Planned Care	We will transform our approach to planned care to ensure timely and equitable access to modern, planned	• Operational performance remains challenged in terms of Referral to Treatment, as described within the IPR – however the Trust is committed to improving this position. The new Divisions continue to work on recovery plans. • Notably, the Trust has introduced Robotic Surgery, transforming surgical care pathways within Cornwall with roll out now underway.

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Area of Clinical Focus	Overarching Strategic Ambition	Areas of Strategic Development
	care.	• The new theatre Start Right Programme is supporting operational productivity improvements within theatres. • Outpatient transformation continues, enhancing digital access to services. • A new preventive healthcare initiative utilising a digital tool designed to identify patients at risk of liver disease before clinical symptoms manifest has been implemented through use of the hapatoSIGHT system. • Review of the waiting list using a health inequalities lens has been completed and reported to Quality Assurance Committee. • The Trust secured re-accreditation of its Endoscopy services by the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy, reflecting the continued delivery of high-quality services and adherence to national standards.
Women & Children's Services	We will embrace our new Women & Children's Hospital and the opportunities this brings for women and children to support lifelong health.	• Work remains ongoing to develop the Outline Business Case for the Women & Children's Hospital, with this expected to be submitted in March 2027. • Within maternity, significant focus has remained on safety, particularly in response to publication of Baroness Amos' Review of Maternity Safety, which Board has reviewed. • The acute paediatric teams continue to develop new neighbourhood models with Integrated Neighbourhood Teams. • With partners across the Integrated Care Board and Cornwall Partnership Foundation Trust, the Trust is supporting plans to transform Integrated Child Health Services to enable greater integration of services across acute, community and education settings though the development of a new service specification.
Cancer Care	We will enable the earlier diagnosis and treatment of cancer, with more cancer	• The Trust is working with the Peninsula Radiology Network to secure long-term PET-CT provision to the Trust, with the ambition remaining a static unit at the Royal Cornwall Hospital site. National procurement exercises remain

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Area of Clinical Focus	Overarching Strategic Ambition	Areas of Strategic Development
	care provided in Cornwall.	underway with an outcome expected later this year. • Environmental improvements to the Mermaid Centre remain underway with expected completion in December. This will see changes to the courtyard garden and installation of an accessible toilet in the waiting room. This development would not have been possible without significant charitable funding from Duchy Health Charity. • Introduction of local robotic surgery as described above will support significant improvements in some cancer pathways with local provision. • A new minimally invasive treatment for kidney cancer has been introduced following the successful completion of the first microwave ablation procedure for the treatment of renal cancer at Royal Cornwall Hospital.
Neighbourhood Care	We will co-design, partner and integrate with impact, ensuring that the neighbourhood health model of Cornwall and the Isles of Scilly enables both excellence in acute and specialist secondary care services as well as transforming the health and delivery of care in our local communities.	• The Trust has secured funding through the Neighbourhood Health Enabling Fund to trial a 12 month peri-operative medicine project, working with Integrated Neighbourhood Teams to support patients to be more fit for surgery while they are waiting for their appointments. • The Trust continues to be an active partner in the Neighbourhood Innovation Delivery Team, supporting system-wide neighbourhood development. • Neighbourhood leads within each Division have been identified; alongside a group of neighbourhood champions. • Current areas of focus include transformation of the Musculo-skeletal pathway, frailty and paediatrics. • A new glaucoma project is launching on the Isles of Scilly to help patients stay at St Mary's for Glaucoma Surveillance instead of travelling to the mainland. Additionally, work is underway between the Trust, University of Exeter and the islands with regards to Xray provision to the islands.
Research and Development	We will grow our clinical academia, increasing participation in research and	• The Trust continues to enjoy a vibrant research and development programme; with strong partnership working across the One Cornwall Research approach. • The Commercial Research Delivery Centre is now starting to yield positive

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Area of Clinical Focus	Overarching Strategic Ambition	Areas of Strategic Development
	become a University Hospital by 2030.	outcomes against its ambitions; enabling more commercial research to take place locally with our strategic partners. • A new Hub and Spoke Model with Plymouth has enabled local participation in a haematology study – supporting ambitions to broaden local access to research. • A new University Hospital Steering Group is being established which will enable the Trust to coordinate university partnerships across the Trust while also supporting planning for University Hospital Status ambitions. • A Clinical Academia Strategy is now in early development – which will bring together ambitions across research and development, university hospital, and clinical education.

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3.3 Next Steps

The next steps, are:

- Continued delivery of year one strategy milestone and strategic development against all areas of clinical focus.
- Continued communications and engagement to support embedding the new strategy across the Trust. A programme of continued monthly communications in line with the communications plan previously approved by Board will continue, aligned to key elements within the Strategy, and installation of new visual displays across each of the main hospital sites. Key will be supporting translation of the strategy from a Trust-wide document, to a 'what it means to me' approach across our services. The launch video has been shared internally and with partners Following the positive feedback to this video, we will build on this model to provide updates of our achievements and celebrate our successes with further videos.
- Priorities for year 2 of the strategy will be identified and confirmed ahead of 2027/28+ operational planning to inform development of the Trust's plan.
- The Trust's new Planning Manager will work with Divisions to develop strategic development plans, drawing out divisional-level strategic priorities alongside local divisional plans to both support continued strategic delivery and to inform medium term planning requirements.

4. Risk

There is a reputational risk to the Trust should there be insufficient progress against our identified strategic priorities.

5. Accountability

The Chief Strategy Officer is accountable for the overall Strategy; ownership for priorities within the strategy rest with all Executive Directors in line with agreed executive portfolios.

6. Recommendations

The Board are recommended to

- **Note** the progress in delivery of the Trust Strategy Year 1 milestones and ongoing strategic development across all areas of clinical focus.

Neave,Lynsey
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Meeting: Trust Board in Public

Date of Meeting: 03 September 2026

Item Number: 11

Title of Report: Guardian Of Safe Working Hours Quarter 2 report 2026/2027

Executive Director Lead: Dr Meridith Kane, Chief Medical Officer

Author and Job Title: Dr Sarah Coulter, Guardian of Safe Working Hours

Email Address: sarah.coulter1@nhs.net

Key points:

- Exceptionally high number of exception reports in September, partially explained by doctors reporting missed breaks and working late on the same shift.
- Cardiology once again has started flagging due to high numbers in a small specialty.
- Most other reports related to ward workload and clinical deterioration near the end of shifts; the out-of-hours medical rota requires attention because of poor staffing and gaps in handover arrangements.
- Several reports were initially raised as Immediate Safety Concerns but were downgraded because they did not meet the defined threshold; 8 fines were issued in total - 5 for shifts exceeding the 13-hour contractual maximum and 4 for having less than 11 hours rest (1 ticked both boxes)
- Ongoing issues include inefficient bank holiday rota arrangements and the need for a suitable rest space in Trelawny.
- Problem with access to rest rooms in Tower
- The Board is asked to receive and note the Quarter 2 2026/27 report.

Purpose of the Report:

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

To update the Trust Board on the Trust's compliance with the terms of the resident doctor contract and present data on exception report activity.

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Consultation:

- Resident Doctor Forums
- Guardian meetings (held monthly)
- Medical director engagement sessions
- Ongoing communication and engagement with management teams
- Freedom of information department
- Rota coordinators
- Resident Doctor committee
- Informal feedback from Resident Doctors and their representatives

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 – no decisions requested.

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Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	N/A – no decisions requested.
Sustainable and efficient use of NHS resources by RCHT	N/A – no decisions requested.

Recommendation(s):

The Board is recommended to:

- **Receive** and **note** the Quarter 2 report (2026/27) report from the Guardian of Safe Working Hours.

Neave,Lynsey
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Guardian Of Safe Working Hours Annual Report 2025/2026

1. Situation / Executive Summary

The number of exception reports has reached a new high in September. It is nearly double previous high numbers. It is worth however highlighting that missed breaks have been reported 34 times this month whereas in previous months it has only been a handful of times. We knew doctors had been missing breaks to complete work but we had struggled to capture that data previously. Exception reports in August and September are always high due to the new intake so it often difficult to ascertain if there is a genuine problem in that area.

Whilst numbers are high there is only cardiology causing undue concern, the vast majority of the other reports are due to the volume of work on the wards and clinical deteriorations at the end of the working day. The cardiology team are aware of the issues.

The out of hours medical rota does still need some attention as there have been exception reports due to poor staffing and no one to hand over to, resulting in late finishes.

2. Background

Exception Reports

As explained in the last report, the team in HR review the reports and agree repayment or TOIL which is led by doctor preference. They escalate any concerning reports to me to review, the main reason for this would be working in excess of an extra 2 hours. All reports relating to working over EWTD hours or missed breaks come directly to me to review.

The Director of Medical Education now receives all educational reports. As previous the reports are reviewed anonymously in the monthly Resident Dr Contract Forum.

The doctors need to provide evidence of staying late as per guidelines, whilst these are not all checked roughly 1:30 will be asked for the evidence. This has been communicated to the doctors and is in line with other trusts.

Exception reports are discussed at all level of resident doctor inductions. They are all encouraged to report and to make sure they have their log in early in their rotations. There were a handful of doctors who did not have automatic access this August, but it was corrected promptly when highlighted.

3. Assessment

3.1 Areas of Concern

Cardiology, for the reasons mentioned above. I am waiting to hear back from the team.

3.2 Bank Holidays

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The bank holidays on some of the medical rotas still need some attention; often all doctors are rota'd to work resulting in overstaffing, and also unnecessary TOIL created, which can be difficult to facilitate. This is an ongoing issue, and with the 3 bank holidays coming up needs review again.

3.3 Level 1 reviews

I have asked for a cardiology level 1 review, in the meantime they are reviewing the start time of the ward round on CIU.

3.4 Tower rest rooms

Due to an IT issue doctors have had their access to these rooms removed. Often, they only find out when trying to access on call. The access team have been very responsive and added when requested but this is often after the on call.

3.5 Rota changes

There have been a few instances when a doctors rota has been changed without their knowledge (and therefore agreement) once the rotas have been released. We have fed back to the teams that this is not acceptable, and all swaps need to be discussed no matter how far in advance if the rotas have been published,

See below for Exception report numbers across all specialties.

Exception Reports total numbers

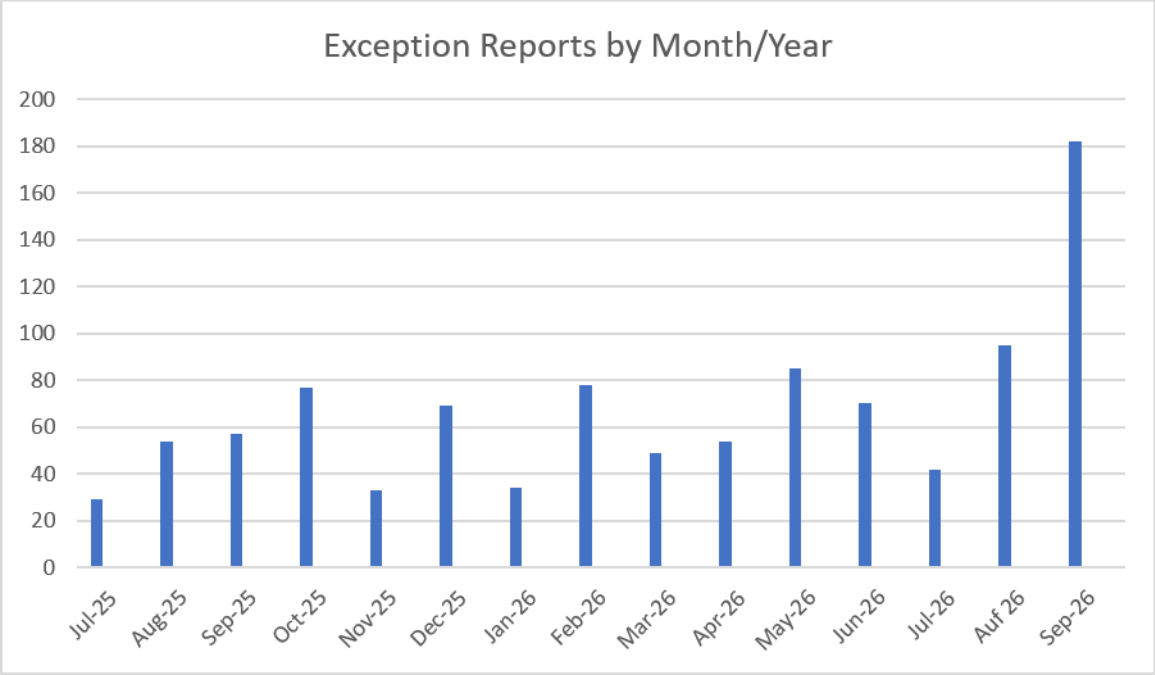
	Total	Med	ED	Paeds	O&G	H &O	OMF	ENT	AMU	Elder	Oph	Surgery	GP
21-22	36												
22-23	57												
23-24	62												
24-25 av.	64												
Apr 25	40	15	3	2						14		5	
May 25	27	13	3	1	1				2	4		2	1
Jun 25	36	16	3				3			12		2	
Jul 25	29	7					1	1		16		4	
Aug 25	54	21				13	3		2	12		2	
Sep 25	57	20				4	2	3	2	10		16	

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	Total	Med	ED	Paeds	O&G	H &O	OMF	ENT	AMU	Elder	Oph	Surgery	GP
Oct25	77	34				7		1	3	17		13	1
Nov 25	33	18	1			1	2			3		8	
Dec 25	69	44			4			1	1	9		10	
Jan 26	34	18							4	10	2		
Feb 26	78	38	1		8	3			4	10		14	
Mar 26	49	24	3		5				5	9		3	
AVE 25/26	49												
Apr 26	54	26			1	3			2	6		16	
May 26	85	54	4		4	6	2			8		7	
Jun 26	70	30	3		4	2				6		25	
Jul 26	42	22	2			1			3	5		9	
Aug 26	95	45	3		5	7			12	5		18	
Sep 26	182	69	13		2	7			30	18		41	
Ave YTD	88												

- Med - Medicine; cardiology, respiratory, gastroenterology, renal, diabetes and endocrine
- ED – Emergency Department
- Paeds- Paediatric
- O&G - Obstetrics and Gynaecology
- H&O – Haematology and Oncology
- OMF – Oral and Maxillofacial Surgery
- ENT – Otolaryngology
- AMU – Acute Medicine Unit
- Elder – Eldercare, including community placements
- Oph – Ophthalmology

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- Surgery – General surgery, Urology, Breast, Trauma & Orthopaedics and Vascular surgery
- GP – General Practice
- Derm – Dermatology

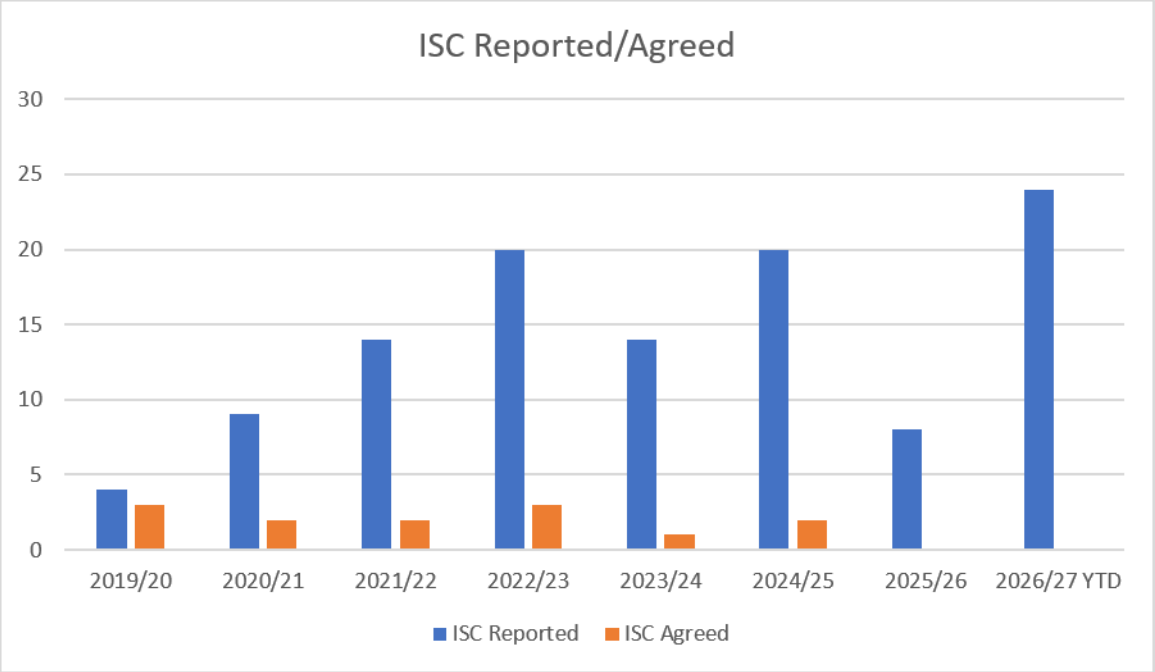
There was 2 from the anaesthetic team not included in the chart.

3.4 Immediate Safety Concern (ISC)

Harm, or near harm, comes to a patient because you don't have capacity to deliver safe care and escalation to seniors have failed to provide that safe care.

	Medicine	Surgery	Specialist Surgery	Derm	Haem & Onc	Total
2018/19	(6) 1		(1)1			(7)2
2019/20	(1)1	(3)2				(4)3
2020/21	(9)2					(9)2
2021/22	(6)2	(2)0			(6)0	(14)2
2022/23	(19)3	(1)0				(20)3
2023/24	(11) 0		(3) 1			(14) 1
2024/25	(16) 0			(4) 2		(20)2
2025/26	(5)0	(1) 0			(2) 0	(8)0
2026/27 YTD	(17) 0	(6) 0	(1) 0			(24) 0

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There were 15 ISC's reported but were all down graded as did not meet criteria (or ticked in error), It is worth noting that 6 of them were by the cardiology team.

3.5 Fines

8 fines issued in total across a variety of specialties; 5 for breaching maximum 13 hour shift and 4 for not having 11 hours rest (1 breached both).

3.6 Freedom of Information

Nil this Quarter

4. Risk

Rest facilities Trelawny

We still need a solution for as rest space in Trelawny.

5. Accountability

The Executive Director Lead is Dr Meridith Kane, Chief Medical Officer.
The Guardian of Safe Working is Dr Sarah Coulter.

6. Recommendations

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The Board is recommended to:

- **Receive** and **note** the Quarter 2 (2026/27) report from the Guardian of Safe Working Hours.

Meeting: Trust Board In Public

Date of Meeting: 05 November 2026

Item Number: 12

Title of Report: Freedom to Speak Up Half Year Report - April to September 2026

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Joanne Burton, Lead Freedom to Speak Up Guardian

Email Address: joanne.burton6@nhs.net

Purpose of the Report:

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

This half year report provides the Board with information and assurance on the effectiveness of Freedom to Speak Up (FTSU) arrangements at Royal Cornwall Hospitals NHS Trust (RCHT) for the period April 2026 – September 2026. It also invites discussion on trends, lessons learnt and future priorities.

Consultation:

The Lead Guardian provides reports to the Board twice a year and attends the People and Organisational Development Committee to give FTSU updates. The report was discussed at the Executive Leadership team meeting 28th October 2026 and feedback is incorporated into this report.

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') – 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 regard to one or more of those three areas (known as the 'triple aim').

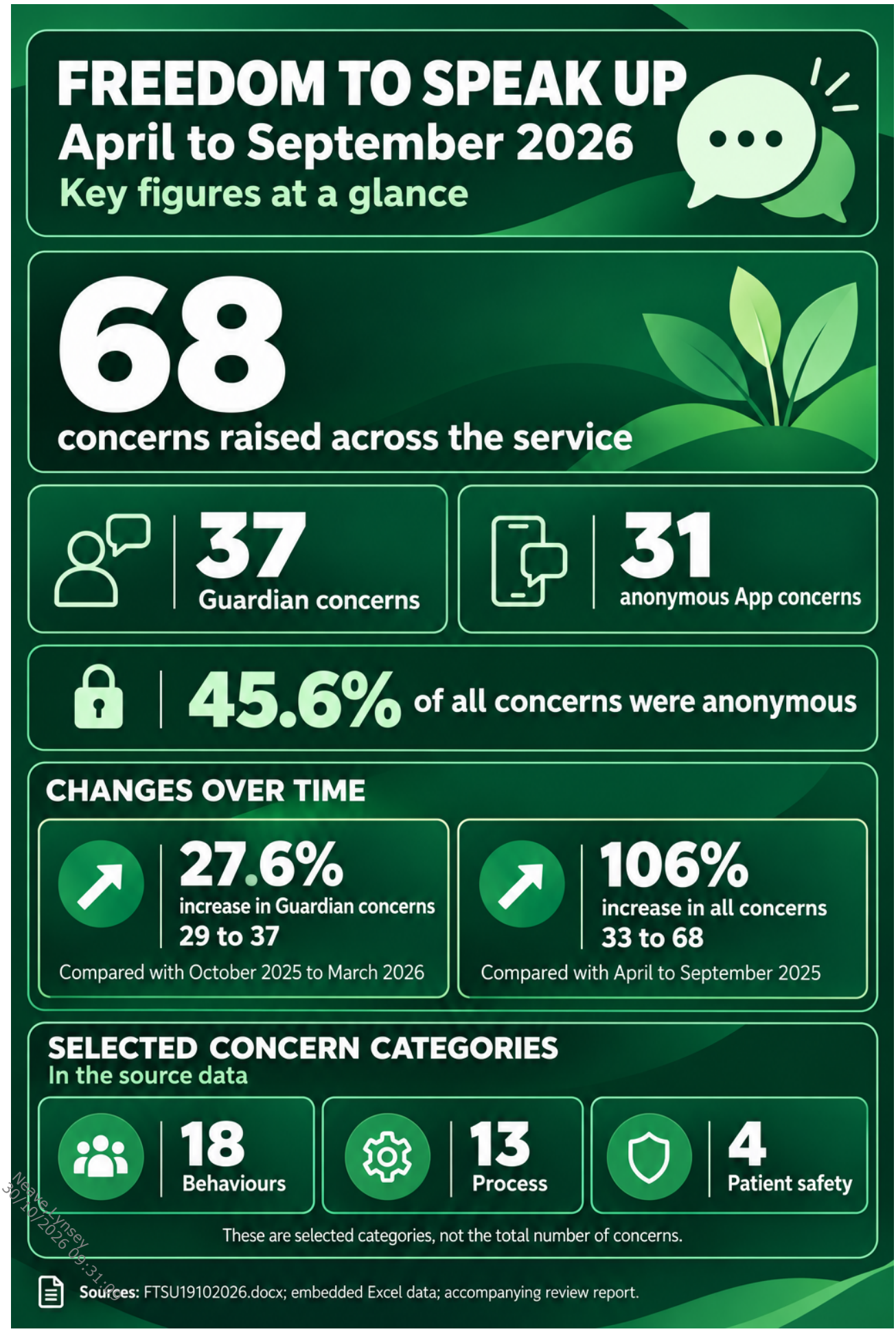
Considerations	Summary of considerations (if one or more does not apply, state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	N/A
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	N/A
Sustainable and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

Recommendations:

The Board is recommended to:

- **Receive and discuss for assurance** the key issues identified in the half year report.
- **Discuss for assurance**, the increase in concerns raised through the FTSU service, including anonymous concerns.

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FREEDOM TO SPEAK UP
April to September 2026
Key figures at a glance
68
concerns raised across the service
37
Guardian concerns
31
anonymous App concerns
45.6%
of all concerns were anonymous
CHANGES OVER TIME
27.6%
increase in Guardian concerns
29 to 37
Compared with October 2025 to March 2026
106%
increase in all concerns
33 to 68
Compared with April to September 2025
SELECTED CONCERN CATEGORIES
In the source data
18
Behaviours
13
Process
4
Patient safety
These are selected categories, not the total number of concerns.
Sources: FTSU19102026.docx; embedded Excel data; accompanying review report.

Half Year Freedom to Speak Up (FTSU) Report

1. Situation / Executive Summary

From April 2026 to September 2026, 68 concerns were raised through the Freedom to Speak Up service. 37 concerns were raised directly with the FTSU Guardians (a 27.6% increase on the previous six months' data) and 31 were submitted via the anonymous platform, meaning 45.6% of contacts were anonymous. This compares with 13 anonymous cases in the previous six months.

The proportion of anonymous cases remains higher than the national average (12% nationally). It is important to note that not all organisations have a platform where staff can raise anonymous concerns. RCHT has had an anonymous platform since 2019 with various responders including our chief executive. Concerns raised with Guardians continue to be principally about behaviours and relationships and process issues. Cases often have several elements of categories within them, the most common being cultural issues.

The Lead Guardian and Executive Lead continue to note cases becoming more complex in nature, frequently requiring HR investigations and Executive input due to the nature of the concerns. People speaking up included nursing and midwifery staff who raised the most concerns (14) followed by additional clinical services colleagues (8). The Lead Guardian has also noted more conversations with senior leaders throughout the organisation requiring supportive conversations due to 'constant pressure.' The Guardians received 1 concern from medical staff in this time frame, although we now have 6 medical colleagues who are trained Freedom to Speak Up champions and they are having frequent supportive FTSU conversations throughout the organisation.

Many concerns coming to FTSU need never become formal grievances – but if the behaviour driving them isn't addressed early, that is where they often end up. We need to show colleagues that staff voice will drive learning and improvement across the board, not solely from the Guardian service.

This report summarises the themes raised and aligns the Trust's processes with our speak-up policy across all three of our hospital sites.

2. Background

During this reporting period, the Trust has navigated two significant organisational change processes alongside ongoing financial pressures and the wider impact of increased scrutiny across the NHS following the publication of the Thirlwall Report. Collectively, these factors have contributed to a period of considerable uncertainty and emotional strain for many colleagues. The Freedom to Speak Up Guardians have engaged in numerous conversations with staff regarding organisational change, workforce concerns, and the impact of these developments. In many cases, colleagues have requested that concerns are not escalated due to fears of detriment.

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The Thirlwall Report showed the serious consequences of concerns not being heard, acted on or escalated, and of staff feeling unable to challenge decisions or behaviours. It reinforces the need for all staff, regardless of role or seniority, to feel psychologically safe to speak up, confident they will be taken seriously and protected from detriment. Together, the Ockenden and Thirlwall Reports highlight that open, curious cultures which welcome and act on concerns are essential to patient safety, staff wellbeing and organisational learning, particularly during significant change.

Speaking up is everyone's responsibility. Staff must feel safe to raise concerns and ideas without fear of silence or detriment. At RCHT, Guardians remain a trusted route for doing so. The Lead Guardian regularly meets the Chief Executive and Executive and Non-Executive Leads to review themes and cases, support learning, and ensure effective escalation and triangulation.

RCHT's diverse champion team has grown to 119 (84), including six medical staff, with regular training continuing. Deputy Guardians strengthen capacity and resilience across RCHT and CFT, supporting openness, psychological safety and listening, while enabling greater strategic focus within RCHT's new divisional structure.

FTSU promotion through induction, the staff app, champion biographies, screensavers, communications and mandatory training has increased awareness. Training compliance has improved slightly but remains low among senior leaders. The Guardians promote the mandatory training at induction. The Lead Guardian is attending the next mandatory training cluster group to discuss the modules that senior leaders complete.

Following discussion at the Executive leadership Team meeting it was raised that completing all three modules may not be the most effective way of delivering this training. The Lead Guardian will discuss next steps with each division and consider one training session to cover learning required and to also promote honest engagement around FTSU conversations and learning for our senior leaders.

Speak Up: 72.1% (all workers)
Listen Up: 60.3% (managers)
Follow Up: 44.7% (senior leaders)

During walkabouts, colleagues often say they learned about speaking up through mandatory training, induction or posters.

Guardians attend network and culture meetings, and team sessions, to present and hear staff views. They will continue supporting staff and the Board to foster a healthy, compassionate workplace aligned with Trust values.

3. NHS England FTSU Guidance

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RCHT Guardians participate in NHS England regional networks. The Lead Guardian submits quarterly national data, mentors new Guardians and works with the NHS England Guardian Support team to share learning and align with national priorities. A planned national Executive Lead network will strengthen oversight and best-practice sharing. The

Southwest network is also arranging a champion development session, including Nycki Grey Cooper's presentation, "Active Allyship: My Lived Experience", and a regional Guardian conference in February for learning, networking and support.

4. Listening to Colleagues

RCHT offers several internal speaking-up routes, including managers, department leads, patient safety, Employee Relations, unions, FTSU champions and Guardians. Concerns can be raised openly, confidentially or anonymously.

Curious listening is essential to make speaking up routine. Behaviours, relationships and process issues remained the main themes over the past six months.

Increasingly complex cases require formal HR support, prolonging resolution and sometimes contributing to staff absence and reduced wellbeing.

Employee Relations formal cases have risen by 27% while the team is reduced. Guardians often support colleagues through these lengthy, stressful processes.

Guardians have heard concerns about senior leaders' behaviour and colleagues' experiences of organisational change. Many fear detriments and do not want a case opened. A negative speaking-up culture risks patient safety, morale, teamwork, attendance and retention.

5. Guardian Activity

Guardians promote FTSU at corporate and medical inductions, alongside the staff support team. Visibility across all sites is central to their role and deputy Guardian induction. Recent visits include the food production unit, St Austell Surgical Hub, maternity, St Michael's, West Cornwall Hospital and most wards.

The Lead Guardian meets regularly with divisions and key teams to discuss FTSU themes, culture, improvement and support. The divisional meetings are useful for case theme discussion and updates and for triangulation of work that is happening in areas to improve staff and patient experience, this often leads to more through feedback for the individual speaking up. Some examples include divisional directors following up on feedback that the Guardian provided after a walk around of the hospital. Discussions around a lack of medical cover in an area have also started a positive conversation regarding nurses receiving extra training in this area. Both Guardians attend triangulation and Culture Group meetings and work with our organisational development practitioner. At the culture meetings the Guardians focus on themes and trends of concerns and examples of good practice. There are no identifiable details shared, this enables attendees to better understand parts of the organisational picture and to take improvement action .

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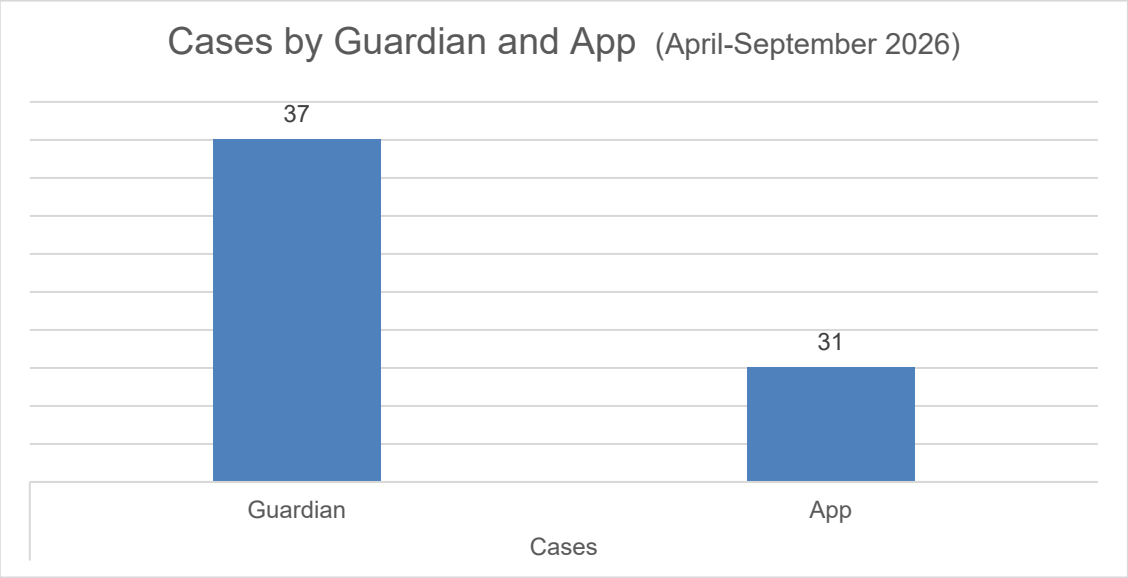
The thriving champion network receives regular training and holds well-attended monthly meetings. Champions refer colleagues and discuss concerns with Guardians, who also attend Southwest network meetings for learning and peer support.

5. People Speaking Up (April 2026 to September 2026)

Over the past six months 68 concerns were raised through the FTSU service compared with 33 cases in the same period last year, an increase of 106%.

31 cases were raised on the anonymous reporting platform compared to 14 in the same period last year. This shows that the Guardians remain a primary route, though the use of the anonymous platform continues to attract colleagues who prefer anonymity, and perhaps a choice in whom they speak up to.

The increased anonymous concerns point to our colleagues feeling unsafe to raise their concerns more openly which is a worry for us culturally. We continue to need to focus on improving psychological safety to enable more open conversations ideally starting with colleagues and their line managers.



6. Category of Concern

Over the previous six months the greatest number of cases raised has been concerning behaviours and relationships (18 cases).

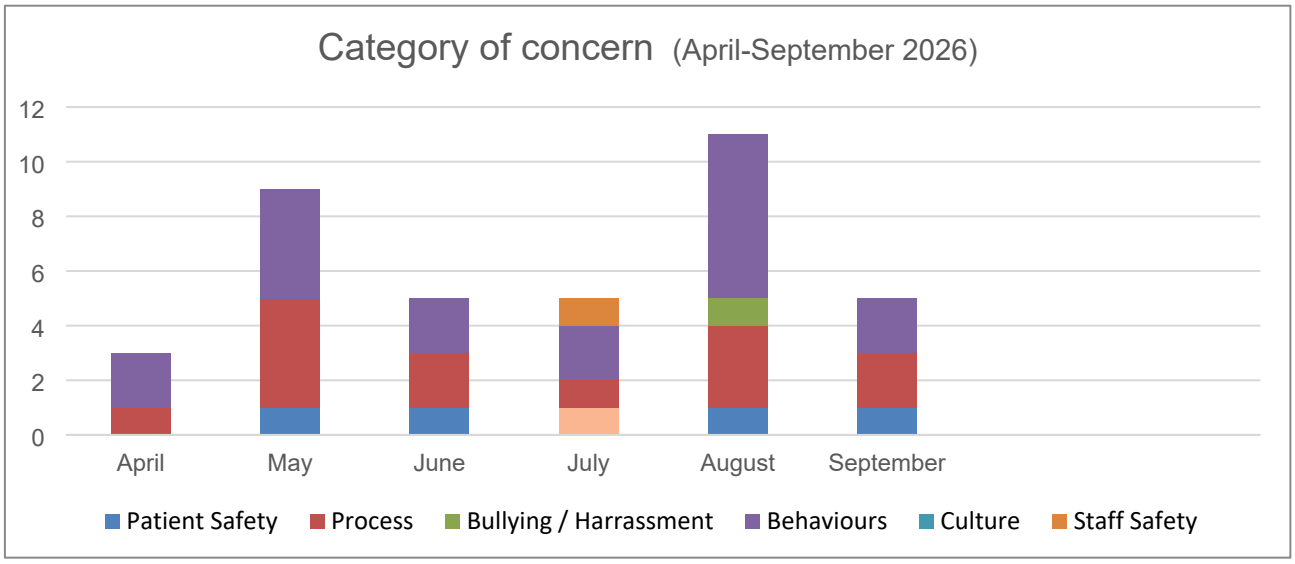
Cases are often a mixture of categories, and nearly all cases will have an element of cultural issues within them. Process issues are the second highest group with 13 concerns raised (3 more than in the previous six months).

Examples of these concerns include speaking up about formal processes including investigations and organisational change. The launch of our Culture Transformation work and recruitment of organisational development practitioners should steadily improve how it feels to work at RCHT and over time we would hope to see an improvement in relationships and behaviours, and a decrease in formal resolution and an increase in facilitated conversations and mediation.

Mary Clynsey 30/01/2026 04:31:09

Four patient safety cases were received, which have received robust actions and good communication and conversations from divisions. We receive low numbers of cases with

bullying as a theme which is positive; often these cases are better suited to a more formal process to investigate.

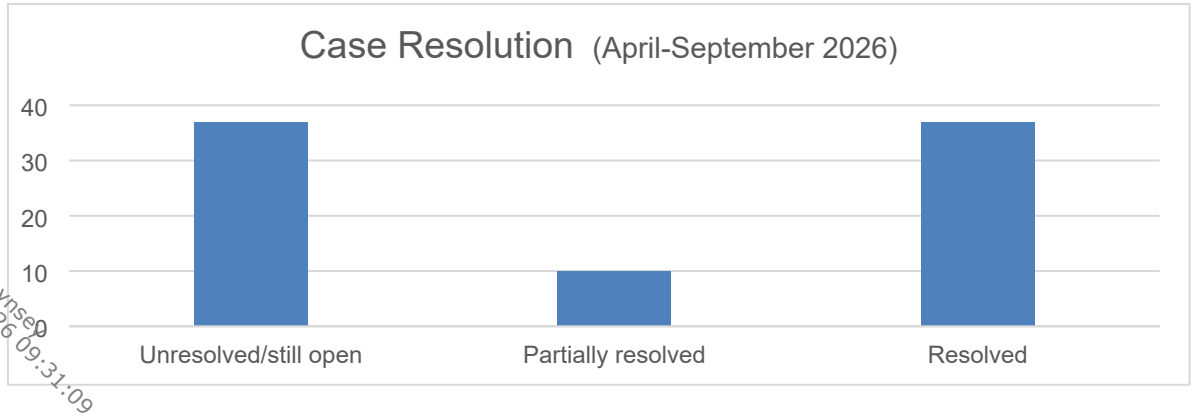


7. Case Resolution

At the time of writing, 37 cases remain unresolved. There are actions on all cases, and the Guardians regularly check progress and provide feedback. Cases are often prolonged due to formal ongoing investigation processes, and/or lack of engagement and feedback. 18 of the cases currently open currently have an element of Employee relation involvement, including ongoing investigations and informal support where the colleague has also involved the Guardian. One case was opened in April 2025, the colleague has now left the organisation, and the formal Employee Relations process remains open.

Partially resolved cases denote that there are still outstanding issues and at times ongoing formal investigations and sickness.

The Guardians will always communicate with relevant staff to gain updates on cases to ensure the person who has spoken up is really listened to and to avoid the feeling that 'It is being brushed under the carpet.' Our aim is to resolve cases as soon as possible, but again we are noting more complex lengthy cases which often require greater intervention. The Guardians always maintain regular communication and offer ongoing support and case updates for colleagues raising concerns.



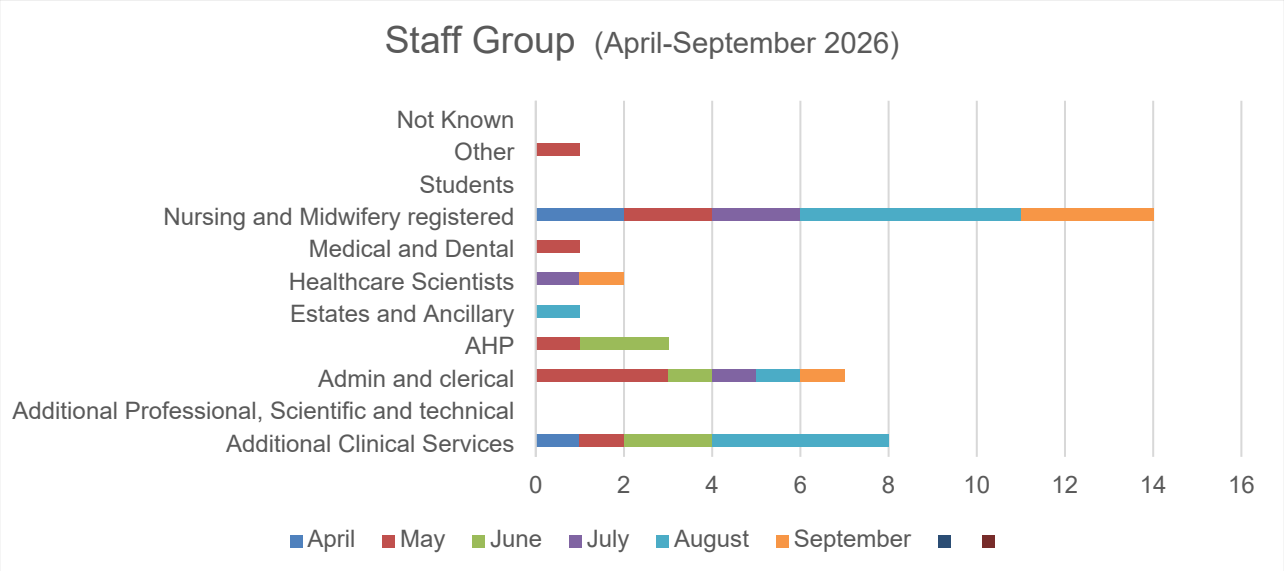
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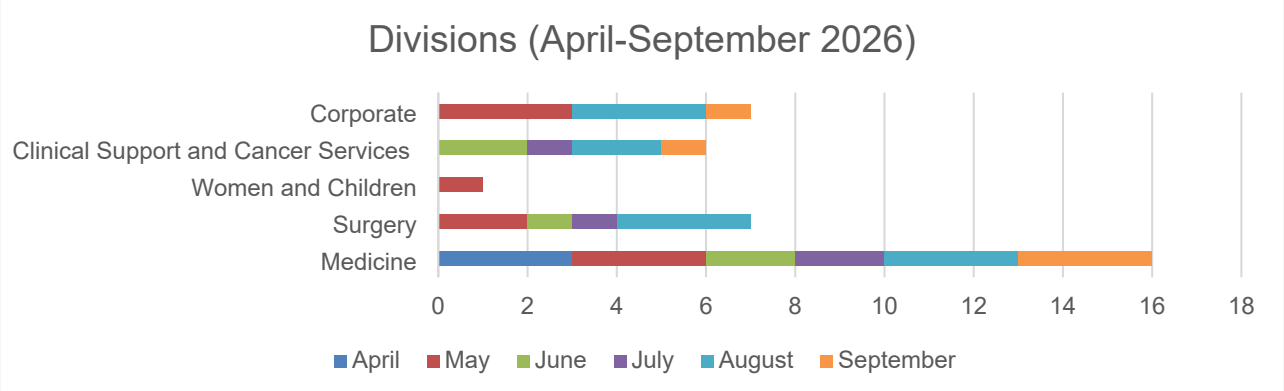
8. Professional Groups and Care Group Reporting

During the six months nursing and midwifery staff have raised the largest number of concerns (14) followed by additional clinical services staff raising 8 concerns, both an increase on the previous year. We had one member of medical staff raising concerns with the Guardian in this time frame; however, we now have 5 members of the medical team trained as champions, including our Chief Resident Doctor.

These doctors are already actively supporting work around sexual safety and speaking up. We are actively seeking more colleagues from the Allied Health Professions (AHP) community to join our champion team.

We have no cases from students in this time frame but do liaise with clinical practice educators and our champion, who is a university lecturer and promotes speaking up both in the university and through the Guardian route.





The medicine division has the highest number of cases and the themes and actions around these cases are discussed regularly to resolve concerns in a timely manner. Guardians aim to support workers and leaders to discuss concerns in a comfortable environment.

Alexandra Jersey
30/10/2026 09:42:10

The Lead Guardian has noted some more junior leaders feeling underconfident with leading on these issues. The Fundamentals of Management course, which was launched in September, aims to support these more junior leaders.

The Lead Guardian will work with each division to address local speaking-up themes and help staff and managers raise and resolve concerns safely.

The Guardian will encourage leaders to share appropriate speaking-up stories and case studies, while holding managers accountable for preventing victimisation.

FTSU cases in Maternity have historically been low. The Lead Guardian has discussed this with senior divisional leaders, supported by frequent walkabouts and newly trained champions.

We must show that staff voice drives organisation-wide learning and improvement, not just the Guardian service.

The Guardian seeks feedback after each case closes. In response to requests for greater visibility, both Guardians have spent one day a month at peripheral sites since April 2026, alongside regular visits across the Trust.

Before starting the process, I felt a lot of anxiety because it was all new to me and I didn't know anyone who had used the service before. The actual experience was very positive – I felt genuinely supported, and I felt that my concerns were listened to and taken seriously.

I am incredibly grateful for the swift guidance and intervention you provided.
I think talking to you and taking me seriously made a huge difference and I would like to

Based on how well I was supported and kept informed, I would definitely speak up again.

The regular check-ins were incredibly helpful. Not only did they keep me up to date with the process, but just having someone ask 'how are you?' meant a lot. It reassured me that I hadn't been forgotten about.

Thank you so much for being there for me when I needed help. I hope everyone out there would also reach out to you when they are having a difficult situation at work.

Neave-Lynsey
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10. Learning and Triangulation

FTSU learning is shared with relevant colleagues and the new patient and staff safety triangulation group to review themes and lessons.

Themes are triangulated with patient safety incidents, HR cases and staff survey data to identify systemic issues. A dashboard is being developed to strengthen oversight.

After appropriate case closures, the Guardian meets relevant colleagues to embed learning. Increased referrals suggest staff trust the Guardian route, but they should feel safe to raise concerns locally.

Behaviour and relationship cases indicate a need for compassionate leadership and conflict resolution support. Unresolved cultural issues can reduce morale, increase sickness and affect patient safety and satisfaction.

Colleagues are encouraged to provide feedback at case closure, including through a recent session with the Chief Operating Officer and Dual People Officer. Communication, particularly between colleagues and line managers, remains a recurring theme.

12. Champions

Our 118 diverse champions across CFT and RCHT promote speaking up and meaningful conversations. Guardians train champions with line-manager support; recent recruits include a midwife, senior clinical coder, finance administrator and deputy ward sister.

Champions volunteer time, support and signposting to colleagues. They meet monthly with Guardians for learning, theme review, planning and peer support.

The network spans all hospital sites, offering colleagues a choice of people to approach. Champion biographies and contact details are available on SharePoint and regularly promoted to staff. Examples below include a newly trained champion and feedback from a colleague who completed the training.

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13. Conclusion

Over the past six months, colleagues continued to raise concerns through Guardians and the anonymous app amid organisational change and financial scrutiny. The champion network has strengthened, and new deputy Guardians at CFT and RCHT are managing cases and regularly meeting staff locally.

FTSU remains vital to organisational culture, enabling concerns that improve safety, experience and wellbeing. Compassionate leadership, mandatory training and consistent Trust-wide messaging on behavior's and speaking up will help ensure every voice counts.

14. Risk

Freedom to Speak Up links to the NHS People Plan by ensuring workers have a voice that counts and by developing a speaking up culture where we value the voice of staff as a vital driver of learning and improvement. Failure to listen, improve and create a positive speaking up culture will risk patient safety and fail to promote retention and recruitment of staff.

- **Clinical risk.** Patient safety may be compromised without a safe, skilled workforce.
- **Financial risk.** Failure to listen and act may increase sickness, turnover, temporary staffing costs, investigations and employment claims.

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30/10/2026 09:31:09

- **People risk.** Failure to listen and protect those who speak up from detriment may harm recruitment and retention.
- **Reputational risk.** A poor speaking-up culture may damage our reputation, staff experience and quality of care.
- **Legal/regulatory** risk**.** If FTSU is not maintained and supported, the Trust's CQC "Well-led" rating may deteriorate.

15. Accountability

- Operational lead: Joanne Burton, Lead Freedom to Speak Up Guardian.
- Executive Lead: Bernadette George, Acting Chief Nursing Officer.
- Non-Executive Director: Richard Kramer.
- The next annual report will be presented to the Board in May 2027.

16. Recommendations

The Board is recommended to:

- **Receive and discuss for assurance** the key issues identified in the half year report.

- **Discuss for assurance**, the increase in concerns raised through the FTSU service, including anonymous concerns.

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: XX

Title of Report: Quality Assurance Committee Assurance Report – September and October 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

The following were either approved or recommended to refer for decision by the Board.

- **Winter Plan and Board Assurance Statements** – Committee approved as per delegation by the Board

Issues for escalation or notification to the Trust Board

The Committee identified **unlawful access to patient records and the current gap against national requirements** as the principal matter requiring escalation in public.

The Board is also asked to note the Committee's continuing oversight of:

- UEC recovery and the need to ensure that improvement in ward corridor care does not displace risk elsewhere in the pathway;

Neave Lykey 30/10/2026 09:31:09

- quality guardrails during enhanced financial controls, including patient experience and staff wellbeing;
- safeguarding training and professional curiosity following consideration of the Thirlwall Inquiry;
- the continuing recovery requirements for fractured neck of femur services;
- overdue incident reviews; and
- the strengthened consideration of mental health assessment performance within future UEC reporting.

Summary of assurance and risk

Quality Assurance Committee (QAC) Assurance Report – September 2026

The Committee received an update from the **Acting Chief Nursing Officer and Chief Medical Officer** on the national and local quality context. Positive assurance was received regarding the anticipated national volunteer accreditation following assessment.

The Committee considered the implications of the Thirlwall Inquiry, including organisational oversight, responsiveness to safety concerns, safeguarding, data and mortality surveillance, communication and candour. Immediate national requirements were being reviewed locally, with further Board communication planned. Wider organisational implications require further consideration. The Committee also noted the future extension of Martha's Rule to emergency departments.

The **BAF** was in transition following Board approval of the revised approach. Although controls and oversight had strengthened, principal risks remained outside tolerance and there was not yet evidence of sustained risk reduction. The Committee agreed that its focus should remain on delivery, impact and recovery, rather than the existence of additional controls or actions. The Committee's agenda continued to align with the principal risks within its remit.

The Committee considered the extensive programme to recover **UEC** standards and eliminate corridor care, including strengthened seven-day flow arrangements, revised escalation processes, implementation of GIRFT clinical operational standards, divisional delivery assurance, improved discharge planning and defined requirements of system partners. Members recognised the considerable operational focus and commitment but questioned whether the volume of actions, meetings and data collection was identifying and prioritising the interventions most likely to improve outcomes. In particular, the Committee sought assurance that root-cause analysis of corridor care was generating useful learning, that ineffective interventions would be

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stopped, and that progress would be assessed by sustained improvement rather than completion of actions.

Challenge focused on discharge before midday, which remained materially below the 30% ambition, and on the Trust's ability to sustain improvement across seven days. The Committee heard that earlier discharge required decisions, diagnostics, transport and other arrangements to be completed or planned on the preceding day, supported by greater use of the discharge-ready unit. Members also questioned whether system partners were sufficiently aligned with the actions required to improve flow. Although regular partnership and regional oversight arrangements were described, the Committee remained concerned that recovery depended on capacity and actions beyond the Trust's direct control.

The Committee received assurance regarding the strengthened governance and operational arrangements but did not yet have sufficient assurance that these were delivering sustained improvement in patient flow, ambulance handovers, 12-hour waits and corridor care. Further assurance was therefore requested through outcome-focused reporting, including clear trajectories, evidence of the impact of priority interventions, learning from corridor care reviews and delivery against agreed system partner actions.

The Committee recognised the considerable operational effort under way but did not yet have sufficient assurance that the volume of interventions was delivering sustained improvement. Future reporting should demonstrate trajectories and impact, rather than primarily describing actions.

The Committee considered the baseline assessment against the 15 **Model Acute Pathway standards.** No standard was fully compliant Trust-wide; 14 were assessed as partially compliant and continuity of care was non-compliant. The proposed divisional workshops, consolidated action planning and linkage with CQC assurance processes were supported. The Committee endorsed development of a single prioritised plan, focused particularly on actions most likely to influence four-hour and 12-hour performance.

Committee members concluded that a fuller progress update should be provided at approximately three months rather than waiting six months for formal reporting.

The Committee received the **Winter Plan and Board Assurance Statements** and questioned whether the automatically generated rating of 4, substantial assurance, adequately reflected a Board Assurance Statement containing a number of "No" responses and areas requiring further system work. Members considered that positive and negative responses both required clearer evidence and qualification to provide an appropriate audit trail.

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Further assurance was sought on how equality and population health considerations informed the plan, including disproportionate winter impacts on older people, those with long-term conditions and deprived communities, or what further work was required.

Members questioned whether organisational winter plans supported coordinated system decisions, particularly over weekends. Approval should await incorporation of learning and changes from regional and local exercises, including the local exercise held that day.

The Committee also required explicit residual safety risks from overcrowding, escalation spaces and corridor care, including fire safety and evacuation, recognising that mitigation depended partly on patient flow and system capacity beyond RCHT's control.

The Committee supported the direction of travel but did not approve the Winter Plan and Board Assurance Statement. Approval required a clearly defined plan and supporting references; evidenced, qualified assurance responses; balanced partnership wording; explicit health inequalities and residual safety risks; and incorporation of winter exercise learning. With submission due on 30 September 2026, approval of the revised version through e-governance was recommended once these requirements were addressed. This was subsequently actioned before the deadline.

The Committee concentrated its scrutiny on quality indicators in the **Integrated Performance Report.** UEC remained the principal concern alongside continued elective, workforce and financial pressures. Mixed quality performance was noted, with particular concern regarding fractured neck of femur performance, complaints and duty of candour. The deterioration in complaints performance following divisional restructuring was highlighted. Enhanced weekly review and targeted support had been put in place.

The Committee emphasised the importance of monitoring the quality and patient safety consequences of financial recovery measures, including any unintended effect of enhanced financial controls on the pace of necessary safety interventions.

With regard to the **Learning from Deaths report**, overall mortality remained stable, with HSMR continuing a downward trend from 2022. Potential coding issues affecting SHMI were being investigated.

Fractured neck of femur mortality was reported at 6.4% against a national average of 5%. The Trust had received correspondence indicating that it might be moving towards outlier status.

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Learning from reviews continued to identify deterioration, delays in investigations and specialist referral, documentation, discharge planning, overcrowding and flow. The relationship between mortality and health inequalities was also highlighted.

Committee concluded the relevant fractured neck of femur correspondence and improvement plan should return to the next meeting.

The Committee received positive assurance on overall progress but noted that eight actions remained off track, including six mandatory “must do” actions on the **CQC Improvement Plan**. Key areas included VTE assessment, clinical supervision, Mental Health Act assessment arrangements, mandatory training and appraisal.

The Committee requested revised target dates for off-track actions and endorsed the revised Statement of Purpose for onward approval.

The Committee considered the **Patient Safety Incident Response Group assurance report** and the learning from recent Never Events and other patient safety incidents. Learning had been communicated through governance and safety mechanisms, with further audit and assurance planned to test whether changes in practice were embedded.

Duty of candour performance had improved, although the Committee stressed the importance of sustaining this improvement. The deteriorating position regarding overdue incidents was noted, with targeted work under way, particularly within Medical Services, and improvement expected over the following three months.

The Committee received a comprehensive **end of life care report** and noted generally strong delivery of responsive, person-centred end-of-life care. Further assurance was required regarding participation in national bereavement survey arrangements, advance care planning, recording of nutrition and hydration plans, and the continuing high risk associated with patients not receiving care in their preferred setting.

Of particular concern was the lack of substantive movement in the number of patients entering hospital during their final 100 days of life. Further system and neighbourhood working was required.

The Committee welcomed a positive baseline assessment against the recently published **Sepsis Modern Service Framework.** Good assurance was received regarding the acute phase of sepsis identification and management. Further development was required in prevention and population health, health inequalities, patient and family involvement, and post-sepsis recovery and rehabilitation. Continued oversight was supported, with fuller assurance to follow when national core standards become available.

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The Committee considered **Perinatal Safety, Thirlwall Inquiry: Immediate Actions, and Maternity and Neonatal Workforce** together. It received assurance on the immediate review and staff-support arrangements following recent perinatal deaths, including a maternal death and stillbirth, recognising the significant effect on staff, exceptional teamwork and cross-trust collaboration. Members challenged whether reviews would address the joined-up care of mother and baby; the maternal, perinatal and family-focused processes would collectively provide this review, with learning required through established governance routes. The Committee approved the revised maternity triage baseline, welcoming the evidence-based reassessment of three elements from green to amber because collection, analysis and triangulation of ethnicity and deprivation data were not yet fully embedded.

The five immediate Thirlwall requirements had been identified and were being progressed: consideration at the next available public Board meeting; application of SUDIC to unexpected neonatal deaths; alignment with the National Bereavement Care Pathway; secure insulin storage; and safeguarding training compliance. Neonatal policy and communications were being updated, a bereavement gap analysis had been commissioned and removal of rarely used insulin from the neonatal unit was proposed. Members required confirmation that each action was complete or had a clear completion plan with a formal update to the next Board meeting were agreed; a Board development session was suggested to improve Board safeguarding training compliance.

Maternity staffing was fully recruited, with additional cover for maternity leave and supernumerary new starters. There were no service closures or out-of-county escalations, triage performance improved from 52% to 86%, and no elective caesarean delays occurred in the preceding six months. The workforce report was endorsed for onward Trust Board approval.

Obstetric workforce risk remained high, including pressures on gynaecology capacity. Neonatal qualified-in-specialty staffing improved from 25% in January to 48.86%, below the 70% BAPM standard. Recruitment, international appointment and staged training aimed to achieve approximately 68% to 70% over the following year. Members welcomed the recruitment, development and retention focus; the neonatal risk score had reduced to 12.

The Committee received assurance on immediate perinatal review and staff support, good assurance on maternity staffing and improving assurance on neonatal staffing. The revised triage baseline was approved and the workforce report endorsed for onward Board approval. Further assurance remained necessary on joined-up review learning, embedding ethnicity and deprivation data, formal Board confirmation of completion or clear completion plans for all five immediate Thirlwall actions, and progress towards the BAPM staffing standard, with the high obstetric workforce risk remaining unresolved.

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Overall **health and safety assurance** was assessed as moderate. Established governance and improvement arrangements were evident, but significant residual risks and assurance gaps remained. The Committee sought greater clarity on a risk-prioritised occupational health surveillance programme, including timescales and residual risk, and on health and safety training compliance. Challenge also focused on learning from incidents and near misses, wider organisational communication, and reinforcement of health and safety culture and personal responsibility. Further assurance was sought on learning from fire evacuation exercises, COSHH and fit-testing arrangements, and evidence of progress in areas assessed as providing limited or moderate assurance.

The Committee required future reporting to include a time-specific improvement plan setting out the actions needed to move areas of limited and moderate assurance towards substantial assurance, with evidence of progress.

The **Unlawful Access to Patient Records** substantive report was deferred to October. The Committee agreed that the existing action should remain open pending consideration of the report.

The Committee considered the 2026/27 **Provider Capability Self-Assessment,** with proposed amber-green ratings across all six domains. Members recognised strong governance, leadership and strategic arrangements, but considered whether the ratings sufficiently reflected the Trust's current operational, performance, workforce and financial challenges following movement into NHS Oversight Framework segment 3.

From a quality perspective, there was considerable evidence of governance, challenge and assurance processes, while recognising the need to balance this against organisational delivery. A minor amendment was requested to strengthen wording on violence prevention and reduction. The Committee supported continued refinement ahead of Trust Board consideration and subsequent submission.

Quality Assurance Committee (QAC) Assurance Report - October 2026

The Committee received the **Chief Nursing Officer/Chief Medical Officer Update** and members sought further assurance regarding the national findings relating to SAS and locally employed doctors, particularly whether the national picture reflected the experience of doctors locally and whether there were sufficiently safe mechanisms through which individuals could raise concerns. Existing forums and support arrangements were described, and further engagement with the relevant staff groups was requested to test whether additional provision was required.

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Following publication of new national guidance relating to NHS facilities and mixed-sex accommodation, the Committee asked how compliant the Trust was with the revised requirements. Assurance was provided regarding the previous requirements,

but it was recognised that the new guidance could create gaps relating to areas including estates, policies and training. An initial assessment will return in November, followed by a fuller gap analysis in December.

The Committee welcomed the revised **Board Assurance Framework** and considered whether it accurately captured the principal risks, gaps in assurance and actions relevant to the Committee. Members noted that prior review of the BAF against the Committee work programme had provided assurance that the agenda was appropriately aligned to the principal areas of risk. The revised BAF will proceed to Trust Board for approval.

The Committee also noted that discussions were underway with CFT regarding the future form and purpose of the Part 2 Quality Assurance Commtitee arrangements. The next existing Part 2 meeting has been paused to allow further consideration of how the arrangements could be strengthened and aligned to both organisations' strategic priorities and assurance needs.

The Committee reviewed the **IPR**, welcoming continued improvement in stroke services and infection prevention, while noting further work required across the stroke and community pathways. Members raised concern regarding increased formal complaints and response times, particularly within ED, cardiology and orthopaedics, and the lack of sufficient progress with delirium assessment and improvement actions. The Committee also requested greater visibility of prolonged stays within AMU, including the cardiology cohort, given the impact on patient flow. Overall, the Committee was assured by the progress reported while maintaining oversight of areas requiring further improvement.

With regard to **Urgent and Emergency Care** performance, members noted that current trajectories were not yet being achieved but welcomed sustained progress in reducing ward corridor care and improvements in ambulance handovers and four-hour performance. However, members challenged whether improvement in one part of the pathway might be displacing risk elsewhere, specifically through 12-hour waits and continuing corridor care within the Emergency Department. It was acknowledged that there had been some impact on 12-hour performance and that further work remained necessary.

The Committee also challenged whether sufficient out-of-hospital capacity was available to support patient flow, including Acute Care at Home and the wider community pathway. Members supported the ongoing review of integrated transfer of care and out-of-hospital urgent care capacity, with particular emphasis on identifying missed opportunities to provide care outside hospital. The continued presence of corridor care within ED remained an area requiring focus.

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Members requested greater visibility of prolonged patient cohorts within AMU, including cardiology-related waits and their impact upon throughput. It was agreed that the next UEC report would include a specific section on the cardiology position.

With regard to **Fractured Neck of Femur** the Committee scrutinised the Trust's potential mortality outlier position and the associated recovery actions. Particular challenge focused on performance against early mobilisation measures and whether the right therapy and ward resources were available at the appropriate time. Members heard that in-month improvement was stronger than the rolling position suggested and that greater use of ward teams was being developed alongside therapy input.

The Committee also challenged the resilience of the pathway in advance of winter, including trauma surgical capacity and therapy support. Further assurance was provided regarding strengthened divisional oversight, fortnightly MDT arrangements and recruitment to support trauma capacity. The Committee will continue to maintain oversight of the recovery trajectory.

The Committee received generally good assurance on the **Seven Day Services** programme but focused challenge on areas where evidence remained incomplete. Members questioned the position regarding timeliness of mental health assessments, noting that the current information did not provide sufficiently robust longitudinal assurance. It was agreed that this information should be developed with partners and incorporated within future UEC reporting rather than creating a separate reporting route.

The Committee also requested further assurance regarding Standard 2 and consultant review within the acute medical areas following implementation of the revised acute medical model. A repeat audit is required, with an exception update scheduled for December.

The Committee was assured by the improvement in **clinical audit** governance and divisional engagement and noted the progress made since previous reviews. Members specifically tested whether accountability and engagement within divisions had strengthened sufficiently and received assurance that clinical chairs had been integral to the improvement.

The Committee nevertheless retained focus on areas requiring improvement, including dementia and delirium recognition and the actions resulting from the paediatric diabetes audit. Further work was already underway concerning delirium assessment and the Committee was assured that the paediatric diabetes action plan would continue to be monitored through the **Clinical Effectiveness Group.**

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The Committee considered whether progress at Quarter 2 on the **Quality Priorities** was sufficient and received assurance that overall delivery was broadly where

expected. However, members identified staff influenza vaccination and communication/patient experience as areas requiring continued focus. Assurance in relation to communication was recognised as less strong than for the other quality priorities and will therefore continue to be monitored.

The Committee considered the Trust's position against the immediate actions arising from the **Thirlwall Inquiry** and challenged whether sufficient assurance existed around safeguarding training, particularly for managers, professional curiosity and the organisational ability to identify emerging patterns of concern.

Members also challenged whether multiple national reviews and sets of recommendations were sufficiently coordinated and asked that overlapping requirements be brought together wherever possible to avoid duplication and support clearer organisational oversight. Further consideration was requested of opportunities to strengthen professional curiosity and challenge across professional groups.

The Committee approved the gap analysis and noted the immediate actions, recognising that there remained further work to achieve the required position.

The Committee noted the **CQC Assurance report** and endorsed the Statement of Purpose and sought assurance regarding the ongoing CQC renal inspection. The inspection process was nearing completion and the Committee was advised that the resulting report would return to both the Committee and Trust Board once available.

The Committee received the **Patient Safety Incident and Response Group** report and focused challenge on the 886 overdue incident reviews, seeking assurance that the recovery plan was deliverable without additional staffing and that divisions were giving the work sufficient priority. Assurance was provided that recovery depended upon improved grip and control using existing resources and that this was being actively monitored with divisional governance teams. The Committee expects further assurance on improvement in December, ahead of transition to Radar Healthcare.

The Committee welcomed strengthened arrangements for **Equality and Quality Impact Assessments** EQIA oversight but noted that divisional senior leadership approval remained a bottleneck requiring continued attention.

In considering the proposed **quality guardrails** for the period of enhanced financial controls, members strongly supported the approach but challenged whether it would be sufficiently sensitive to identify emerging quality consequences from financial recovery actions. Particular emphasis was placed on patient experience and staff health and wellbeing, alongside conventional safety and performance measures.

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The Committee requested that the quality guardrails be incorporated into divisional IPR reporting so that data are accompanied by appropriate interpretation and narrative, allowing emerging concerns to be triangulated rather than considered in

isolation. The Committee approved the framework and agreed that EQIA reporting should return from quarterly to monthly reporting during the period of enhanced financial control.

The Committee noted via the **Patient Experience report** the deterioration in complaints response times and challenged whether improvement in UEC and corridor care should subsequently be reflected in patient experience. It was agreed that improvement should become evident through future quarterly reporting, particularly in relation to clinical assessment and treatment.

The Committee supported extension of the **Patient Experience Strategy** to January 2027 to enable fuller patient engagement and consideration of emerging national policy requirements before the refreshed strategy is finalised.

The Committee sought assurance via the **Perinatal Safety report** that the numerous national maternity and neonatal recommendations were being considered collectively rather than through separate workstreams, particularly where requirements overlap. Assurance was provided that overlapping recommendations were being mapped within the same action planning arrangements.

Members also questioned the implications of maternity activity relating to temporary residents and whether there was further system learning regarding high-risk pregnancies and transfer of information. The continuing challenges affecting North Devon neonatal provision were also discussed. The Committee was advised that there had been no negative patient safety incidents reported as a consequence of the closures, although the position remained challenging and continued to be monitored.

Preventing Unlawful Access to Patient Records was the principal matter identified for escalation to Trust Board. The Committee considered the completed gap analysis against the national framework and was specifically advised that the Trust was not compliant with all the relevant NHS digital requirements. A task and finish group had been established, chaired by Alison Thorne-Henderson, to oversee delivery of the required improvements.

The Committee challenged whether the Trust was taking a sufficiently clear and consistent approach where staff unlawfully access records. Members emphasised that inappropriate access is already identified as gross misconduct and challenged whether the Trust should take a firmer and more transparent organisational stance, whilst ensuring consistency and parity in application.

Further challenge concerned whether identified cases demonstrated only the breadth of inappropriate access or could indicate deeper cultural issues within particular teams or services. The task and finish group was asked to consider whether audit

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activity should examine this more fully. Members also emphasised the importance of clear communications to staff.

An additional delivery risk was noted relating to information governance capacity, with interim arrangements being explored to support delivery. The Committee requested monthly assurance reporting until sufficient assurance can be demonstrated that the action plan is being delivered and compliance achieved.

The Committee strongly endorsed the **2026–29 Volunteering Strategy** and recommended it to Trust Board for approval. Members acknowledged the significant contribution volunteers make to both patients and staff. Further consideration was requested of opportunities for Trust staff themselves to undertake volunteering activity.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board In Public

Date of Meeting: 05 November 2026

Item Number: 13.1

Title of Report: Perinatal Safety Report

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer, Dr Meridith Kane, Chief Medical Officer

Author and Job Title: Josie Dodgson, Director of Midwifery / Ellie Lawes, Neonatal Specialty Lead Consultant / Michael Cross, Project Manager – Compliance and Governance, Naomi Wakeley, Neonatal Governance Lead

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Purpose of the Report:

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

This paper provides the Trust Board 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 27th October 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	
Quality Impact Assessment completed?			X	
Data Protection Impact			X	

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
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	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.

Recommendation(s):

The Board **is recommended to:**

- **Receive for assurance** the Perinatal Report which was endorsed by the Quality Assurance Committee 27th October with no matters for escalation to the Trust Board.
- **Receive for assurance** the PMRT Quarter 2 report which was endorsed by the Quality Assurance Committee 27th October 2026.

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Perinatal Safety Report

1. Situation / Executive Summary

This report provides assurance on RCHT maternity and neonatal safety, progress, risks and oversight.

In September 2026, there were:

- There was 1 reportable Patient Safety Incidents (PSI or PSII).
- There was 0 Maternity and Neonatal Incident reported to Maternity and Newborn Investigations (MNSI).
- There were 0 Stillbirths (SBs).
- There was 0 Neonatal Deaths (NND).

The reopening position for perinatal services at North Devon District Hospital remains unchanged. There were no September cot reductions or neonatal closures, although Devon capacity pressures continue to increase network demand. RCHT continues to monitor activity, acuity, workforce and transfers with regional partners to maintain safe care.

Continued oversight is required for Maternity Incentive Scheme Year 8 compliance, Maternity Care Bundle, appraisal rates and safe maternity, neonatal and obstetric staffing.

Focused work on Obstetrics and Gynaecology retention and recruitment has maintained the risk level although there has been increased pressure owing to sickness to middle grade doctors and further pressures on dualists. The risk has been revised to capture this. The challenges continue to be monitored through the Division and established governance arrangements.

Overall, safety governance remains effective, with improvement actions progressing and emerging risks monitored through established routes.

The report was discussed in full at the Quality Assurance Committee, there were no matters of escalation to the Trust Board.

2. Background

This report provides the ICB and Trust Boards with current and emerging perinatal safety concerns, supporting two-way multidisciplinary ‘ward to board’ insight.

It summarises local and national maternity and neonatal safety measures aligned with the NHSE Perinatal Quality Oversight Model (August 2025). The revised format reflects 2025 national guidance, with the maternity dashboard in Appendix 1.

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Perinatal Mortality (Appendix 2 and 3)

The current summary of the September is below.

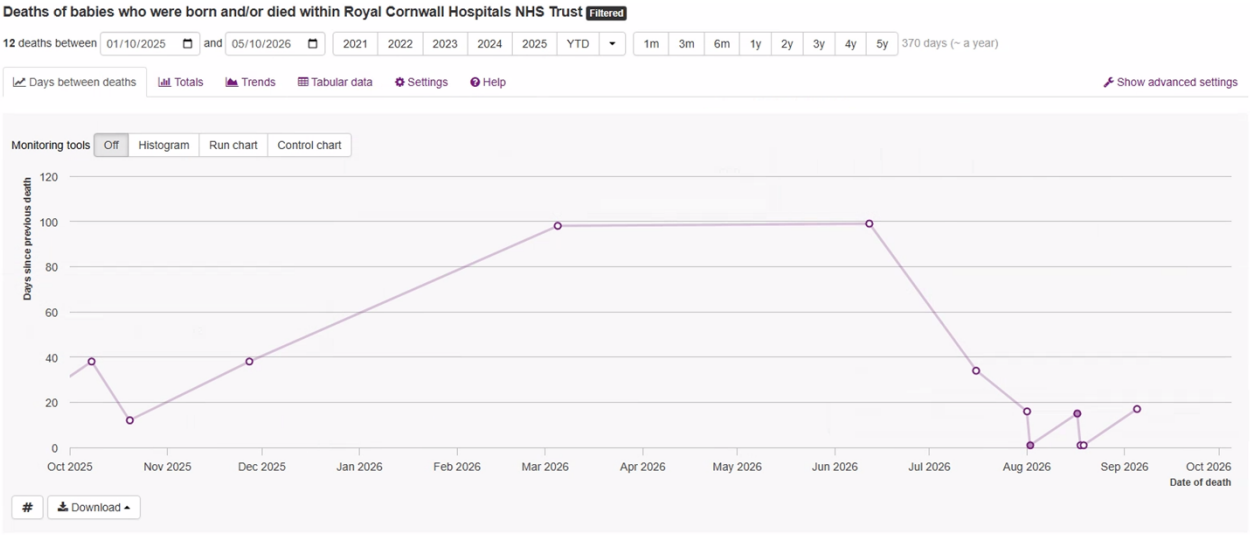
Stillbirth (Pre-term)	0
Stillbirth (Term)	0
Intrapartum Stillbirth	0
Neonatal death < 7 days	0
Neonatal death > 7 days	0
Perinatal Mortality %	0%
Miscarriage 14-21+6	1
Late fetal loss 22-23+6	1
Total Termination of Pregnancies for Medical Reasons (TOPMR)	
TOPMR < 24 weeks	0
TOPMR >24 weeks SB certificate issued	1
TOPMR resulting in livebirth (MCCD issued)	0
Maternal death	0

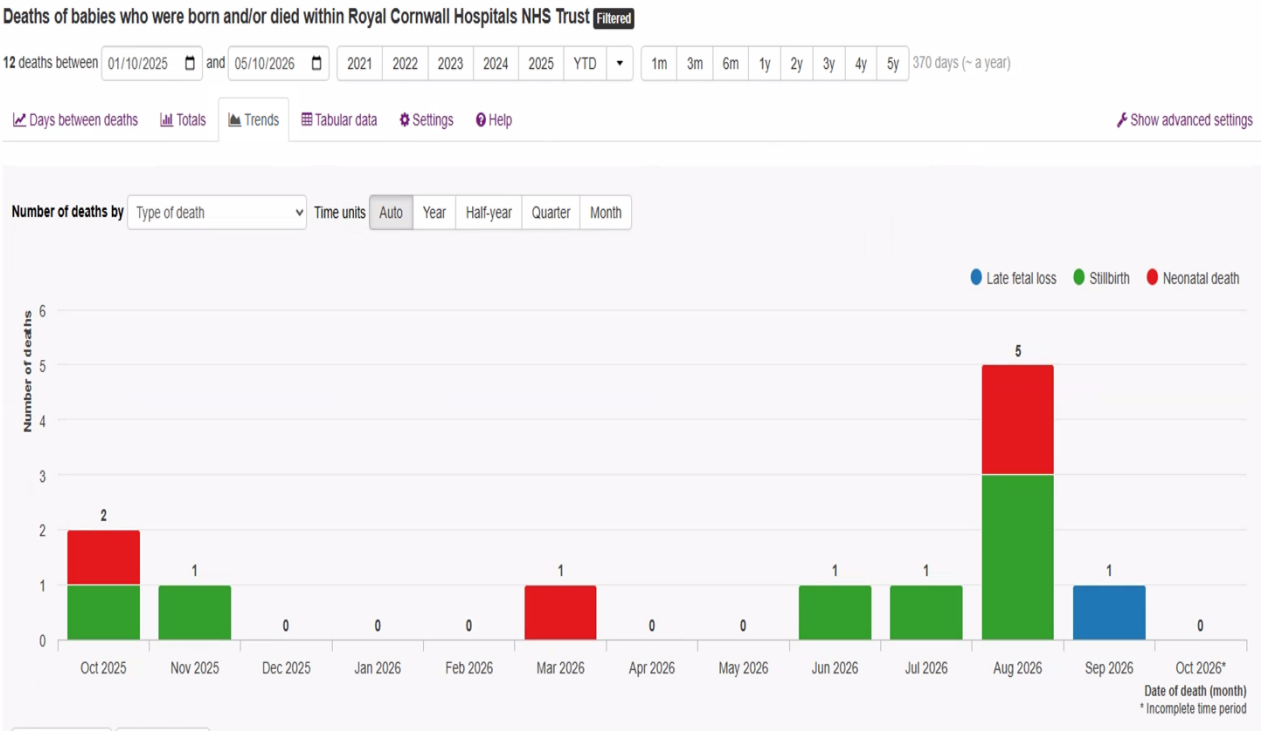
Perinatal Mortality Review Real Time Data Deaths in last 12 months.

The Quarter 2 PMRT report (Appendix 1) shows increased stillbirths, reversing the previous 12-month trend, particularly among families visiting Cornwall. Regional work is strengthening travel-risk advice, early escalation and safe handovers where prior information is limited.

Despite the wider UK decline in perinatal mortality, RCHT recorded a Quarter 2 increase, considered a spike in adverse events and under close monitoring. No systemic issues have been identified.

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Stillbirth and neonatal mortality remain higher among families in the most deprived areas and in Black and Asian communities. Cases are reviewed to identify modifiable factors. In Cornwall, housing challenges recur even where deprivation scores are not elevated and are reflected in specialty safety reviews. Earlier risk identification will help but coordinated system support is needed.

3. The Maternity and Newborn Safety Investigation Programme (MNSI) and Maternity Patient Safety Incidents (PSIs) (Appendix 1 – at the end of this report)

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3.1 Investigation progress update

MNSIRef	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	Final Report Received
MI-051647	Suspected brain injury	27/01/2026	Yes	Y	Early Notification Scheme, complaint
MI-053370	Suspected brain injury	24/02/2026	Yes	Y	Early Notification Scheme
MI-066067	Maternal death	20/08/2026	Yes	Y	PMRT, MBRRACE

3.2 Learning from MNSI reviews

There were no final reports received from the MNSI in September 2026. The August 2026 maternal death referral was declined by MNSI in September because next-of-kin consent was not obtained. The Trust is exhausting all contact options; if consent remains unavailable, RCHT and the external antenatal Trust will commission a joint PSII.

3.3 Patient Safety Incidents and Learning from Investigations (PSI)

Maternity Patient Safety Incidents during the period of September 2026. There were 1 PSR1 reports completed for Maternity and Neonatal specialties during September 2026.

Ref No.	Incident category	Outcome/learning/Actions	Responsible role	By when
	Moderate	One maternity PSR1 review was underway in September 2026 following a fourth-degree tear after instrumental delivery. Learning was identified and actions taken, including: Strengthening communication and environmental awareness during instrumental deliveries to support teamwork and situational awareness; Rolling out OASI Care Bundle training to improve prevention, recognition and management of severe perineal trauma;		

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		Reinforcing MEWS assessment, escalation and management requirements; Improving bladder care and monitoring to support safer postnatal recovery and reduce complications. These actions aim to embed learning, improve safety and prevent recurrence.		

3.4 Coroners' report

Identifier	Date Listed	Summary
N/A	N/A	None to report in September 2026

3.5 Regulation 28 report issued

Identifier	Action required	Progress	Responsible role	By when
N/A	N/A	None to report in September 2026	N/A	N/A

3.6 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

We are continuing to scrutinize themes from the scorecard to examine ways in which we can act proactively to reduce risk and prevent harm. The key area of focus for maternity remains bladder care. There continue to be sporadic incidents related to catheter care, and this has also been raised as part of a recent PMRT review. Whilst not related to the outcome, this was identified as concern linked to overall care. We are conducting an audit to be confident that we have covered all system causes to address fully.

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3.7 Maternity Outcomes Safety Signals System (MOSS)

We have received 0 MOSS alerts in September 2026.

3.8 Perinatal Improvement Plan (Progress updates from National reports / Thematic review action plans as required)

The Maternity Improvement Plan focuses on the Maternity Care Bundle, Triage Improvement Plan and Amos 10-point plan. The Patient Safety Champions Board approved the Neonatal Improvement Plan on 25 September 2026, noting clear progress and a thorough, honest review.

3.9 Maternity Incentive Scheme Year 8 (Appendix 4)

As MIS Year 8 reporting concludes, evidence is being finalised with regional partners and Internal Audit. Compliance is progressing across Safety Actions, with some areas requiring further work or presenting as risk to full compliance. A full detailed presentation of our current status can be found in Appendix 4.

- Workforce investment may be required to maintain compliance with national standards and care bundle requirements.
- External digital dependencies and changing national requirements, particularly in relation to the Maternity Care Bundle, may affect the ability to demonstrate full compliance.

The Trust remains broadly compliant and on track for MIS Year 8 submission. The principal residual risks relate to workforce investment requirements, external digital dependencies within care bundles, completion of supporting evidence, and finalisation of the Perinatal Culture Improvement Plan. A detailed self-assessment has been provided separately for assurance and scrutiny.

3.10 National Maternity Triage Specification

Since submission against the National Maternity Triage Specification, triage processes, governance and delivery have strengthened through BSOTS-compliant triage, the 15-minute assessment standard, a dedicated Day Assessment Unit (DAU), a two-midwife triage model, routine audit and weekly governance review. Patient experience has improved, with significantly fewer maternity self-discharges.

Outstanding gaps include dedicated consultant obstetric presence in triage and DAU, workforce alignment with demand and capacity modelling, and implementation of national competency and assurance requirements. Estates constraints still affect privacy, accessibility, visibility and patient flow.

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Key risks:

- Workforce and senior obstetric cover remain below national specification requirements.
- Estates limitations continue to hinder full compliance.

- Competency and assurance framework delays may weaken ongoing practice assurance.

The service remains at Extreme Risk due to workforce, medical cover and infrastructure gaps. Delivering the workforce model and compliance programme is critical to full compliance and reducing risk to the target level.

3.11 10-Point Plan for Maternity & Neonatal Services (Amos Improvement Programme)

The 23 September 2026 national submission showed substantial progress in maternity governance, safety and assurance: PSIRF implementation, stronger Board oversight and safety governance, equity and outcomes reporting, completed maternity triage baseline assessment, funded nursing and midwifery workforce plans, and routine sharing of learning and actions.

Outstanding priorities:

- Complete maternity demand, capacity and workforce reviews.
- Fully implement and assure the Maternal Care Bundle.
- Finalise the Perinatal Culture Improvement Plan and equity improvement programme.

Key Risks

- Workforce and Capacity: Reviews may identify investment needed for national maternity standards compliance and sustainable staffing.
- Care Bundle Compliance: Evolving national requirements and workforce and digital dependencies risk full implementation and assurance.
- Triage Compliance: Workforce, senior medical cover and estates constraints may delay full National Maternity Triage Specification compliance.
- Culture and Equity: Programme delays may limit evidence of sustained improvement and compliance with national expectations.

Next Steps (3 Months)

- Complete demand, capacity and workforce reviews and associated business cases.
- Finalise and implement the Perinatal Culture Improvement Plan and equity programme.
- Complete outstanding Maternal Care Bundle actions and assure compliance.
- Progress workforce and estates proposals for Board approval.

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Governance, safety oversight, workforce planning and learning systems have strengthened. Full compliance and risk reduction remain dependent on workforce

capacity, care bundle implementation, triage compliance, estates and completion of culture, equity and assurance programmes.

3.12 Maternity Care Bundle (MCB)

Core elements are established, but compliance is 21%, with VTE prevention, maternal mental health and capacity gaps. NHS Resolution requires a Board-approved implementation plan by March 2027, with oversight, reporting, escalation and risk management.

Where external dependencies delay delivery, MIS Year 8 does not require full implementation by March 2027. RCHT will be assessed on planning, governance, risk management, escalation and progress.

Key progress:

- Updated maternity and neonatal clinical guidelines.
- Improved interfaces with SWAST and labour ward teams.
- Embedded PPH audit and monitoring.
- ROTEM procured and nearing use.

Main challenges:

- VTE gaps persist across RCHT and the Peninsula: LMWH prescribing and supply vary, with no consistent GP-led mechanism. Locally governed PGDs may enable prompt midwife initiation, but prescribing, supply, follow-up and commissioning need system solutions. The ICB has escalated nationally.
- Workforce and capacity needs, including specialist maternal medicine midwifery posts, are under assessment.

Priorities:

- Complete the Demand and Capacity Review; identify resources.
- Deliver the MEWS audit and improvements.
- Improve maternity wayfinding and the environment.

Risks to compliance:

- Workforce and capacity constraints may delay delivery; review proposals will need Board support.
- National policy and digital dependencies may constrain progress.
- VTE and maternal mental health standards may need further investment, including midwifery capacity for perinatal mental health assessments.

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Full MCB compliance depends on the Demand and Capacity Review, resolving external dependencies and targeted investment in VTE prevention, maternal mental health and workforce capacity.

3.13 Saving Babies Lives

Compliance is stable. Monthly monitoring is validating Quarter 2 audits, data and Doppler implementation; policies remain under review.

Element 1: Smoking in pregnancy

- Smoking at delivery remains 9%; data cleansing affects reporting and training records.

Element 2: Fetal growth restriction

- FGR assessments remain timely; appointment capacity limits uterine Doppler adoption.

Element 3: Reduced fetal movements

- Advice by 28 weeks remains current; outsourcing may increase scanning capacity.

Element 4: Fetal monitoring in labour

- Training competency exceeds 90% against a 95% target; audits must exceed 80%.

Element 5: Preterm birth prevention

- Consultant leadership, audit, improvement and multiple-pregnancy risk management are established.

Element 6: Diabetes

MNVP feedback, outcomes and audit will guide diabetes service improvement.

Performance remains sustained towards 100% compliance in 2026.

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Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	70%
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	40%
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	81%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	93%	Partially implemented	71%

3.14 CQC Picker Survey

We have received the currently embargoed 2026 CQC Picker Maternity Survey. We have drafted an action plan summarising findings, changes since 2025, cultural themes and proposed improvements for Board endorsement in November 2026, once the embargo has been lifted.

3.15 Temporary Closure of Perinatal services at North Devon District Hospital

The closure continues to have minimal impact on RCHT intrapartum services, although some women have required care in Cornwall due to capacity pressures elsewhere in Devon. RCHT continues to monitor activity, acuity and capacity.

4.0 Performance Metrics

4.1 Service Suspensions

	31/08/2026	07/09/2026	14/09/2026	21/09/2026
Obstetric unit	0	0	0	0
Homebirth Service	0	0	0	0
Midwifery Led Unit	0	0	0	0
Neonatal unit (internal)	0	0	0	0
Neonatal unit (external)	0	0	0	0

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Month 2026	Shift	NNU Internal OPEL 3	NNU Internal Opel 4	NNU closures to SW ODN
April	Day	3	5	0
	Night	8	8	
May	Day	1	6	0
	Night		6	
June	Day	2	0	0
	Night	13	2	
July	Day	3	0	0
	Night	3	0	
August	Day	6	0	0
	Night	5	0	
September*	Day	12	0	0
	Night	7	1	

An audit of the OPEL tool is under way to ensure accurate escalation is being followed.

4.2 Number of Opel 4 days:

	Fortnight Commencing		
	24/08/2026	07/09/2026	21/09/2026
Neonatal unit (internal OPEL 3)	4	6	5
Neonatal unit (internal OPEL 4)	6	0	0
Neonatal Unit closures to SW ODN	0	0	0

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Reasons/ Mitigations:

The Neonatal Unit (NNU) did not close or reduce cot capacity in September 2026.

4.4 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

September 2026	PROMPT	Saving Babies Lives	Safeguarding	Maternity Care Day	NLS 1 Yearly
Midwives	96%	94%	93%	95%	96%
Maternity Support Workers	93%	95%	90%	97%	
Obstetric consultants	100% (11/11)	91% (10/11)			
Obstetric trainees	100% (19/19)	95% (18/19)			
Anaesthetic consultants	94% (16/17)				
Anaesthetic trainees	93% (26/28)				
Neonatal Consultants/ Doctors					97%
Neonatal Nurses					98%

Maternity, Neonatal and Anaesthetic services met the first Maternity Incentive Scheme training compliance target through cross-specialty and divisional collaboration.

As the Postgraduate Centre is unavailable, alternative options for on-site divisional training are being explored.

4.5 Safe Maternity Staffing

Fill rates – planned verses actual

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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:

September 2026	Acute Registered Midwives		Acute Maternity Support Workers	
	Day	Night	Day	Night
Planned Hours	6774	5115	2385	1980
Actual Hours	6133	4741	1793	1287
Planned vs Delivered Fill Rate	91%	93%	75%	65%

Actions taken and impact on care:

- Fill rates for midwives have continued to improve as per predicted trajectory.
- We have not seen the notable improvement for MSW's. This is primarily due sickness, which has impacted the service in recent months. There are clear individual management processes in place to best support people to return to work in a safe and supportive way.

Obstetric Medical Staffing

Obstetric Cover on the Delivery Suite	September 2026
Planned Hours	830
Actual Hours	820
Average Fill Rate	99%

There were 2 CS Lists uncovered due to annual leave and sickness in September 2026.

Appraisal Rates for September 2026

Maternity appraisal rates remained at 70% in September. A new values-based tool supports career and wellbeing discussions. ESR issues affect staff with multiple assignments and new starters, while ward leaders and Matrons are taking targeted action.

Neonatal appraisal rates remained at 80% in September 2026, with the greatest improvements among consultants and neonatal nurses.

4.6 Staffing Vacancy Rates

Staff group	Vacancy rate
Midwifery	0 (10 will be inducted by December 2026)
Midwife Support workers	7.4 all in the recruitment process
Neonatal Nurses	Total All Bands = 5.89 WTE B7 = 0.9 WTE vacancies

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	Band 6 = 2.52 WTE vacancies Band 5 = 1.65 WTE vacancies Band 4 = 0.2 WTE vacancies
Neonatology consultants	Fully recruited
Neonatal resident doctors	Under recruited by 0.5WTE

4.7 Red flags, actions, exceptions and mitigations

Work continues to improve red flag awareness and strengthen assurance against national maternity safety standards.

Planned actions:

- Update and circulate the Red Flag Trigger List.
- Clarify reporting requirements for induction delays.
- Include red flag reporting in mandatory training.
- Monitor epidural-related red flags, anaesthetic staffing and availability, and women's experience of delays.

4.8 Epidural Delays Review

The Lead Obstetric Anaesthetist and Obstetric Anaesthetic Safety Champion has completed a review of epidural delays. The available evidence suggests that epidural delays are a multifactorial issue rather than the consequence of a single process failure. While reported incidents have increased over time, available performance data does not demonstrate a corresponding increase in severe delays (>60 minutes), which have remained relatively stable at approximately 5%. The emerging query appears to be a gradual deterioration in the proportion of women receiving epidural care within 30 minutes, although overall performance within 60 minutes remains stable. The analysis also identifies limitations in data quality, investigation processes, and measurement definitions, making definitive conclusions difficult at this stage.

A programme of re-audit, workload analysis and governance review is underway to improve data quality, quantify the impact of competing clinical demands, and determine whether workforce, capacity or service model changes are required. Findings and recommendations will be reported through our Quality Assurance Committee to inform any further improvement actions.

4.9 Neonatal Workforce

Neonatal Workforce Calculator (2020) Quarter 1 (April – June 2026) submission including roles providing only direct patient care:

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DIRECT PATIENT CARE - *DO NOT INCLUDE ANY NON-DIRECT PATIENT CARE WTE*				
Role Title	Band	WTE Budget	WTE in post	Head Count in post

Sister / Charge Nurse	7	0.92	0.92	2
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	14.23	12.03	16
Staff Nurse QIS	5	2.6	2.6	3
Subtotal QIS Nurses		17.75	15.55	21
Staff Nurse NON QIS	5	16.51	13.96	16
Subtotal Non QIS Nurses		16.51	13.96	16
Subtotal - Registered Nurses		34.26	29.51	37
Nursing Associate	4	0	0	0
Trainee Nursing Associate		0	0	0
Nursery Nurse	4	5.47	4.21	6
Healthcare Support Worker	3	2.45	2.38	3
Subtotal - Other direct patient care staff		7.92	6.59	9
TOTAL DIRECT PATIENT CARE		42.18	36.1	46

Neonatal staffing has improved but remains reliant on bank shifts. Recruitment is on track to approach the 70% Qualified in Specialty target by September 2027, although additional education capacity may be needed. Meeting BAPM Tier 2 standards may require eight additional medical staff through phased investment. Our next steps include:

- Continue recruitment and retention initiatives to reduce reliance on bank staffing and improve establishment resilience.
- Continue review of education and practice development capacity to ensure sufficient support for staff undertaking specialist neonatal qualifications.
- Develop a phased workforce plan to achieve compliance with BAPM Tier 2 standards, including modelling of the requirement for up to eight additional medical staff.
- Prepare a business case setting out workforce requirements, investment implications, implementation timescales and expected risk reduction.

Capacity to deliver planned and emergency care

The Neonatal Unit capacity to provide planned and emergency care:
Commissioned Cot capacity:

- ITU – 3
- HDU – 4
- Special Care – 13

Maximum cot capacity per month during 1st April – 31st September 2026:

Cot description	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
ITU	90	93	90	93	93	45

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HDU	120	124	120	124	124	60
SCBU	390	403	390	403	403	195

Total number of cot days per month during 1st April – 15th September 2026:

Cot description	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
ITU	55 (61%)	27 (29%)	13 (14%)	13 (14%)	11 (12%)	13 (29%)
HDU	114 (95%)	**155 (124%)**	86 (72%)	47 (38%)	56 (45%)	81 (135%)
SCBU	175 (49%)	173 (43%)	155 (40%)	185 (46%)	134 (33%)	175 (90%)

% number of days Nurse Staffing met BAPM Guidance for Neonatal Nurse Staffing for an LNU:

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Nursing – Day	90.00%	96.77%	100.00 %	96.77%	100%	96.67%
Nursing – Night	70.00%	87.10%	99.67%	100%	100%	100%
QIS – Day	60.00%	64.52%	100%	96.77%	96.77%	93.33%
QIS – Night	**23.22%**	54.84%	83.33%	96.77%	100%	96.67%

During May and September, the demand for the HDU cots exceeded cot capacity. This was offset by a lower demand for ITU and Special Care cots overall.

4.10 Perinatal Safety Champions meetings

There latest Perinatal Safety Champions Board Meeting was held on the 25 September 2026.

Date	Role	Attendance
25/09/2026	Board Safety champion – Bernadette George	Yes
25/09/2026	Board Safety Champion – Rebecca Hopkins	No
25/09/2026	Perinatal Obstetric lead – Tom Smith-Walker	Yes
25/09/2026	Perinatal Midwifery lead – Josie Dodgson	No
25/09/2026	Perinatal Neonatal lead – Ellie Lawes	Yes
25/09/2026	Perinatal Management team – Caroline Chappell	Yes

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25/09/2026	ICB representative – Charity Gladstone	Yes
25/09/2026	MNVP lead – Morwenna Gee	Yes
25/09/2026	Clinical Chair – Chris Warren	Yes

Additional Attendees: Mel Gilbert (Divisional Head of Nursing), Zita Warren (Neonatal Matron), Trudie Roberts (Deputy Director of Midwifery), Lyndsey Collins (Maternity IT)

Feedback raised by staff	Action and progress
The key focus of the meeting related to the feedback of team members regarding the cultural review together with the on-going feedback being provided by the leadership team. Concerns were raised regarding Equality, diversity and inclusion.	The Perinatal Leadership Team have committed to a clear cultural strategy, inclusive of the feedback from the Neonatal Cultural review. This was discussed at length within the meeting and will become a standing item on the agenda at Safety Champions Board.
Feedback raised by service users	**Action and progress**
The meeting was utilised to discuss progress regarding actions from the Thirlwall Inquiry.	Actions are being monitored as part of bi-weekly meetings with the compliance team. Progress is tracked closely, particularly in relation to cross Division actions related to CCTV and medication security and storage.
Additional safety champions intelligence	**Action and progress**
We are continuing to await formal confirmation of the extension of the KMNVP contract extension	If there has not been formalised feedback the team will contact Bernadette George to pursue clarification with the ICB

4.11 Insights from service users and Kernow Maternity & Neonatal Voices Partnership (KMNVP) co-production

15 Steps

We have now confirmed the invoices for new signage, and better wayfinding across the hospital. This has long been an aspiration, very clearly demonstrated in the 15 Steps report and Divisional complaints and concerns. The introduction of the signage should provide a better experience for families requiring perinatal services at RCHT.

Debriefs / Birth Afterthoughts	Action and progress
We have seen increased feedback regarding wait times for Triage assessment. This has been both in	This is captured in our National Triage Specification but also in business cases whereby we are requesting additional funding for greater medical cover to

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family feedback but also seen through Datix.	provide prompt and nationally guided response. This would reduce our reporting of missed timeframes for seeing women attending our service.
Friends and Family test	Action and progress
Neonatal Unit - September 2026 feedback from two responding families demonstrates highly positive experiences regarding staff kindness, compassion, communication and clinical support. Areas achieving 100% satisfaction included cleanliness, support with feeding, emotional support and opportunities to ask questions. Improvement opportunities centre on admission orientation, family involvement in decision-making, support for wider family engagement, and preparation for transfer and discharge.	Admission checklist and strengthened discharge documentation is being reviewed with a view to improve the welcome and discharge families experience in the Unit. This project is being undertaken in consultation with KMNVP. Given the small sample size, trends should continue to be monitored over upcoming months these themes. KMNVP now have a dedicated agenda item in the NNU Business and Governance Meeting affording opportunities to work together to improve parent experience.
Complaints and compliments	Action and progress
The Neonatal Unit have received 0 complaints during September. This low number remains a source of pride. Maternity and obstetric have continued to see a reduction of complaints during quarter 2.	We are currently trialling a program to strengthen our actions to reduce risk and be more effective in preventing repeated complaints and incidents. This is in conjunction with the Patient Safety Team.

4.15 Neonatal/ Transitional Care

Transitional Care is now embedded within the working practices of the Neonatal, Maternity and Obstetric Teams.

5. Red Risks/ Risk Register highlights

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Risk ID	Risk Title	Update	Score
10080	Obstetric (and Gynaecology)	The risk has been adapted to better capture the increased challenge relating to middle grade	20

	Medical Staffing	doctors and dualist Consultants regarding the on-call support. This has been approved at our Maternity Operational Assurance Meeting with further scrutiny scheduled for the Divisional Meeting at the end of the month. The score has not changed however we have bolstered the actions in draft for approval and recognised the wider reaching impact across the Division.	
9524	Maternity Triage	We have revised and updated this risk to incorporate the National Triage Specification. The risk remains at 16 despite review and progress in a number of areas, as highlighted earlier in the report. The key risk relates to Obstetric medical cover and the overall estate. This has been reviewed and approved at ERG.	16
9006	Neonatal Nurse Staffing	Neonatal nurse staffing has been recognised as being significantly improved and has reduced from 20 to 12. Plans to continue to improve the current situation have been set out in the Neonatal Improvement Plan and shared with the wider safety team. This will be monitored via our governance processes and scrutinized as a standing item at the Patient Safety Champion Board.	12
9284	AHP and Pharmacy Support for NNU	We are continuing to await the outcome of the Business case presented at NNU Business and Governance meeting and Divisional Board.	12
9940	Lack or Ward Clerk Cover	We are reviewing this risk in light of the completion of the Clinical Administration reorganisation and our recruitment.	12
9792	Maternity Staffing	September fill rates have continued to see noticeable improvement for midwives but are static in regard to MSW's. The improvement to MSW fill rates is the focus this month with a push to improve this to 80+% in October.	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	12

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		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.	
9487	Transitional Care Incubators for low-birth-weight neonates	Procurement is in process therefore once received we will close this risk once assured.	12

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 and Chief Medical Officer is responsible for the oversight of maternity services.

7. Recommendations

- **Receive for assurance** the Perinatal Report which was endorsed by the Quality Assurance Committee 27th October with no matters for escalation to the Trust Board.

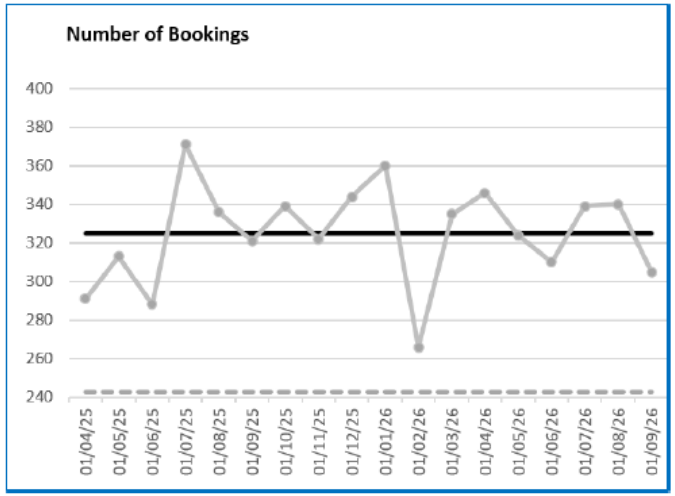
- **Receive for assurance** the PMRT Quarter 2 report which was endorsed by the Quality Assurance Committee 27th October 2026.

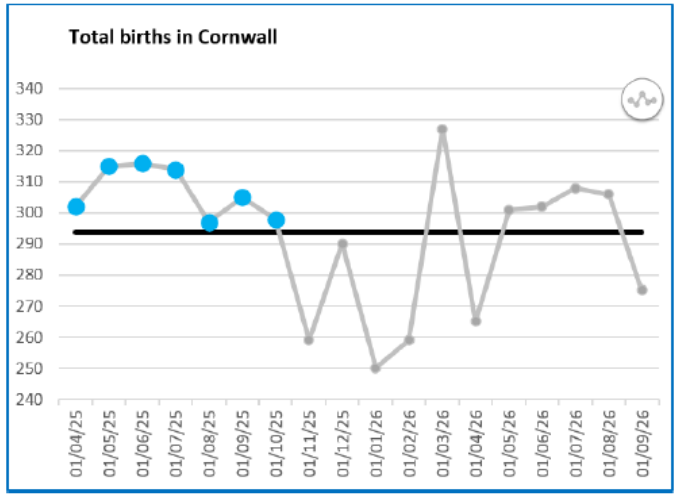
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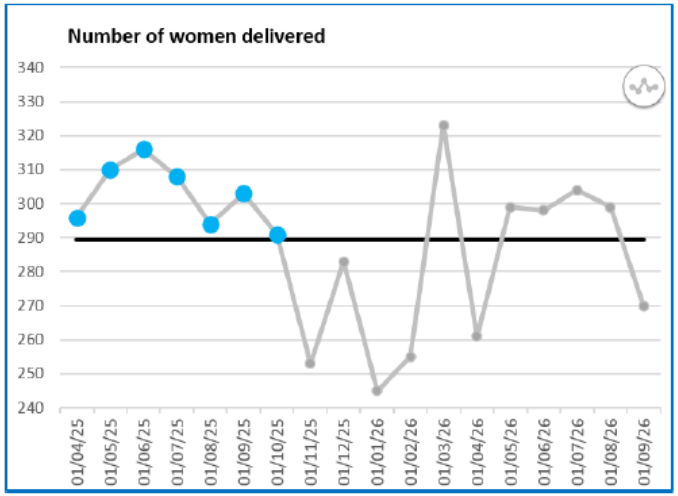
Appendix 1. Maternity and Neonatal SPC charts

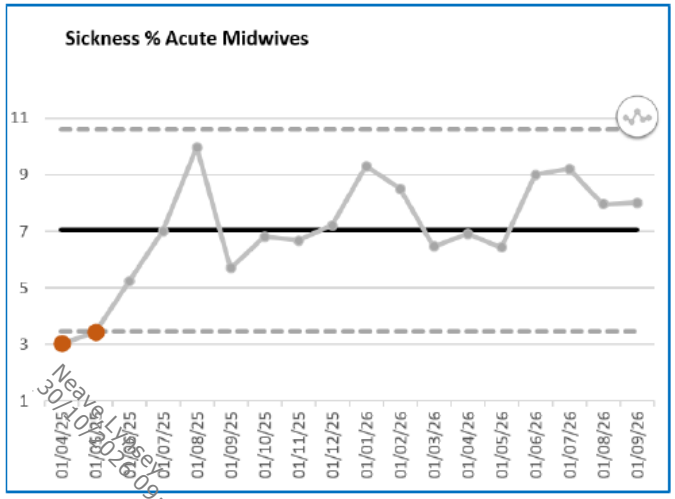
Please find below nationally recognised metrics taken from our maternity and neonatal dashboards. We will be providing further charts and measurements for review in future reports.

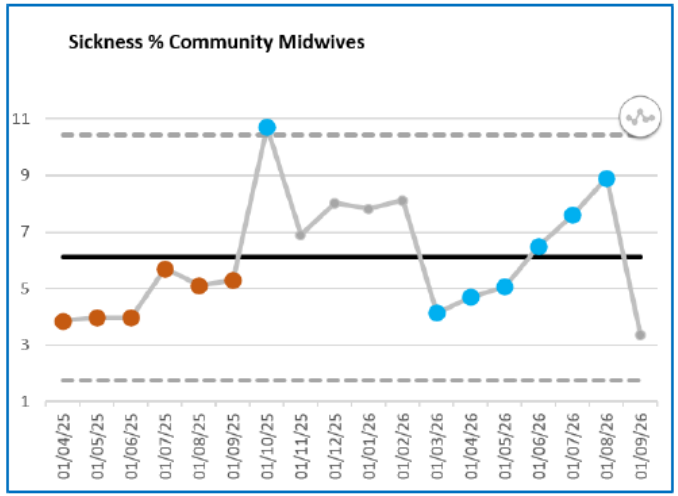
Royal Cornwall Hospitals NHS Trust

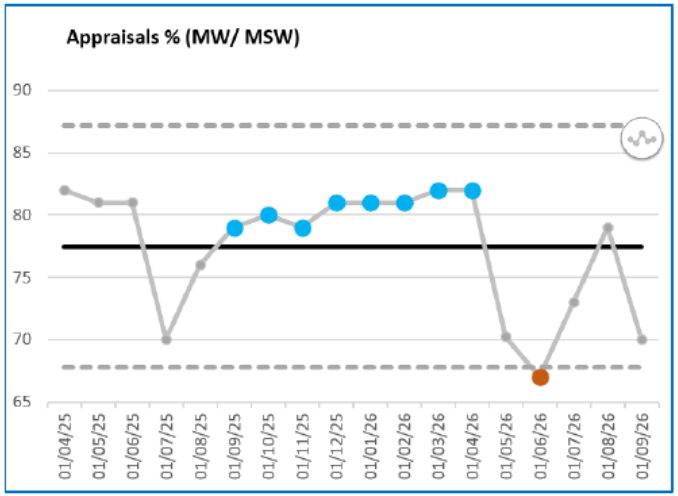


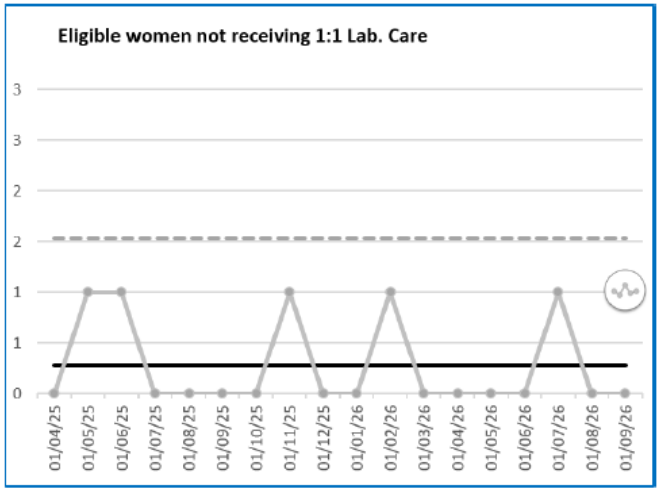


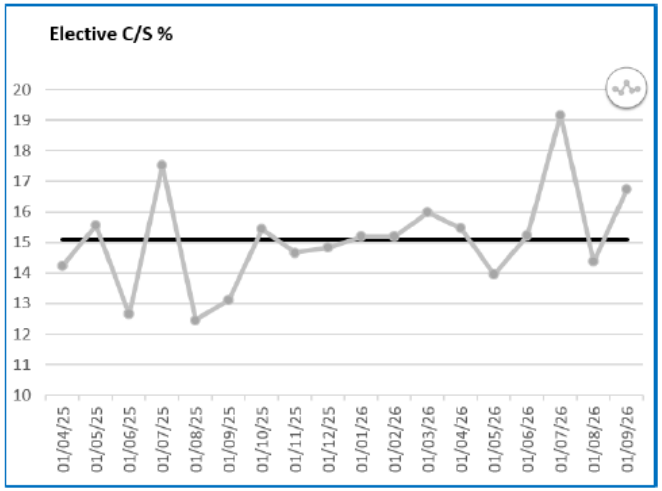


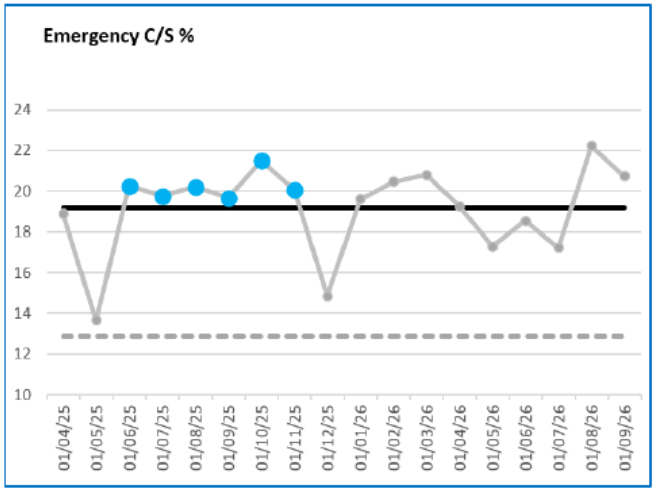


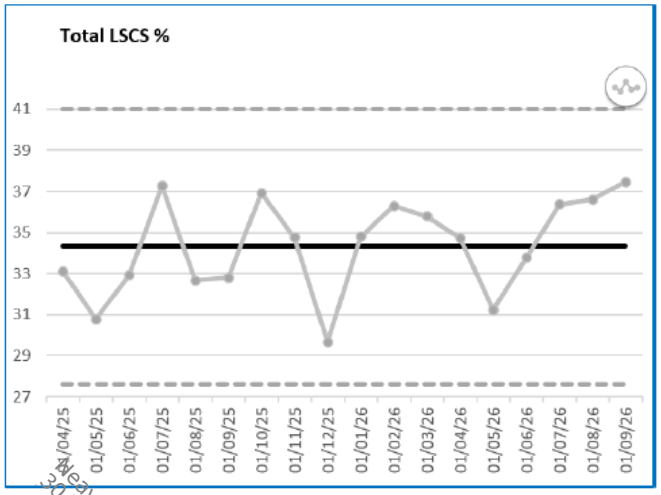


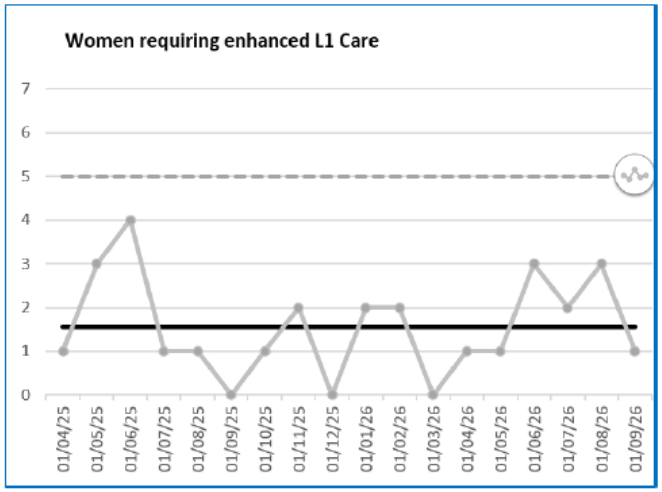


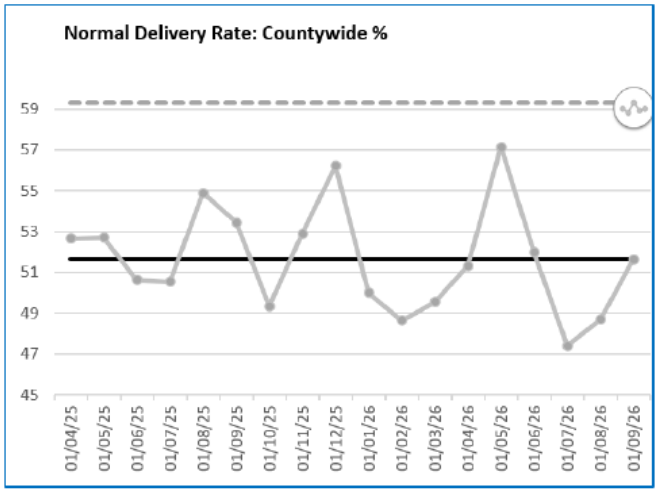




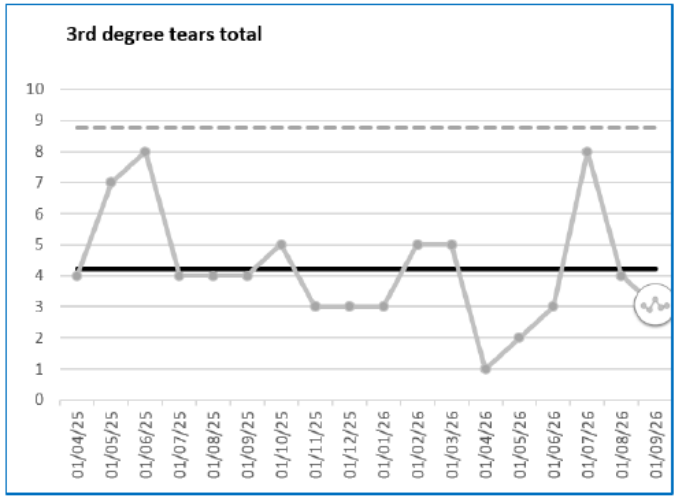


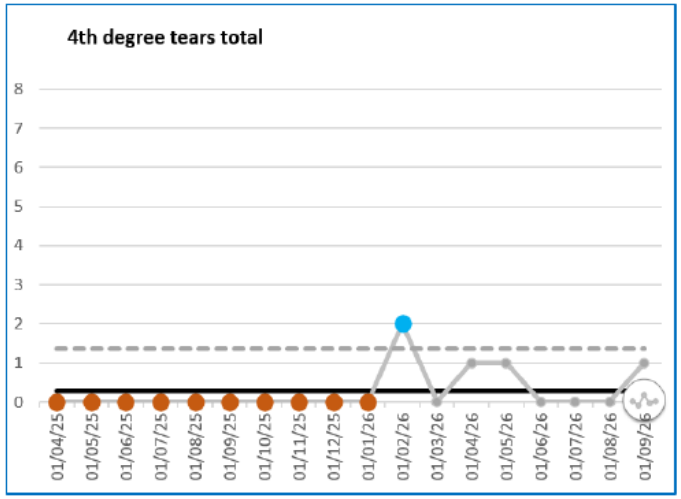


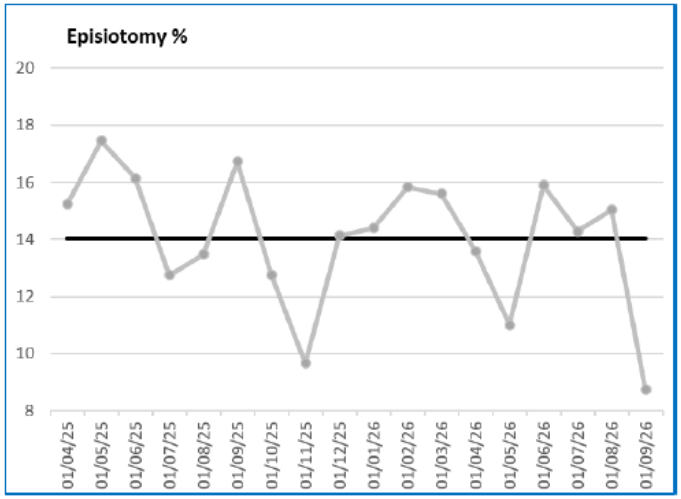


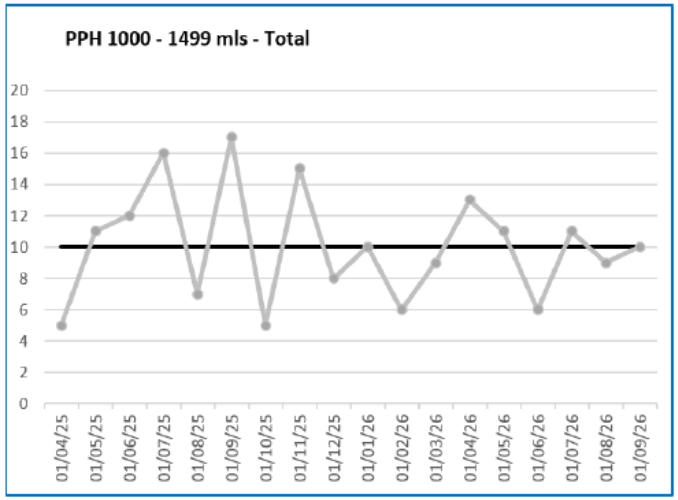


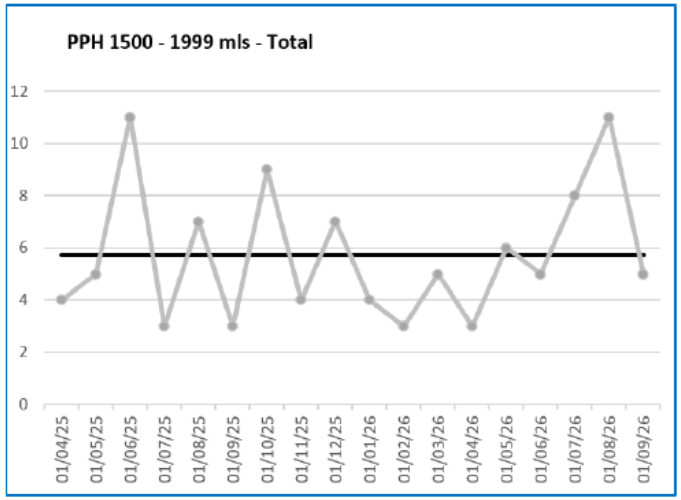
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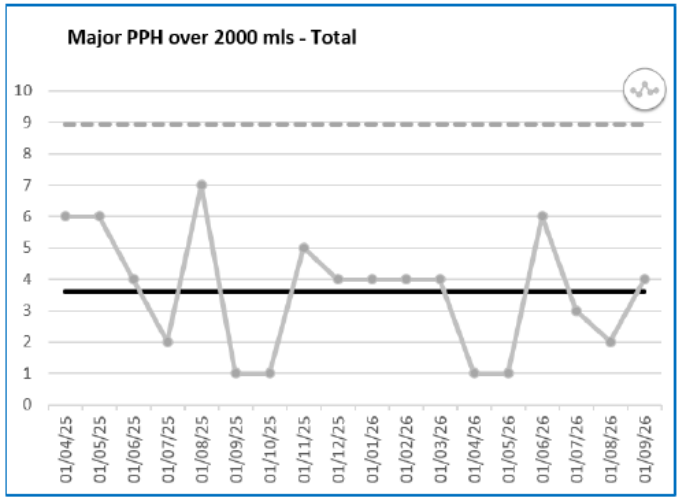




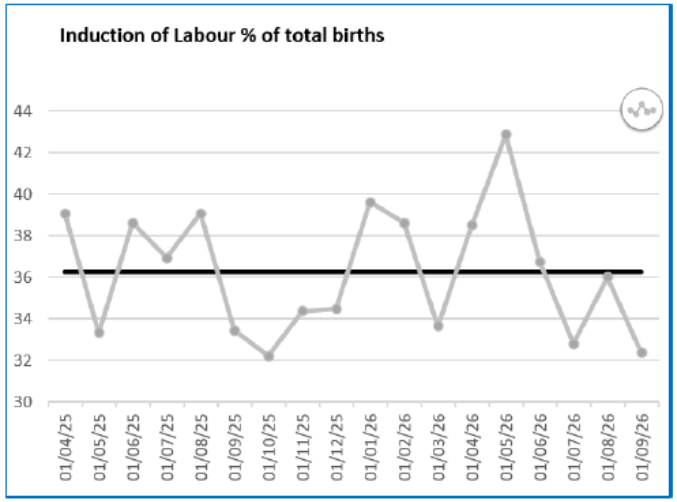


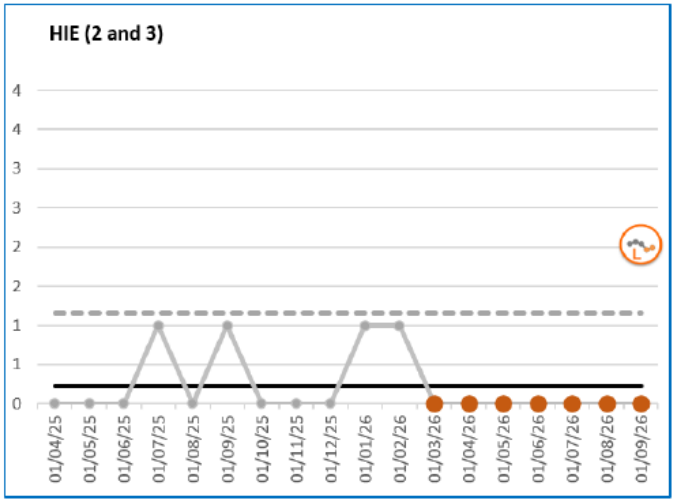


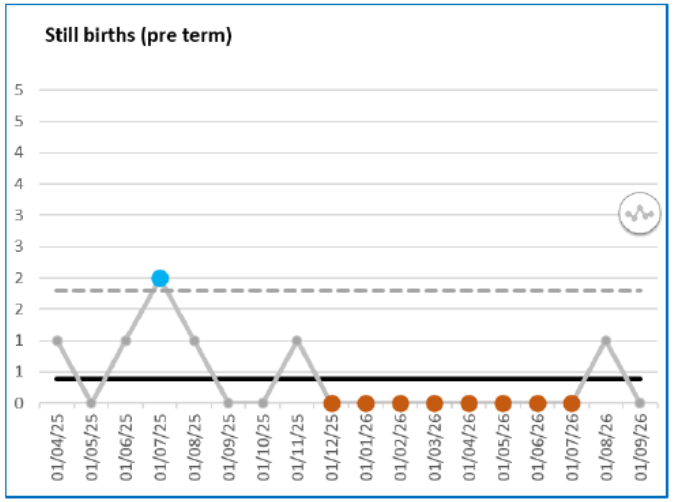


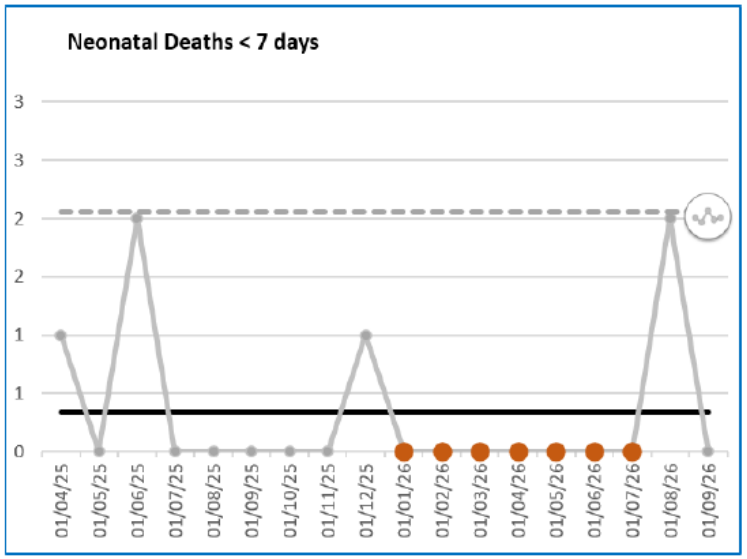


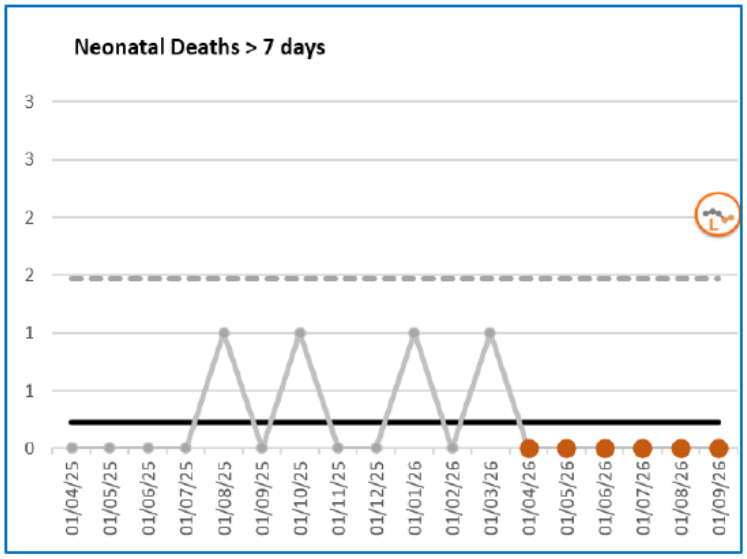
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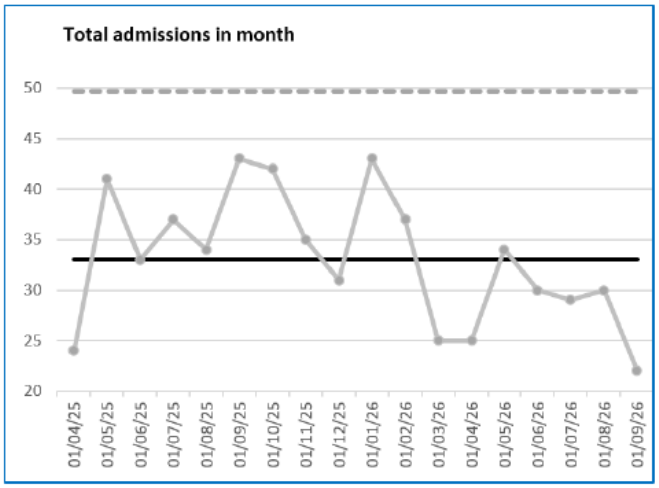


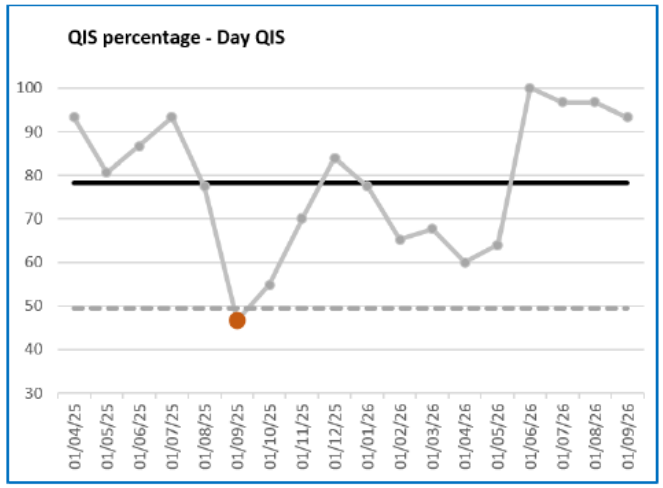


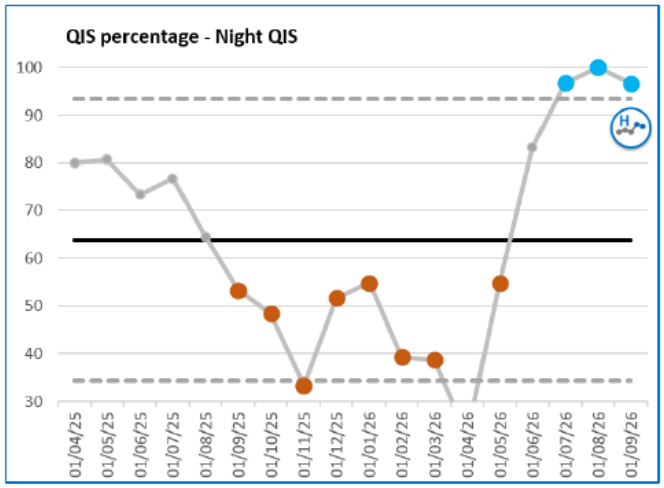


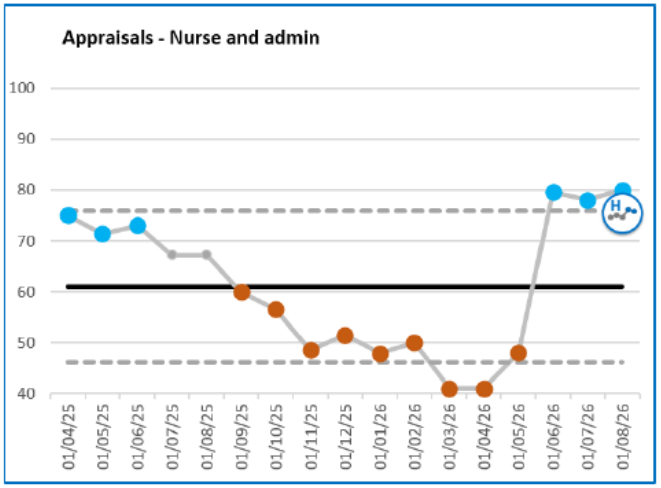


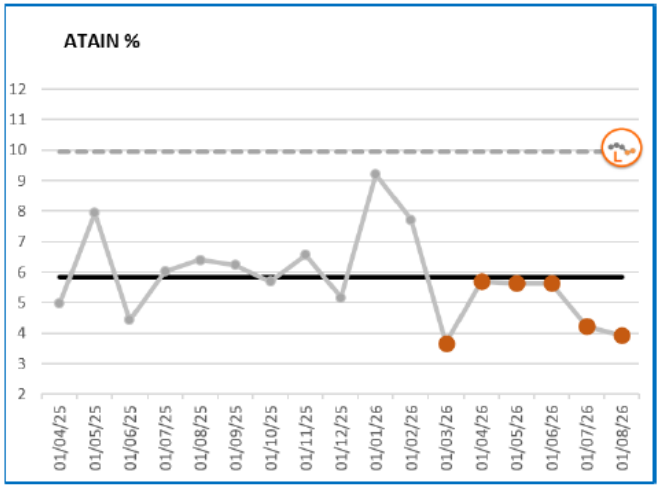
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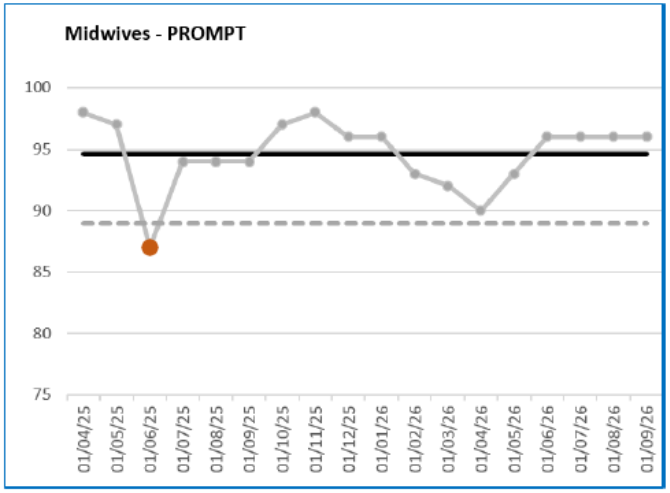


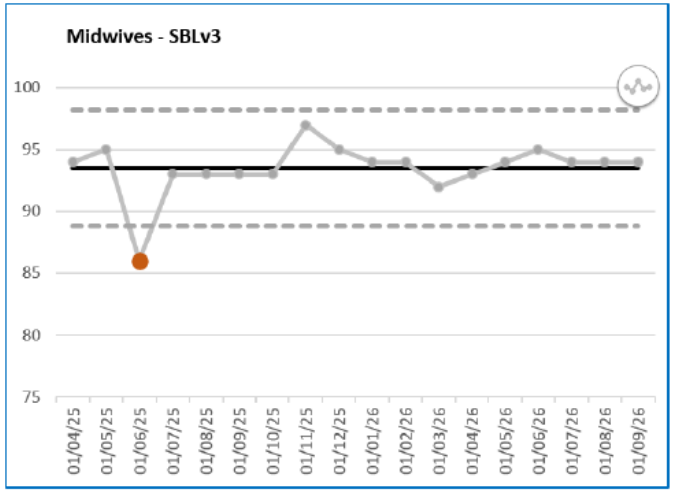


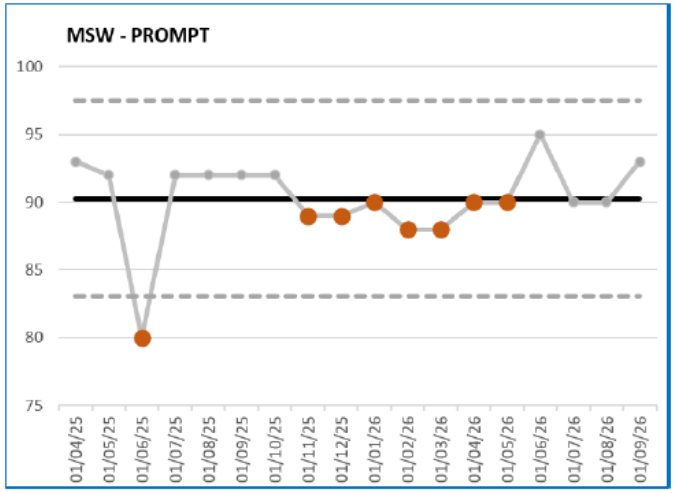


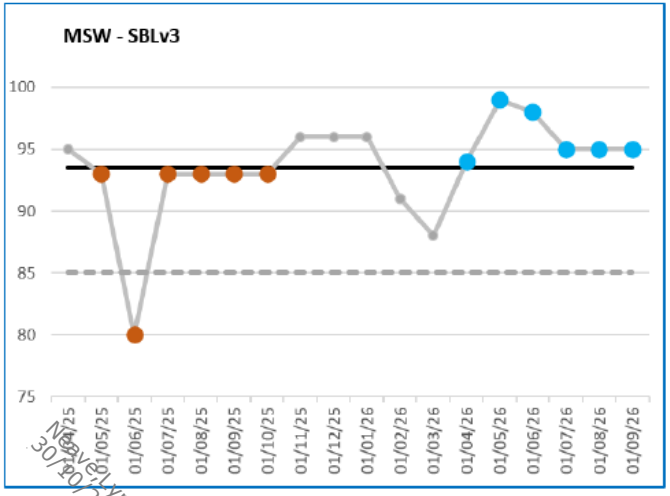
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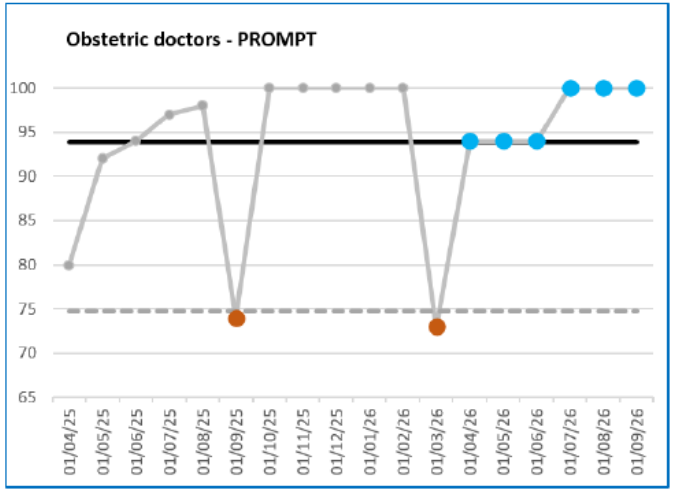
Training

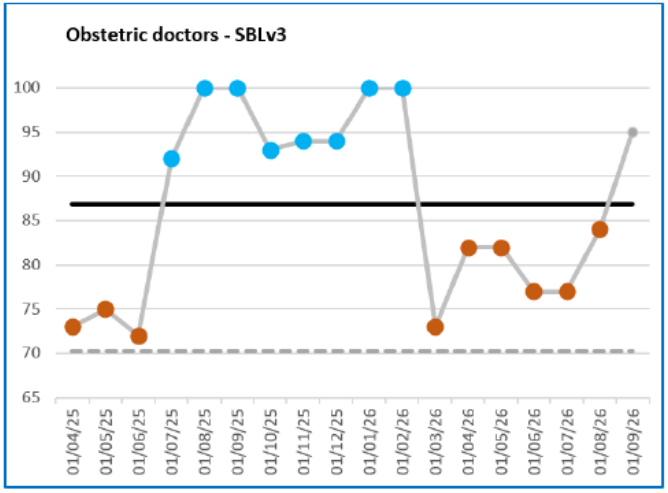




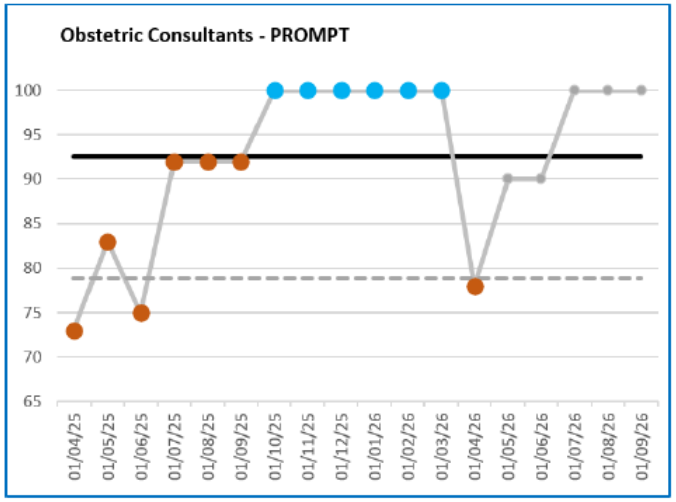


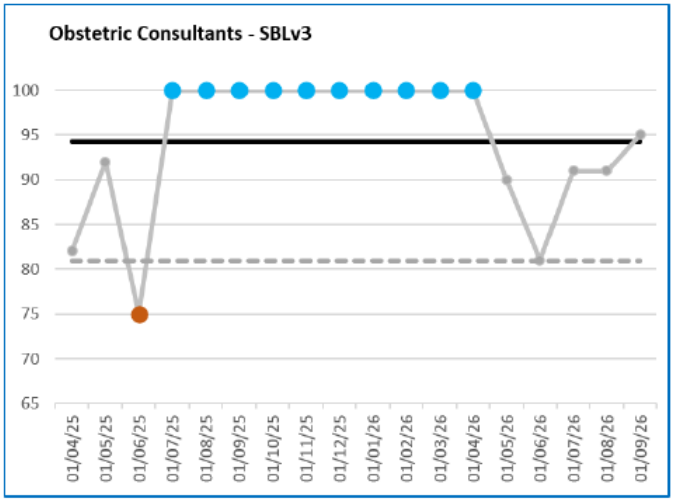


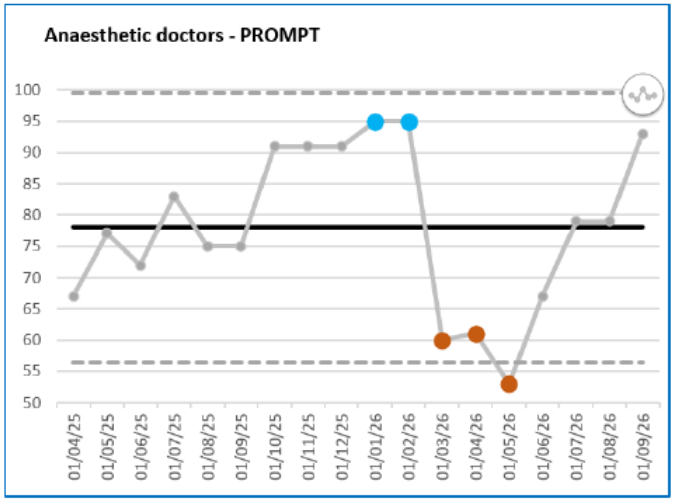


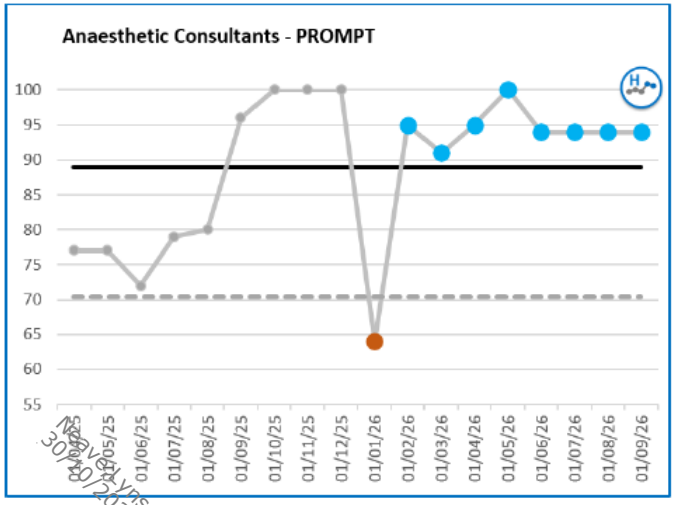


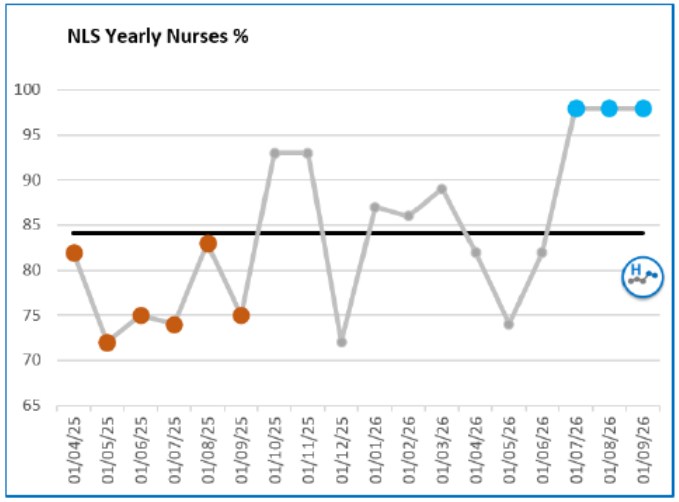
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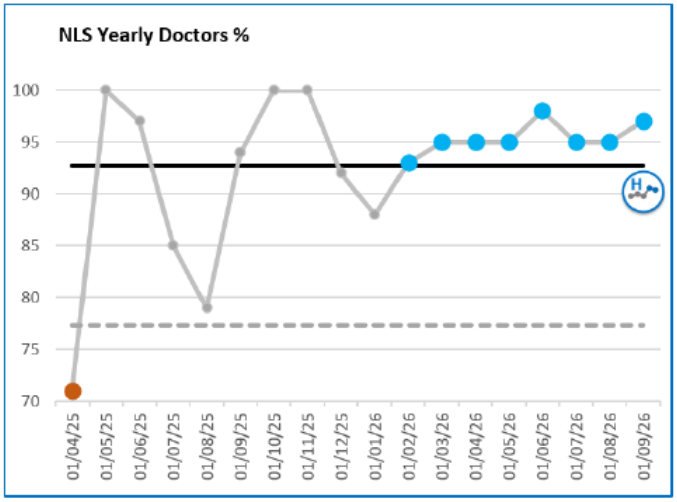












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Provider/site	Date of most recent submission
Cornwall and The Isles Of Scilly - Royal Cornwall Hospitals NHS Trust - Royal Cornwall Hospital (Treliske)	13 October 2026

Suspension of services

Obstetric-led maternity services suspended	No - services fully operational and no suspensions in last 24 hrs
Maternity services diverted internally	N/A - Single site unit
Homebirth services suspended (or planned suspension)	No - services fully operational and no suspensions in last 24 hrs
MLU services suspended (or planned	No - services fully operational and no

OPEL 1

Capacity

Delivery suite bed capacity	Yes – delivery suite beds available and no delays in admissions, elective activity and inpatient activity
Maternity ward based bed capacity (excl planned admissions not yet arrived)	Yes - ward beds available and no delays in admission or transfers
Capacity to accept external elective activity (ECLS/inductions)	Maybe – on a 1:1 basis

Care quality

1:1 care for all women in established labour	1:1 care given to all women
Labour ward coordinator solely responsible for any 1:1 care (as defined within CNST)	No - Supernumerary and have full oversight of labour ward and able to support other midwives

Safe staffing

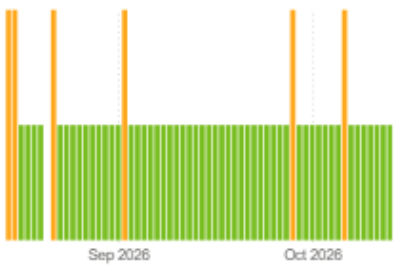
Delivery Suite Birthrate Plus activity and dependency score	Birthrate Plus rating GREEN - no safety concerns
Anesthetic staffing shotfalls as per RCoA guidance (& impact on safe care delivery)	No - No staffing shortfalls
Obstetric staffing shortfalls (& impact on safe care delivery)	No - No staffing shortfalls
Staff redeployed or non-clinical midwifery staff utilised to meet safe staffing	No

Maxine Lynsey 30/10/2026 09:39

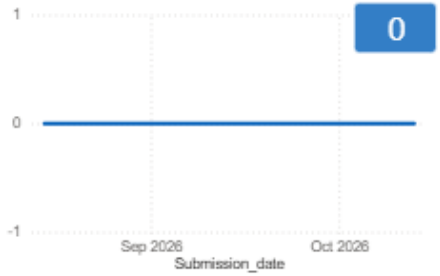
Escalation

System wide support requested (issue resolved or further mutual aid required	Not requested
Escalation to the ICB System Coordination Centres of support required (if OPEL 3/4)	N/A

OPEL maternity status trend



Confirmed covid-19 women and babies



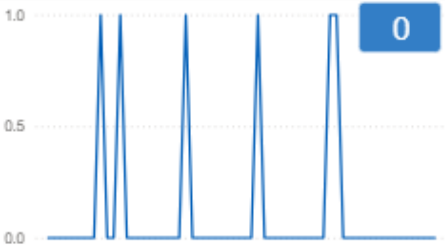
Women whose commencement of IOL is delayed >6hrs from point of admission to IOL suite



Women delayed >6hrs from decision for Syntocinon augmentation to transfer to delivery suite room for 1:1 care



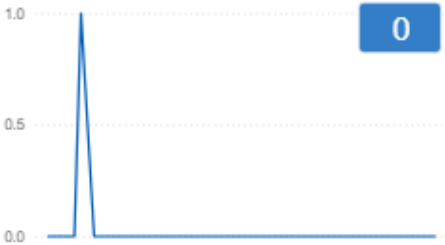
Women receiving enhanced maternal care in the maternity unit



Women delayed >6hrs from decision for ARM to transfer to delivery suite room



Women who have prolonged SROM >24hrs and planned IOL is delayed



Women delayed admission for IOL from day of planned admission



Provider/site

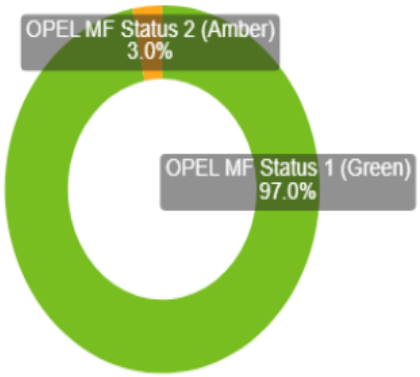
Cornwall and The Isles Of Scilly

26/08/2026 27/09/2026

More measures

	Count:	
Obstetric-led maternity services suspended:	0	0.0%
Obstetric-led maternity services diverted:	0	0.0%
Homebirth services suspended:	0	0.0%
MLU suspended:	0	0.0%

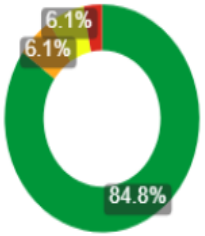
OPEL Maternity Status



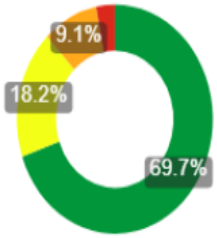
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Bed capacity

Delivery suite

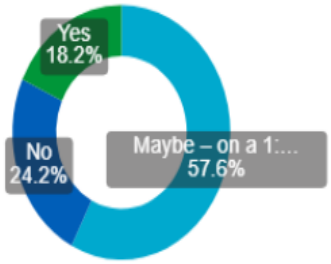


Maternity ward



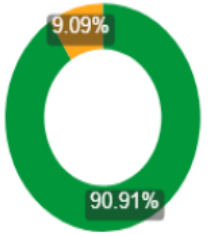
- Yes - ward beds available and no delays in admission or transfers
- Yes - reduced ward bed capacity but no impact on inpatient flow
- Yes - limited ward beds available impacting on inpatient flow
- No - no ward beds available and no planned discharges

Capacity to accept external elective activity (ELCS/inductions)



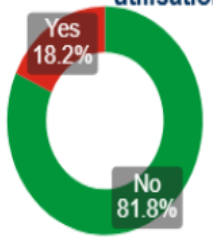
Staffing

Delivery Birthrate+/Acuity Score



- Birthrate Plus rating GREEN - no safety concerns
- Birthrate Plus rating AMBER - mitigating actions taken to maintain all services to continue safe care delivery
- Birthrate Plus rating RED - mitigating actions taken and services stood down to maintain safe care delivery
- Birthrate Plus rating RED - mitigating actions taken, services stood down and safety remains compromised

Staff redeployed/non-clinical midwifery staff utilisation



Anesthetic staffing shortfalls



Obstetric staffing shortfalls

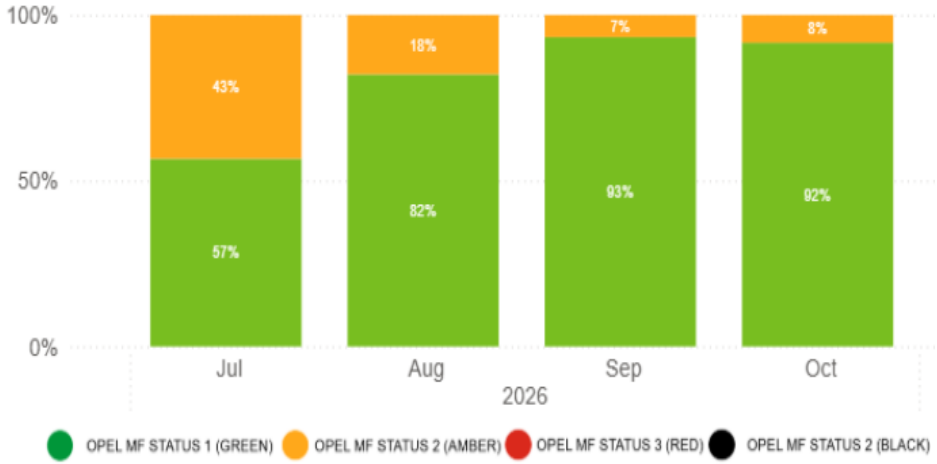


- No - No staffing shortfalls
- Yes – Staff shortages with no impact on patient care or delays
- Yes - Staff shortages impacting on patient care and elective activity delayed
- Yes - Staff shortages impacting on patient care and delays in emergency care

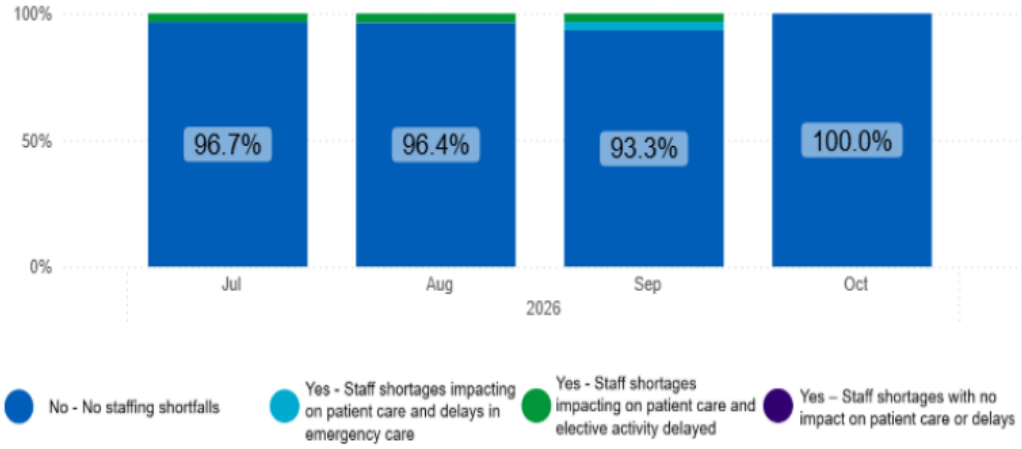
Provider/site

Cornwall and The Isles Of Scilly

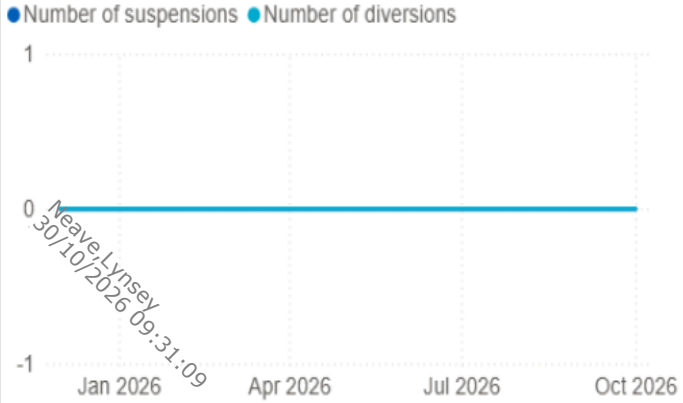
OPEL Maternity Status - % of submissions



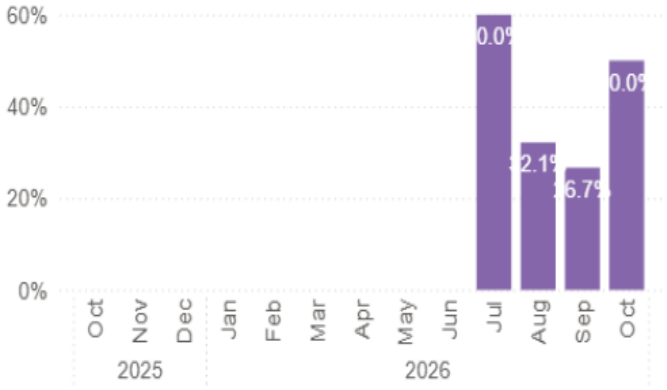
Obstetric Staffing Shortfalls



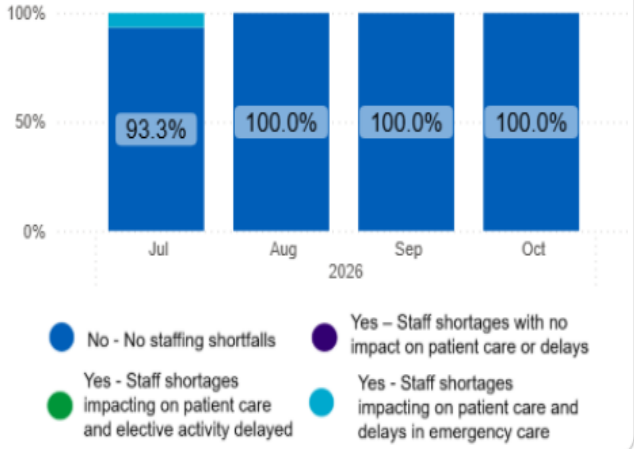
Service suspensions and diversions (obstetric-led units only)



Staff redeployed or non-clinical midwifery staff utilised to meet safe staffing levels



Anaesthetic Staffing Shortfalls



We will continue to share national data, although referring to older data, as this provides context to our work and development.

Neave,Lynsey
30/10/2026 09:31:09

Royal Cornwall Hospitals NHS Trust

SUMMARY REPORT Q4 July- September 2026		
Maternity Governance Group		**Agenda Number:**
Title of Report	Perinatal Mortality Report	
Accountable Officer	Josie Dodgson	
Author(s)	Claire Moors and Laura Quinn	
Purpose of Report	To provide an update of the activity of the Patient Safety Meetings. This report refers to the meetings	
Recommendation	The Group is recommended to note the report	
Consultation Undertaken to Date	Engagement with Community midwives, consultants, pharmacy and external Trusts	
Signed off by Executive Owner	N/A	Chief Operating Officer
Reviewed by Executive Team	N/A	Trust Management Group
Reviewed by Board Committee (where applicable)	N/A	Finance Committee
Reviewed by Trust Board (where applicable)	N/A	
Date(s) at which previously discussed by Trust Board / Committee	N/A	
Next Steps	N/A	

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30/10/2026 09:31:09

All maternity unit deaths

Miscarriage | Stillbirth | Neonatal | Termination of pregnancy for

Month	Type of Pregnancy Loss	Details
July	1. Miscarriage	P0 14/40. Attended with PV bleeding. Intrauterine death diagnosed. Medical management of acre.
	2. TOPMR	P1 21+1 TOP for open spina bifida.
	3. Miscarriage	P0 16/40 Planned TOP for higher chance NIPT/ SROM & miscarriage diagnosed prior to TOP
	4. Miscarriage	P3 13+1 Acrania and exomphalos diagnosed
	5. Stillbirth	P0 39+4 IUD diagnosed in triage following reduced fetal movements
August	6. Stillbirth	P1 at 39+2 weeks gestation attended with first episode of RFM. IUD diagnosed
	7. Early NND	Primigravida, temporary resident from Bristol. Attended Maternity triage with PV bleeding. Admiotted top the ward. Rapid on-set of active labour. Baby born with signs of live and sadly died shortly after birth.
	8. Miscarriage	Primigravida, temporary resident from Warwick. Attended with PV bleed. IUD diagnosed.
	9. TOPMR	P1 21 weeks. TOP for open spina bifida.
	10. Stillbirth/Maternal Death	P1 24 weeks, temporary resident on holiday from Norfolk. Attended via ambulance feeling unwell and with abdominal pain. Rapid delivery of stillborn infant.
	11. Stillbirth	P2 35 weeks, temporary resident on holiday from Derby. Attended Maternity Triage with RFM. An IUD was diagnosed.
	12. Early NND (died UHP)	Primigravida at 34+5 weeks, temporary resident from Dunstable attended maternity triage with pain and bleeding. Under fetal medicine for multiple abnormalities. Abnormal CTG was rapidly escalated and Cat 2 LSCS performed. The baby was transferred to the University Hospital Plymouth and sadly the baby died 4 days later.
September	13. Miscarriage/ Late Fetal loss	P1 at 22+6 weeks gestation. Attended via ambulance in advanced labour. Ultrasound USS prior to delivery diagnosed an IUD.
	14. Late NND (born at UHP, died Bristol)	P1 who received antenatal care at RCHT was transferred to Derriford with concerns of pre-term labour. Born at UHP. Transferred to Bristol for on-going care. Died at a month of age in Bristol

Steve.Lynsey 09/10/2026 09:31:09

	15. Stillbirth (TOP)	P1 at 35+5 weeks gestation. Late diagnosis of full chromosome 9p duplication and a large chromosome 3p25 duplication After extensive counselling parents consented to TOP.
	16. Infant death (born at Wolverhampton, died in Birmingham	P5, following 20 week anomaly USS diagnosed with a complex cardiac condition. Moved to Wolverhampton in pregnancy for support with a planned caesarean section in Birmingham. Pre-term labour at 34+6 weeks and delivered in Wolverhampton. Transferred to Birmingham and sadly died at 4 months of age.

Perinatal Mortality Statistics Q2 July- September 2026

This report provides evidence that the Perinatal Mortality Review Tool (PMRT) has been used to review eligible perinatal deaths and that the required Maternity Safety Standards have been met, as outlined in the Maternity Incentive Scheme. Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed. The quarterly reports are shared with the Trust Maternity Safety Champions.

PMRT uses a national standardised framework led by MBRRACE-UK, it is designed to include parent involvement and support systematic, multidisciplinary, high-quality reviews. PMRT reviews care in all perinatal deaths from 22+0 weeks gestation to 28 days following birth (excluding terminations of pregnancy and where birth weight is less than 500g) and the deaths of babies who die in the post-neonatal period having received neonatal care. PMRT provides a structured process of review, learning, reporting, and creating actions to improve future care. Reports enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to drive improvements and prevent the future deaths which are avoidable.

Parents are informed of the PMRT process and invited to contribute through sharing feedback with the Bereavement Midwives, their comments and questions are then added to the tool for discussion. The parents are provided with a copy of the report and are offered the opportunity discuss the report. Production of a report for parents includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.

Case 5 Stillbirth at 39+4

Details: - A primigravida woman with no significant medical history, no mental health concerns, and a deprivation score of 8 booked under low-risk midwifery-led care. First trimester screening identified a low-risk result, the 20-week fetal anomaly scan demonstrated no structural abnormalities.

New Cross Hospital 2026-01-26 10:31:09

The patient attended with 4 episodes of reduced fetal movements (RFM) to maternity triage over 28 weeks gestation - 28+3, 34+0, 34+2 and 38+5. A growth ultrasound scan performed at 34+3 weeks demonstrated an estimated fetal weight on the 9th centile. A subsequent growth scan at 36+2 weeks showed interval growth with estimated fetal weight above the 10th centile. On admission with RFM at 38+5 weeks' gestation a computerised Cardiotocography (CTG) met criteria and was reviewed by the Obstetric Consultant. Induction of labour was discussed but not booked. She re-attended at 39+2 weeks with further concerns regarding RFM, at which point intrauterine death (IUD) was diagnosed. A stillbirth occurred at 39+4 weeks' gestation. This pregnancy was otherwise considered low risk.

This case has been reported MBBRACE-UK through the SPEN notification portal. The first planned PMRT review of this case was on the 12 August 2026.

Key areas of learning that was discussed at PMRT:

- Management and assessment of recurrent RFM – consideration to change guidance.
- Fetal growth findings when the fetus is diagnosed below the 10th centile
- Emergency scan review capacity
- Increasing medical workforce in Maternity triage

Since the initial PMRT review, the parents have shared their perspectives on the care received through telephone discussions and written correspondence. They have raised significant concerns relating to their attendance at Maternity Triage with reduced fetal movements (RFM).

These concerns, alongside the findings of the now-available post-mortem examination, have been reviewed and discussed at a second multidisciplinary PMRT meeting on the 7th October**.** As the panel concluded that there were care issues that were likely to have made a difference to the outcome, therefore the overall care was graded as **Category D**: Care issues care issues which they considered were likely to have made a difference to the outcome for the baby. The Panel concluded that, had the complete clinical picture been fully considered and induction of labour been offered during the final triage attendance at 38+5 weeks' gestation, it is likely that the baby would have been born alive.

The parents have been offered a follow-up meeting to discuss findings of the PMRT review with the Patient Safety Obstetric Consultant and Lead Patient Safety Midwife on 21st of October.

Neave Lynch
07/10/2026 09:31:10

Case 6 Stillbirth 39+2 weeks gestation.

Details: - A multiparous woman (P1) booked under Consultant-led care due to a previous emergency caesarean section. There were no significant medical, mental health, safeguarding, or social concerns identified, with a deprivation score of 4. First trimester screening was

completed and the pregnancy was initially assessed as low risk for fetal growth restriction; however, a low PAPP-A result resulted in escalation to high-risk growth surveillance. A male infant was subsequently stillborn with a birthweight of 3680 g (81st customised centile). Investigation following the stillbirth demonstrated a significantly positive Kleihauer test of 92 mL, indicating a substantial fetomaternal haemorrhage, which was considered a likely contributory factor in the baby's death. No other significant family history or antenatal risk factors were identified.

This case has been reported MBBRACE-UK through the SPEN notification portal. The first planned PMRT review of this case was on the 12 August 2026.

The parents have shared their perspectives of care via written correspondence. They shared no concerns regarding their care.

Key areas of learning that was discussed at PMRT:

- Maternity DNA (Did Not Attend) policy was not followed when the woman did not attend an ultrasound scan arranged following reduced fetal movements.
- Communication following confirmation of stillbirth

As the panel concluded that the issues did not affect the outcome, the overall care was graded as **Category B**: care issues identified that made no difference to the outcome.

The PMRT publish deadline is the 1st of February 2027. Once completed the parents will be offered the opportunity to meet to discuss findings.

Case 7 Early NND

Details: - A primigravida woman, who was a temporary resident from Bristol and holidaying in Cornwall Deprivation score 3, attended Maternity Triage with vaginal bleeding. Initial assessment by the Obstetric Consultant included an ultrasound scan, which confirmed the presence of a fetal heart rate, and a speculum examination, which confirmed that she was not in labour. She was subsequently admitted to the antenatal ward for overnight observation.

Neave Livesey 10/10/2026 09:31:09

Following Consultant ward round review the following day, the woman experienced a sudden onset of abdominal pain. An urgent obstetric assessment was undertaken and active labour was suspected. She was therefore transferred to the Delivery Suite, where she progressed rapidly and delivered a baby girl.

A neonatal emergency call was initiated at the time of birth. Following assessment of the baby's clinical condition, the decision was made by the attending clinical team not to commence resuscitation.

This case has been reported MBBRACE-UK through the SPEN notification portal. The first planned PMRT review of this case was on the 15 September 2026. This review date was chosen to ensure appropriate representation and involvement from the Trust responsible for the woman's antenatal care, enabling a comprehensive multidisciplinary review of the circumstances surrounding the baby's death.

Key areas of learning that was discussed at PMRT:

- Admission over 22 weeks gestation and Obstetric/Neonatal counselling regarding viability and resuscitation
- Escalation of MEWS scores
- Neonatal process for responsible clinician attending birth and certifying death.

As the panel concluded that the issue did not affect the outcome, the overall care was graded as **Category B**: care issues identified that made no difference to the outcome.

Parents have been in regular contact with the Maternity Bereavement team and at present have not felt in a position to want to share any perspectives of care. Once the PMRT report has been completed, the parents will be offered a follow-up consultation to discuss the findings. This can be arranged as a face-to-face meeting, an online appointment, or, should they prefer, a written response by letter.

Case 10 Stillbirth/maternal death at 24+0

Details: - A 37-year-old multigravida was on holiday in Cornwall with her family from Dorset, whilst 24 weeks pregnant. She arrived on Delivery Suite at 07:26 on 18.08.26 via ambulance in pre-term labour and with a history of feeling unwell. An ultrasound scan could not confirm a fetal heartrate, but she rapidly delivered at 08:08 before a consultant could attend to confirm an intrauterine death. A neonatal emergency was therefore called and resuscitation commenced; however, as the baby had never shown any signs of life and considering the ultrasound findings, a stillbirth was confirmed.

Following delivery, the mother rapidly deteriorated. Critical Care Outreach team were contacted at 09:28 and she was moved to theatre at 09:34. At 09:38 a cardiac arrest was called; the mother was intubated and cardiopulmonary resuscitation (CPR) was commenced. Throughout this time, differential diagnoses were considered (sepsis, pulmonary embolism, amniotic fluid embolism, cardiac causes) and all events of reversibility were treated. At 10:55 the decision was made, with the partner present, to cease CPR.

Neave Lynch
07/10/2026 09:21:09

This case has been reported MBBRACE-UK through the SPEN notification portal. The first planned PMRT review of this case was on the **21st of October 2026** to ensure that the mother's local Trust (responsible for her antenatal care) can attend.

The initial key learning themes that have been identified are:

1. Recognising and declaring sepsis as a clinical emergency.
2. Improving handover quality, particularly between services and during shift changes.
3. Ensuring MEWS scoring, escalation and communication of severity are clear and consistent.
4. Balancing simultaneous maternal and fetal priorities.
5. Improving readiness and response for rapidly deteriorating obstetric patients.
6. Strengthening documentation and structured communication processes.

Both the maternity teams at Royal Cornwall Hospitals NHS Trust and Dorset County Hospital have made multiple attempts to contact the mother's partner via telephone, letter, and email to offer ongoing bereavement support and seek his perspectives regarding the care received. In addition, the Maternity and Newborn Safety Investigations (MNSI) team has also attempted to make contact, without success. The Royal Cornwall Hospitals NHS Trust team has sought advice from the Trust's Legal Services Department to help inform and guide the next steps in this process.

Case 11 – Stillbirth – 35 weeks

Details: - A multigravid woman, ordinarily receiving maternity care at the University Hospitals of Derby and Burton, presented to Maternity Triage whilst on holiday in Cornwall with concerns regarding reduced fetal movements (RFM). Following an unsuccessful attempt to auscultate the fetal heart, her care was promptly escalated to the obstetric team. An ultrasound scan was subsequently performed and sadly, confirmed an intrauterine death (IUD).

Management options were discussed sensitively with the family, including the option of returning to their local maternity unit for ongoing care. Following consideration, the family elected to remain under the care of RCHT and proceed with an elective caesarean birth. The procedure was undertaken the following day without complication.

Neal Lyddey 30/10/2026 08:31:09

The family received ongoing care within the designated bereavement suite and were discharged home the following day. Arrangements have been made for continued bereavement support through both Royal Cornwall Hospitals NHS Trust and the University Hospitals of Derby and Burton to ensure continuity of care.

This case has been reported MBBRACE-UK through the SPEN notification portal. The first planned PMRT review of this case was on the 15 September 2026. Representatives from both Royal Cornwall Hospitals NHS Trust and the University Hospitals of Derby and Burton in attendance to facilitate shared learning and multidisciplinary discussion.

Key areas of learning that was discussed at PMRT:

- Bladder care and re-insertion of catheter

As the panel concluded that the issue did not affect the outcome, the overall care was graded as **Category B**: care issues identified that made no difference to the outcome.

The parents have shared their perspectives of care via written correspondence. These Perspectives of care will be shared at the next PMRT meeting scheduled in October.

Case 12 Early NND – Born at RCHT, Died UHP

Details: - A multigravida woman who had received all her antenatal care in Bedfordshire arrived in Maternity triage with concerns of pain and bleeding at 34+5 weeks gestation. She was under the fetal medicine department in her home trust due to multiple abnormalities including ventriculomegaly, pericardial effusion and hypoplastic cerebellum. On admission tests confirmed pre-term rupture of membranes had occurred and an ultrasound scan confirmed anhydramnios. She was initially admitted to the antenatal ward for observations. A CTG was undertaken and as this was abnormal, it was rapidly escalated to the Obstetric team. She was prompt transferred to Delivery Suite and a Category 2 LSCS was undertaken. The baby was born in poor condition and resuscitation was commenced in theatre. The SONAR team were contacted and the baby was transferred to University Hospital Plymouth (UHP) for on-going care that evening. The baby sadly died at 4 days of age in UHP.

The baby’s death will be reported by UHP and they will lead the PMRT investigation. RCHT will be asked to contribute to the review.

Case 13 Miscarriage/ Late fetal loss 22+6

Neal, Lyndsey (NHS) 10/12/2026 09:31:09

Details: - A multiparous woman (P1), receiving low-risk maternity care, with a deprivation score of 8 attended Delivery Suite by ambulance at 22+6 weeks' gestation with concerns suggestive of established labour. Following assessment, care was rapidly escalated to the obstetric team. Ultrasound examination sadly confirmed an intrauterine death (IUD) and a subsequent speculum examination identified advanced labour.

The woman progressed to a rapid vaginal birth of a stillborn male infant.

This case meets the criteria for review through the Perinatal Mortality Review Tool (PMRT) as the loss occurred at more than 22 weeks' gestation. The case has been reported to MBRRACE-UK via the SPEN notification portal. The initial PMRT review is scheduled for 21 October 2026.

The parents have been asked to participate in the review via letter and telephone. Currently we have not yet received official feedback from the family.

Case 14 Late NND (Born at UHP and died St Micheal Bristol). Antenatal care at RCHT

Details: - A multiparous woman (P1), who was initially receiving low-risk maternity care, had a deprivation score of 3. During her pregnancy, she experienced multiple admissions to Maternity Triage with episodes of per vaginal (PV) bleeding. A routine anomaly ultrasound scan performed at 19+5 weeks' gestation identified a low-lying placenta completely covering the internal cervical os (placenta praevia) and a referral was made to Fetal Medicine for ongoing surveillance and management. At 22+4 weeks' gestation, the woman presented with a further episode of PV bleeding. In view of the antepartum haemorrhage in the context of placenta praevia, an in-utero transfer was arranged to University Hospitals Plymouth (UHP) for tertiary-level care.

The baby was born two days later at 22+6 weeks' gestation at UHP. Following birth, the baby was transferred from Derriford Hospital to St Michael's Hospital, Bristol, for specialist neonatal care. Sadly, despite ongoing treatment and support, the baby died at four weeks of age.

The Perinatal Mortality Review Tool (PMRT) review will be led by Bristol, with contributions from both University Hospitals Plymouth (Derriford Hospital) and Royal Cornwall Hospitals NHS Trust (RCHT) to facilitate a comprehensive multidisciplinary review of the care provided.

Case 15 – Stillbirth Termination of Pregnancy 35+5

Details:- A multiparous woman (P1) was receiving high-risk maternity care due to advanced maternal age. Her deprivation score was recorded as 3. A routine fetal anomaly ultrasound scan undertaken at 19+5 weeks' gestation reported no significant abnormalities.

During a scheduled growth ultrasound scan at 31+6 weeks' gestation, concerns were raised regarding the fetal kidneys, prompting referral to the Fetal Medicine team. The woman was reviewed four days later, where further abnormalities were identified affecting both the cardiac and renal systems. A referral was subsequently made to Bristol Paediatric Cardiology for specialist assessment.

Aleaya Synsey 30/07/2026 09:31:09

Further investigations, including amniocentesis, were undertaken. Microarray analysis identified a full chromosome 9p duplication and a large chromosome 3p25 duplication. These findings were reviewed with Clinical Genetics, who advised that the chromosomal abnormalities were associated with a severe lifelong neurodevelopmental condition and significant physical and cognitive impairment.

Following multidisciplinary review, it was agreed that the fetal abnormalities met the criteria under Ground E of the Abortion Act 1967. The findings, prognosis and available options were discussed extensively with the family. Following careful consideration, the parents made the difficult decision to proceed with termination of pregnancy. This case was Reported to MBBRACE-UK but will not be eligible for PMRT review.

Case 16 – Infant death – Born at Wolverhampton died Birmingham (antenatal care at RCHT)

Details:- A multigravid woman (P5) with a deprivation score of 1, was receiving high-risk maternity care due to her obstetric history of two previous lower segment caesarean sections (LSCS).

At the 20-week anomaly scan, concerns were identified regarding the fetal cardiac anatomy, prompting referral to the Fetal Medicine (FM) department. Subsequent assessment within FM confirmed ongoing concerns and the family were referred to Bristol for a fetal echocardiogram. This identified a complex congenital cardiac anomaly, including an interrupted aortic arch and ventricular septal defect (VSD).

The baby's father was known to clinical genetics services, as there was a significant family history of a chromosomal translocation associated with congenital cardiac abnormalities and neonatal deaths. Following counselling, the family were clear that they did not wish to pursue invasive prenatal testing (amniocentesis) or consider termination of pregnancy.

A multidisciplinary plan was made for delivery by caesarean section in Birmingham, where specialist neonatal cardiac services were available. However, at 30 weeks' gestation, the mother relocated to Wolverhampton to be closer to family support. A planned caesarean birth at 37-38 weeks remained the intended management plan. The woman subsequently went into spontaneous labour at 34+6 weeks' gestation and delivered in Wolverhampton. Following birth, the baby was transferred to Birmingham for ongoing specialist neonatal and cardiac care.

Despite intensive treatment and support, the baby sadly died at four months of age in Birmingham.

As the infant received ongoing neonatal care and subsequently died in infancy, this case meets the criteria for a Perinatal Mortality Review Tool (PMRT) review. The review will be led by Birmingham, with contributions from Wolverhampton and the Royal Cornwall Hospitals NHS Trust (RCHT).

PMRT action plan:

Neaves Lynsey
30/10/2026 09:34:09

Due to increased workload and seasonal pressures over the summer period, PMRT audit meetings to review and confirm PMRT actions have not taken place since July 2026. Consequently, cases reviewed during August and September 2026 are scheduled for discussion at the PMRT Audit Meeting in October 2026. Following this review, agreed actions and learning outcomes will be formally recorded on Datix and progressed through the Trust's governance processes.

	Overdue	Maternity	Incident Action		261425	10/08/2026	Action from PMRT: Partners can self-refer to smoking cessation services via Healthy Cornwall. This learning will be shared with teams via Perinatal Learning communications.	Mrs Jenny Thomas
	Overdue	Maternity	Incident Action		261166	30/09/2026	Action from PMRT: Privacy plan to be implemented with support from the 4Louis charity, to support sensitive transport of babies to the mortuary and allowing parents access if they choose.	Claire Moors
	Overdue	Obstetrics	Incident Action		254211	11/09/2026	Action from PMRT: Review of prolonged pregnancy information.	Miss Sophie Haynes

Family Feedback

Compliments	Action and progress
Feedback from family – thankful for all the care they received saying that staff made the most difficult moment in their lives more bearable to endure. Gift received from bereaved family thanking all staff for care provided.	
Complaints/ concerns/ Debriefs / Post-birth Birth After thoughts	Action and progress

Neave,Lynsey
30/10/2026 09:31:09

Concerns that antenatal care was not reviewed holistically. Felt that some behaviours were dismissive and negligent. Patient felt that she and her baby were unimportant and insignificant and that her concerns were not taken seriously or listened to with genuine interest. Felt that staff appeared to be intent of dismissing troubling results and reported concerns.	Care reviewed in PMRT in August and reviewed again in October following PM results and parent feedback. Plan for patient safety team to meet with parents to discuss concerns – 21October.
KMNVP/ External input and feedback	Action and progress

Additional questions:

1. **Were all eligible events notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis?** – Yes. All eligible deaths occurring during Q2 were identified promptly, and a SPEN notification was completed within two working days of the death, ensuring timely notification to MBRRACE-UK, NHS Resolution Early Notification (EN), and the Maternity and Newborn Safety Investigations (MNSI) programme.

2. **Were parents given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting?** - Yes. All families eligible for PMRT review during Q2 were contacted by the Patient Safety Team following discharge and provided with a letter inviting feedback on their experiences of care. The letter includes written prompts to support meaningful reflection and outlines key contacts should families wish to provide feedback or raise concerns. In addition, the Bereavement Team offers a face-to-face home visit to discuss parents' experiences and gather feedback where this is appropriate and desired by the family. Every effort is made to obtain parental feedback before the initial PMRT review meeting. For families who were on holiday in Cornwall and subsequently returned to their local area, home visits were not possible; however, alternative opportunities for feedback have been offered.

Neave,Lynsey
30/10/2026 08:31:49

3. **For a minimum of 60% of the deaths reviewed, were external members of relevant specialties present at the multi-disciplinary review and documented within the PMRT?** - Yes. An external reviewer was present for all PMRT reviews completed in Q2, ensuring independent multidisciplinary input into the review process. Two Q2 cases are scheduled for review on 21 October, and attendance by

an external reviewer has already been confirmed for this meeting. Therefore, all eligible Q2 cases will meet this requirement. RCHT will not be responsible for an external reviewer for cases where the baby died outside of the trust.

4. **Was relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews provided to families in a format that was relevant and accessible to them?** – Yes. Parents were provided with written information regarding the PMRT process prior to discharge from hospital. Following discharge, the Patient Safety Team issued further information explaining the purpose and process of the PMRT review, including the roles of MNSI and the NHS Resolution Early Notification (EN) Scheme where applicable. Information was provided in a clear and accessible format tailored to families' needs. During Q2, there were no requests or identified requirements for information to be provided in alternative languages or Easy Read formats.

5. **Have we produced thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports?** – Yes. Learning, themes and progress against actions arising from MNSI and NHSR Early Notification investigations, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards, and relevant national reports are reviewed and shared through Maternity Business Meetings and the Triangulation, Governance and Assurance Group. We continue to work collaboratively across the perinatal service, in partnership with the KMVP, to maximise the use of available data to identify themes, trends and opportunities for improvement.

6. In addition, all perinatal deaths are reviewed quarterly through the Mortality Review Oversight Group (MROG). MROG provides oversight of mortality reviews, identifies concerns relating to the quality or safety of care, monitors recurrent themes and trends, and ensures that actions and recommendations are implemented and reviewed to support continuous learning and service improvement. MROG summaries for the above cases can be found at the end of this report.

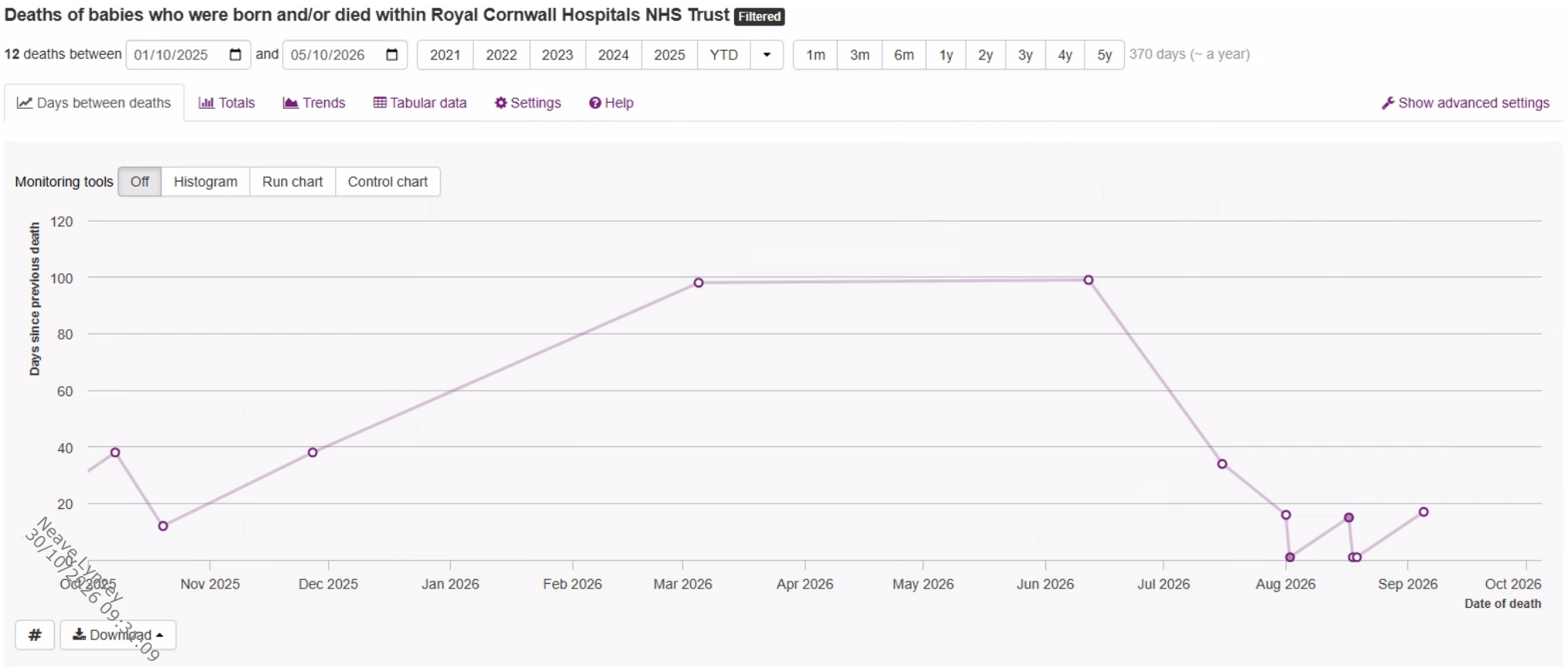
Mortality Cases: Q2 2025 – Q4 2026

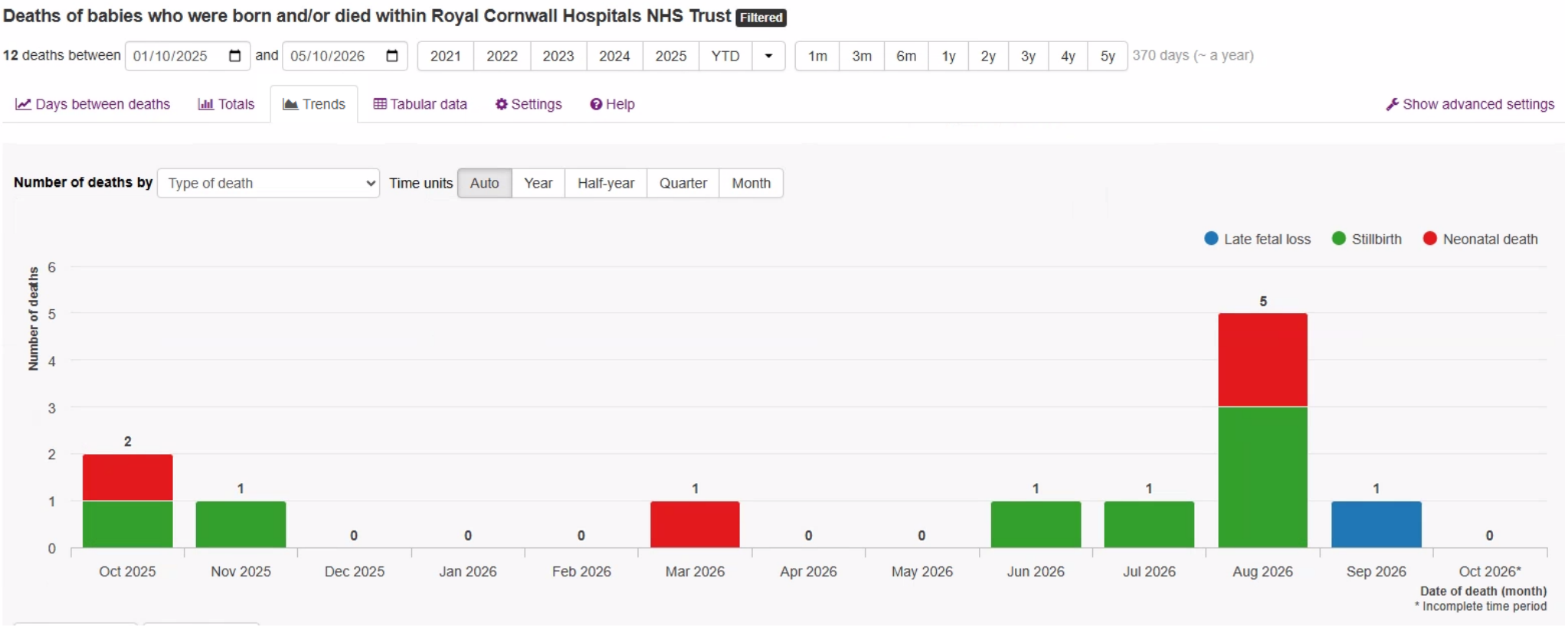
Quarter	Miscarriage	TOPMR	TOPMR and Neonatal Death (NND)	*TOPMR >24weeks	Stillbirth	NND *Infant death	Total
Q2 2026	**5**	**2**	**0**	**1**	**4**	**3**	**16**

Neave,Lynsey 30/10/2026 09:31:09

						*1	
Q1 2026	**3**	**5**	**2**	**2**	**1**	**0**	**13**
Q4 Jan-march	**6**	**9**	**0**	**1**	**0**	**1** ***3**	

Perinatal Mortality Review Real Time Data Deaths in last 12 months.



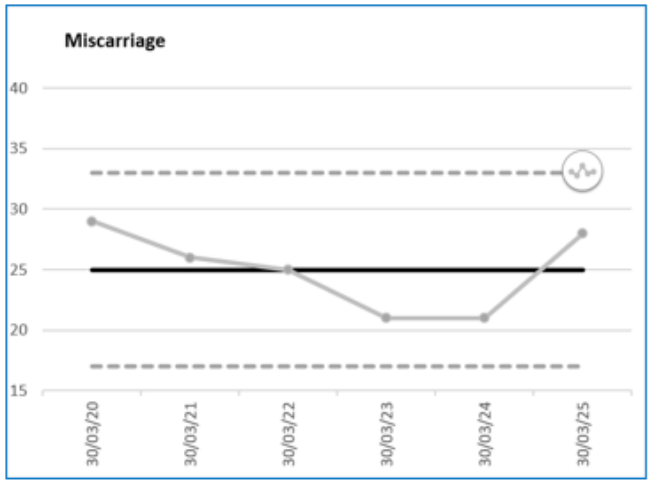


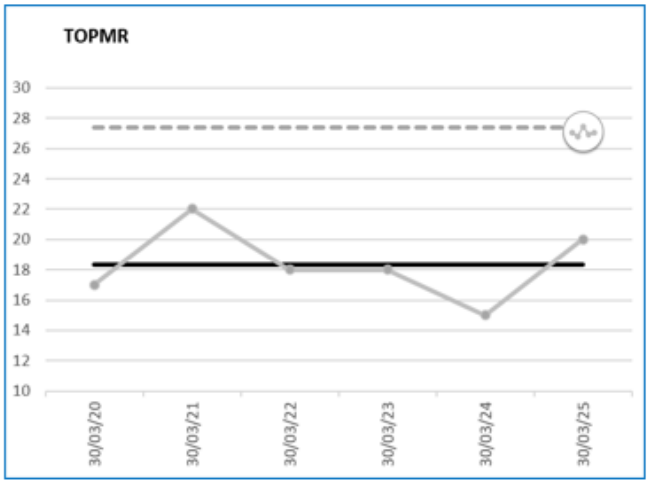
Total Perinatal Mortality 2020 – 2025

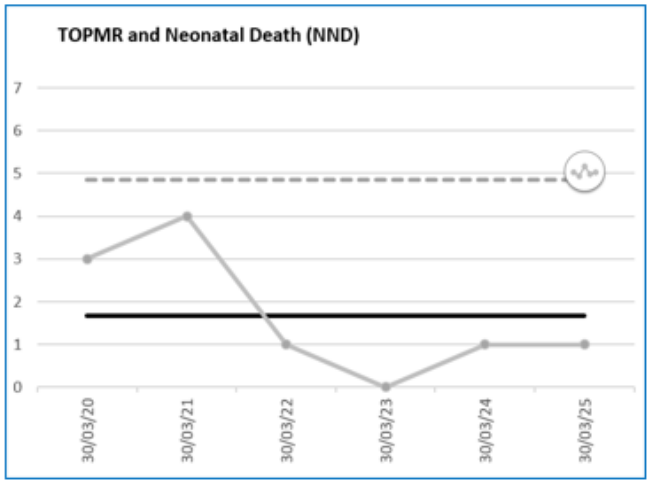
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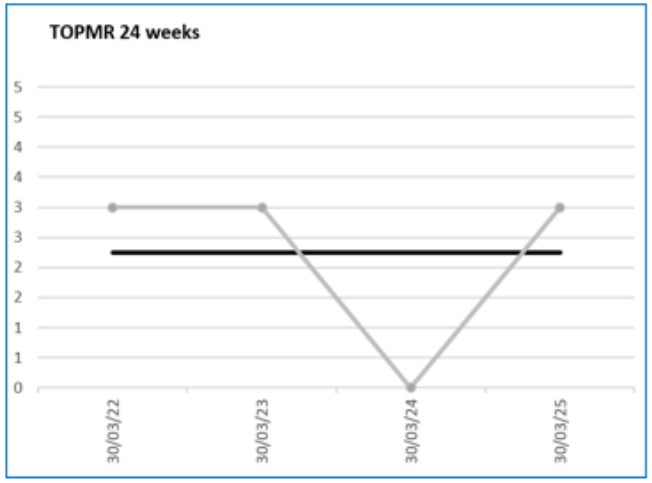
Year	Miscarriage	TOPMR	TOPMR and Neonatal Death (NND)	*TOPMR>24 weeks	Stillbirth	NND Pre-viability NND	Total
2025	**28**	**20**	**1**	**3**	**10**	**4** (x2 died at Bristol) + X1 Born elsewhere. +X3 pre-viable	**70**
2024	**21**	**15**	**1**	**0**	**5**	**6 (x2 Bristol)** **X3 pre-viability**	**51**
2023	**21**	**18**	**0**	**3**	**8**	**5** ***x1 pre-viability NN**	**56**
2022	**25**	**18**	**1**	**3**	**12**	**4 (x2 Bris)**	**61+2 (Bristol) = 63**
2021	**26**	**22**	**4**		**9**	**7**	**68**
2020	**29**	**17**	**3**		**15**	**5**	**69**

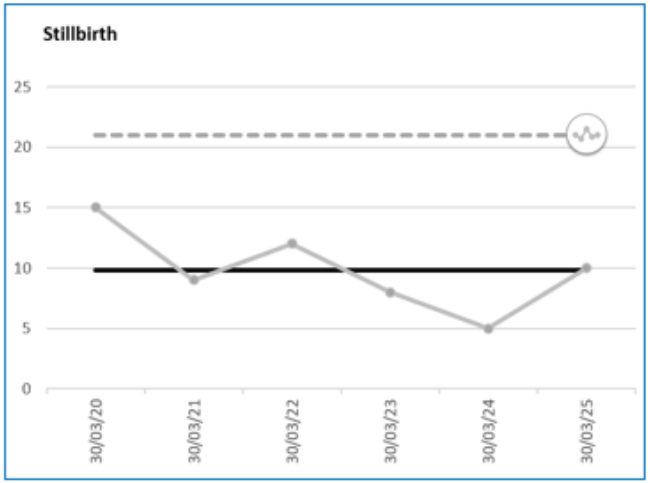
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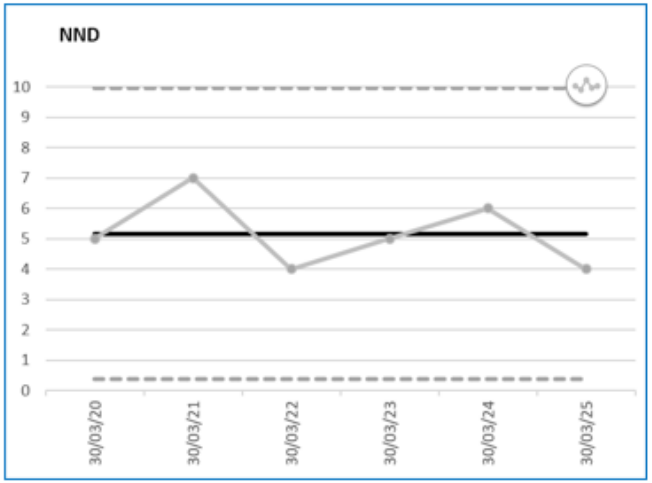












Perinatal Mortality Meetings and cases presented to Mortality Review Oversight Group (MROG).

Reeve,Lynsey
30/10/2026 09:31:09

Summary of case	Risk Factors	Elements of good care	Learning points i.e., what should have happened	Reviews undertaken & classification	Action required / Next pregnancy management
CR: **Date of delivery:** **Category: Stillbirth 39+2** **Summary** A woman in her third pregnancy booked under Consultant led care due to previous LSCS. Due to low Papp-A she was booked under the serial growth scan pathway. At 39+2 weeks gestation she attended triage with reduced fetal movements and an IUD was diagnosed. A kleihauer investigation showed a significantly positive result of 92mls. indicating a substantial fetomaternal haemorrhage, which was considered a likely contributory factor in the baby's death. **Baby** **Male infant** **3680g – 81st centile**	Index of multiple deprivation score = 4 Previous EM LSCS Low Papp-A	Parents perspectives indicate no concerns regarding their care. Individualised care by CMW in bringing LSCS date forward Excellent Individualised bereavement care with home visits and PM consent completed at home.	Maternity Did Not Attend (DNA) policy not followed in scan department and in maternity triage	Patient safety meeting Reported to MBBRACE-UK PMRT: 1047391 1st review meeting: 12th August 2026 **Grading of care: B –** The review group identified care issues which they considered would have made no difference to the outcome for the mother. **Cause of death:** Fetal-maternal haemorrhage	Staff to be updated on change to current guidance of Mifipristone/ Misoprostol regime Review of Did Not Attend (DNA) policy Next Pregnancy Individualised Consultant led care Serial growth scans from 28/40 Recommend aspirin from 12 weeks Offer support in pregnancy after loss clinic

Neave,Lynsey
30/10/2026 09:31:09

Summary of case	Risk Factors	Elements of good care	Learning points i.e., what should have happened	Reviews undertaken & classification	Action required / Next pregnancy management
CR: **Date of delivery:** **Category:** Early Neonatal death 22+4 **Summary** A primigravida woman, who was a temporary resident from Bristol attended Maternity Triage with vaginal bleeding. Initial assessment by the Obstetric Consultant included an ultrasound scan, which confirmed the presence of a fetal heart rate, and a speculum examination, which confirmed that she was not in labour. Admitted to the antenatal ward for overnight observation. The following day she experienced a sudden onset of abdominal pain. An urgent obstetric assessment was undertaken, and active labour was suspected. She was transferred to the Delivery Suite, where she progressed rapidly and delivered a baby girl.Following assessment of the baby's clinical condition, the decision was made by the attending clinical team not to commence resuscitation. Female Infant 380g. Apgars 1,0,0			Elevated MEWS score was not escalated appropriately Neonatal Registrar/Consultant should have attended delivery Discussion with parents re comfort care/transfer should have occurred sooner	Patient safety meeting Reported to MBBRACE-UK PMRT: 105000 1st review meeting: 15th September **Grading of care:** B – The review group identified care issues which they considered would have made no difference to the outcome for the mother. B – The review group identified care issues which would have made no difference for the mother following the death of her baby **Cause of death:** Extreme prematurity	Neonatal team to discuss SHO/Consultant when providing care at limits of viability If any antenatal admission >22/40 with potential for delivery, a review by Neonatal team to discuss care management should be considered - Consultant to discuss with new obstetricians **<u>Next Pregnancy</u>** Individualised Consultant led care Aspirin to be recommended from 12 weeks due to auto immune disease

Neave,Lynsey
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Summary of case	Risk factors	Elements of Good Care	Learning points i.e., what should have happened	Reviews undertaken & classification	Action required / Next pregnancy management
CR **Category: Stillbirth & Maternal death 24/40** **Date:** **Summary** A 37-year-old multigravida was on holiday in Cornwall with her family, whilst 24 weeks pregnant. She arrived on Delivery Suite at 07:26 on 18.08.26 via ambulance in pre-term labour and with a history of feeling unwell. Her observations in the ambulance and on arrival showed clinical signs of sepsis. An ultrasound scan could not confirm a fetal heartrate but she rapidly delivered at 08:08 before a consultant could attend to confirm an intrauterine death. A neonatal emergency was called and resuscitation commenced; however, as the baby had never shown any signs of life and considering the ultrasound findings, a stillbirth was confirmed. Following delivery, the mother rapidly deteriorated. Critical Care Outreach team were contacted at 09:28 and she was moved to theatre at 09:34. At 09:38 a cardiac arrest was called; the mother was intubated and cardiopulmonary resuscitation (CPR) was commenced. Throughout this time, differential diagnoses were considered (sepsis, pulmonary	Significantly raised BMI		Improved quality of handover particularly during shift changes & between services Recognising sepsis as a clinical emergency Accurate MEWS scoring and appropriate escalation Improved recognition of the deteriorating obstetric patient Strengthening documentation & structured communication	Patient Safety Meeting Reported to MBRRACE-UK PMRT ID 105187 1st Review Meeting 21st October **Cause of Maternal Death – Case reviewed by Medical Examiner and cause of death Overwhelming Sepsis** **Cause of fetal Death –** Awaiting PMRT review	

Neave,Lynsey
30/10/2026 09:31:09

embolism, amniotic fluid embolism, cardiac causes) and all events of reversibility were treated. At 10:55 the decision was made, with the partner present, to cease CPR.					

Summary of Case	Risk Factors	Elements of Good Care	Learning Points i.e What should have happened	Reviews Undertaken and Classification	Action Required/Next Pregnancy Management
CR: **Category: Stillbirth 35/40** **Date:** **Summary** A multiparous woman on holiday in Cornwall attended maternity triage with reduced fetal movements. An IUD was sadly confirmed by USS. Options for delivery were discussed and a decision was made for EL LSCS the following day. Ongoing support provided by bereavement teams from RCHT and University Hopsital of Derby and Burton **Baby** **Female infant** **2340g** Neave,Lynsey 30/10/2026 09:31:09	Previous LSCS	Exceptional Care provided by Bereavement Support Worker	Triage process not followed on admission Issues with bladder care – Initial indwelling catheter removed prior to 12 hours Delay in re-siting catheter when urinary retention diagnosed	Patient Safety Meeting Reported to MBRRACE-UK PMRT ID: 105198 1st Review Meeting 15th September **Grading of care: B** - The review group identified care issues which they considered would have made no difference to the outcome for the mother. B – The review group identified care issues which would have made no difference for the mother following the death of her baby Cause of Death – Awaiting PM report	

Type of Death	Date of Death	Date Reported to MBBRACE	Investigations	PMRT letter Perspectives of Care	Date Perspectives Sought & formats offered	Surveillance	PMRT Pre-Meeting	PMRT meeting External panel member	Grading/ Actions Cause of Death	Deadline CNST/published date	Follow up/feedback with parents	
Infant Death 32+3 Born RCHT Died RCHT Bristol care	Available at request	13.04.26 – was not eligible for MBBRACE- as infant death.	PMRT CDOP	27.03.26	01/04 Joint phone call with LW – Positive	✓	21.04.26	22.04.26 Yes Bath	B – Xonovier B – Privacy pram	No deadline		
40+2 Stillbirth	Available at request	14.06.25	PMRT	24.06.25	01.07 Visted at home - Positive	✓	03.07.26	06.07.26 Yes Bath	B – proforma RFM A	12.012.26		
39+4 Stillbirth	Available at request	17.07.26	PMRT	20.07.26	30.7.26 – home visit offered. 08.09.26 – feedback via letter 30.09.26 – 2nd correspondence received	✓	11.08.26	12.08.26 Yes – Bath 7th Oct Yes - Bath	**D –** IOL should have been offered at last admission of FRM. Holistic picture not considered. A	16.01.27	Meeting with Patient safety team 21.10.26	

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39+2 Stillbirth	Available at request	03.08.26	PMRT	21.08.26	13.08.26 Home visit and discussed perspectives 04.09.26 feedback via letter – Positive	✓	10.08.26	12.08.26 Yes-Bath	B- RFM USS booked but not attended – DNA policy not followed B – Bladder care	01.02.27		
22+4 Early NND (holidaymaker from Bristol)	Available at request	4/08/26	PMRT CDOP	21.08.26	Multiple phones calls. 24.09 – family contacted Bristol Bereavement team – do not want to give any perspective. Thankful for care. Feel all Qs answered.	✓	15.09.26	12.10.26 Yes-Bath	B – Joint obs/neo counselling not considered. B – Neonatal consultant should have attended. Guideline not followed B – Keilhauer not taken	02.04.26		

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Early NND Born – RCHT Died UHP Antenatal care Luton	Available at request	UHP	PMRT CDOP	UHP	UHP		Join UHP					
24+0 Stillbirth Antenatal care Norfolk -Kingslin	Available at request	20/08/26	PMRT MNSI	21.08.26	Multiple attempts by both trusts – No answer. MNSI – no answer. Guidance from legal team.	✓	17.09.26	21.10.26		18.04.27		
35 Stillbirth Antenatal care Darby and Burton	Available at request	20/08/26	PMRT	07.09.26	02.09.26 – hamper received with thanks of care. 13.09.26 – Feedback via letter – positive	✓	15.09.26	15.09.26 Yes- Bath. Representatives from home trust.	B – Triage process not followed. B – Bladder care	19.04.27		
Late Fetal Loss 22+6	Available at request	07.09.26	PMRT	10.10.26	Awaited	✓	21.09.26/ 09/11/26	Awaited				

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Infant death 34+6 Born – Wolferhampton Died – Birmingham Antenatal care - RCHT	Available at request	Birm	PMRT CDOP	Birm	Awaited							
Late NND Born – UHP Died – Bristol Antenatal care - RCHT	Available at request	Bristol	PMRT CDOP	Bristol	Awaited							

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Safety Action A - Workforce and Capacity
Outcome: Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.

Why:
- National and local reviews (*including Ockenden, Kirkup, MBRRACE, NHS Resolution claims*) repeatedly highlight that workforce shortfalls and capacity constraints resulting in delays to planned caesarean births are key contributors to avoidable harm, and poor experiences for women, babies, and staff.
- Workforce pressures affect staff morale, retention, and the ability to deliver high quality care.
- Understanding and measuring workforce and capacity issues is the first step to improvement.

Reference documents:
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Supplementary-guidance.pdf
https://www.rcog.org.uk/media/1e0jwloo/roles-and-responsibilities-of-the-consultant-workforce-report-may-2022-update.pdf
https://www.rcog.org.uk/careers-and-training/workforce/safe-staffing/certificate-of-eligibility-for-short-term-locums-cel/
https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/3581/BAPM_Service_Quality_Standards_FINAL.pdf
https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf
https://www.bapm.org/resources/recommended-medical-workforce-standards-for-local-and-special-care-neonatal-units-in-the-uk
https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/3581/BAPM_Service_Quality_Standards_FINAL.pdf
https://www.rcog.org.uk/globalassets/documents/2025-07/ACSA%20standards%202025%20-%20for%20Publication.pdf

Safety Action Element	Requirement as per Safety Action/ MIS Audit Template	MIS Suggestion of "*What good might look like* "	NHSR Prompts and Evidence	NHSR Maturity	Division Supporting Narrative	Compliance Rating
A1	**Consultant Attendance (Obstetric Workforce)** Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: **≥80% Consultant presence in defined acute care situations**.	• A local summary or guideline that clearly sets out the RCOG consultant attendance and "inform" criteria. • Consultant rotas and job plans that show how labour ward responsibilities are covered. • Up to date documentation confirming competence sign off for senior trainees or specialty, associate specialist and specialist (SAS) doctors, where this affects attendance requirements. • Clinical records that note when the consultant was informed or attended, with reasons documented where they did not. • Short audit reports showing consultant attendance against RCOG scenarios, with any exceptions explained. • Examples of case reviews or debriefs that highlight consultant involvement and learning. • Relevant risk register entries or workforce updates where recurring gaps or challenges have been recognised and managed. • Evidence of Board oversight of compliance with this sub-action (linking to sub action A7 and Safety Action F governance and reporting).	**Review Prompts:** •How does the Trust know whether it is meeting the >80% consultant presence requirement in practice? •Can you show a recent example where expected consultant attendance did not occur and what happened as a result? •Are expectations routinely recorded and reviewed, or only considered reactively? •Does the evidence reflect actual practice (e.g. case notes), not just rota design? •Do staff described consultant availability in a way that aligns with the data presented? **What reviewers might expect to see:** •Local consultant attendance/inform criteria •Rotas and job plans showing labour ward cover •Case note audit evidence •Exception review and escalation where recurrent gaps exist.	**1:** No clear local standard or no evidence the organisation knows its level of compliance. | **2:** Some local arrangements exist, but tracking is weak, records are incomplete, or consultant attendance is not routinely auditable. | **3:** Consultant attendance is monitored and there is evidence of local arrangements, but audit, documentation, or exception review is inconsistent. | **4:** Strong evidence that consultant attendance is routinely monitored against RCOG scenarios, exceptions are explained, and gaps are recognised and managed. | **5:** Compliance is well evidenced, exceptions are systematically reviewed for learning, and Board / governance oversight shows active understanding of risks and trends.	Audit provided via Safety Report	5
A2	**Short-term locum certification (Obstetric Workforce)** Trusts **must ensure locum certification and maintain a local** (Trust specific), **continuously updated database of all short-term locums** (**≤2 weeks**) working on their **tier 2/3 Obstetric rotas**. **Eligibility must be verified before first engagement** and **reviewed annually for all locums on the register**.	• A current, Trust specific locum register showing all short-term locums and the dates their eligibility was verified and last reviewed. • Confirmation that each locum has a valid NHS Certificate of Eligibility for Locums (CEL) or, where applicable, documented checks of specialist registration and recent NHS experience. • Records showing that key pre-employment checks (such as GMC status, references, training) were verified before the locum undertook any clinical work. • A brief induction record for each locum, including access to local systems, guidelines, escalation routes, and identification of their named consultant support. • Periodic checks or audits showing all locums on the register remain compliant and that ineligible locums are not being booked. • Notes from governance or workforce meetings showing oversight of locum use and any issues identified with agency supplied locums. • Evidence of Board oversight of compliance with this sub-action (linking to sub action A7 and Safety Action F governance and reporting).	**Review Prompts:** How does the Trust ensure eligibility is checked before a locum starts, every time? •Is the locum register live and reliable, or a retrospective record? •Can you show how annual review is tracked and what happens if certification lapses? •How are locums inducted and supported in practice, particular in escalation scenarios? •Is there evidence that locum -related risks are discussed and managed through governance? **What reviewers might expect to see:** •Live locum register •Dates of verification/ last review •CEL or disseminated alternative checks •Induction evidence and name consultant support •Governance discussion of locum risks	**1:** No reliable locum register or no assurance that eligibility is checked before first engagement. | **2:** A register exists, but it is incomplete, not current, or annual review is inconsistent. | **3:** Register and checks are broadly in place, but there are gaps in induction, audit trail, or governance oversight. | **4:** Current register, eligibility and pre-employment checks, induction records, and periodic compliance review are all clearly evidenced. | **5:** Strong, consistently maintained assurance system with regular compliance checks, clear governance review, and prompt action where issues are identified.	Awaiting approval of SOP aligned to HR/ Trust policy for when/ if we use a locum. Checklist/ induction completed. Chaser to Group Manager via Governance matron regarding urgency of completion.	3
A3	**Neonatal Workforce Establishment (Nursing & Medical)** Trusts **must have a clear plan for a fully funded Neonatal Nursing and Medical establishment** that **aligns with the relevant BAPM standards** for their unit designation (NICU. LNU, SCBU) **and the Neonatal Nursing workforce calculator output** (2020).	• A recent neonatal workforce review that clearly shows how the funded posts compare with what BAPM standards, and the neonatal nursing calculator say is needed. • Identification of any gaps, along with a realistic (SMART) plan for how the Trust intends to move toward full compliance. • Routine monitoring of workforce pressures (for example, cot closures, staffing related transfers, red flags, or mismatch between dependency levels and available staff) with evidence of escalation and mitigations. • A neonatal workforce dashboard or report that is regularly discussed in neonatal and maternity governance meetings. • Clear evidence that neonatal staffing is considered alongside maternity staffing pressures, rather than in isolation. • Evidence of Board oversight of compliance with this sub-action (linking to sub action A7 and Safety Action F governance and reporting).	**Review Prompts:** •How does the Trust know whether its establishment aligns with BAPM standards and calculator outputs? •Can you describe the key workforce gaps and what plan is in place to address them? •How are pressures such as cot closures, transfers or staffing shortfalls monitored and escalated? •Is there evidence of joint working between maternity and neonatal services on workforce risk? •How is this information used at Board or Executive level to inform decisions? **What reviewers might expect to see:** •Recent neonatal workforce review •Comparison against BAPM standards and calculator output •SMART plan for gaps •Evidence of ongoing monitoring and escalation •Neonatal staffing discussed alongside maternity pressures	**1:** No clear assessment of whether the funded establishment aligns to required standards, and no credible improvement plan. | **2:** Some review work has been done, but gaps are poorly quantified or plans are weak. | **3:** Workforce review and improvement plan exist, but monitoring, escalation, or cross-service discussion is inconsistent. | **4:** Clear review against standards, realistic plan toward compliance, routine monitoring of workforce pressure, and evidence of governance oversight. | **5:** Strong integrated neonatal workforce assurance, with clear line of sight from standards to funding, risks, mitigations, dashboarding, and Board level visibility.	Regular review and planning shared with the Board and Pateint Safety Champions. Trajectory to compliance in place but require confirmationof business cases for funding based on the workforce review. •Investment requests and business cases are being developed regarding the workforce reviews, as in previous years. This is with reference to neonatal adherence to BAPM Tier 2 airway requirements, our Allied Health Professional (AHP) and pharmacy workforce and actions identified from the care bundles (MCB).	3

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A4	**Midwifery Workforce Establishment** Trusts **must have a fully funded Midwifery establishment that aligns with a BirthRate Plus** (BR+) **review completed within the last three years** as a minimum baseline. In addition, **further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate**. *Regional Chief Midwives are able to support this process if required.*	• A recent BR+ report (within three years) demonstrating how the funded midwifery establishment compares with the BR+ recommendations. • Evidence of explanation where professional judgement has been used to adjust BR+ numbers (for example, reflecting local case mix, service configuration, acuity trends, development roles and headroom uplifts). • A clear explanation for any differences between funded and required numbers, and an agreed plan for how the Trust intends to address these gaps over time (n.b. aligned midwifery establishment must be funded for MIS compliance). • Routine monitoring of key safety indicators such as one-to-one care in labour, red flags, missed breaks, or high acuity periods, with actions taken in response. • A monthly or quarterly update to governance groups showing workforce trends, pressures, and progress against recruitment or retention plans. • Examples of joint conversations across maternity and neonatal teams to ensure midwifery staffing is seen as part of wider perinatal workforce planning. • Evidence of Board oversight of compliance with this sub-action (linking to sub action A7 and Safety Action F governance and reporting).	**Review Prompts:** •How does the current funded establishment compare to the BR+ baseline, and where are the gaps? •What professional judgement adjustments have been made, and how are these justified? •How are safety indicators such as red flags, missed breaks or one-to-one care monitored? •Can the Trust describe how workforce pressures are escalated and acted on in practice? •Is there evidence that workforce risk are understood and respond to at Board Level? **What reviewers might expect to see:** •BR+ report within three years •Funded establishment versus required establishment •Rational for professional judgement adjustments •Red flags/one-to-one care/missed breaks monitoring •Governance reports on trends and mitigation.	**1**: No recent BR+ baseline or no funded establishment aligned to review findings.	**2**: BR+ reviewed, but funded establishment does not align and there is weak explanation or no credible plan.	**3**: BR+ baseline and broader workforce monitoring are present, but the rationale for adjustments, gap management, or governance oversight is incomplete.	**4**: Funded establishment is aligned or there is a very clear, well-governed position with robust monitoring and active recruitment / retention planning.	**5**: Strong, well-evidenced midwifery workforce planning with clear BR+ alignment, justified professional judgement, active monitoring of safety indicators, and integrated perinatal oversight.	In place although planned for review as although aligned with Birthrates + there are areas (acuity, specialist roles that requrire further scrutiny.	4
A5	**Anaesthetic Workforce** Trusts must ensure that obstetric services have a **duty Anaesthetists available 24/7** in line with ACSA standards 1.7.2.1 **and a trained Anaesthetic Assistant available 24/7** in line with ACSA standards 1.3.1.2	• Rotas that clearly show 24/7 obstetric anaesthetic cover, with arrangements for planned and unplanned leave to maintain safe staffing. • Evidence that a trained Anaesthetic Assistant is always available, including escalation plans when cover is at risk. • A regular review of obstetric theatre delays or incidents where anaesthetic staffing was a factor, with actions recorded where needed (linking to sub action A6). • Evidence of job plans showing named anaesthetic lead for obstetrics, with protected time to support service delivery, governance, and workforce planning. • Meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity. • Examples of collaborative working between anaesthetic, midwifery, obstetric, and theatre teams to ensure the service runs safely during busy or complex periods (also linking to sub-action A6). • Evidence of Board oversight of compliance with this sub-action (linking to sub action A7 and Safety Action F governance and reporting).	**Review Prompts:** •How does the Trust assure itself that 24/7 anaesthetic cover and assistant availability is consistently in place? •What happens when there are gaps in cover or competing demands on anaesthetic teams? •Is there evidence that delays or incidents related to anaesthetic availability are reviewed and learned from? •How doe anaesthetic, maternity and theatre teams work together to manage pressures? •Is anaesthetic workforce risk visibility within governance an workforce reporting? **What reviewers might expect to see:** •Rotas showing 24/7 cover •Evidence of trained anaesthetic assistant availability •Escalation plans and cover pressures •Review of delays or incidents where anaesthetic staffing was a factor •Named obstetric anaesthetic lead and governance input.	**1**: No clear evidence of compliant 24/7 arrangements for anaesthetic cover and assistant availability.	**2**: Cover usually exists, but gaps, weak contingency arrangements, or poor oversight create safety concerns.	**3**: Core cover arrangements are in place, but monitoring of incidents, delays, or resilience is incomplete.	**4**: Clear rota evidence, cover arrangements, risk review, and governance discussion of anaesthetic workforce pressures.	**5**: Strongly evidenced, resilient anaesthetic model with proactive oversight of delays, cross-team working, and clear improvement action where pressures arise.	Escalation Policy is clear and in date. 24/7 cover evident. Review of delays has occurred with future actions derived from the thematic review.	5
A6	**Planned Caesarean Birth Capacity Mapping** Trusts must undertake **annual demand-capacity mapping for planned caesarean birth lists, covering the full pathway** (pre-operative assessment, theatre, recovery, postnatal ward). **Trusts should use existing NHS England regional maternity SitRep data** wherever possible to avoid duplication.	**Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.** • An annual demand–capacity review showing how planned Caesarean activity compares with available theatre time, staffing, recovery and post-natal ward capacity. • Use of regional maternity SitRep data to understand pressure trends and seasonal variation, reducing the need for local data duplication. • A summary of recurring delays, including cases where planned procedures were carried out on emergency lists, outlining the reasons, the impact on services and service users, and any mitigations. • Evidence that outputs from capacity mapping inform service planning, such as increased protected elective lists, improved scheduling, or increased anaesthetic or theatre support. • Evidence of routine monitoring of same day delays, with clear escalation when capacity issues begin to affect emergency or urgent workload. • Regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly.	**Review Prompts:** •Can you describe how the demand-capacity mapping has informed changes to planned care? •Does the analysis cover the whole pathway (pre-op to post-natal), or only parts of it? •What are the main causes of delay, and how are these identified and tracked? •Can you give me example of recurring issue and what action has been taken? •Are maternity and theatre teams aligned in how capacity and delays are understood and managed? **What reviewers might expect to see:** •Annual demand-capacity review •Full pathway coverage •Recurring delay analysis •Evidence of changes made in response •Routine governance discussions with maternity and theatre teams	**1**: No annual demand-capacity review and little evidence that planned Caesarean delays are understood.	**2**: Some local analysis exists, but it is partial, not pathway-wide, or not used to inform action.	**3**: Annual mapping is in place and delays are recognised, but escalation, mitigation, or governance use is inconsistent.	**4**: Good end-to-end mapping, use of SitRep data, routine review of recurring delays, and evidence that findings inform planning and escalation.	**5**: Strong, mature capacity management with pathway-wide analysis, routine same-day monitoring, clear mitigations, and visible governance response to persistent problems.	Demand and capapcity mapping has occurred but requires fianlizing in conjunctionj with anaesthetic colleagues. There have been 2 drafts completed but ensuring accurate data has been a challenge.	3

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A7	**Board and Governance Oversight (as detailed in Safety Action F)** Trusts must have a governance system that ensures **workforce and capacity risks are monitored, scrutinised and escalated appropriately**. This should include **a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps** across medical, midwifery, neonatal, anaesthetic and perioperative teams.	**Trusts must have robust governance processes to monitor workforce risks, escalate issues, and plan for future workforce needs.** • A regular, integrated workforce report to the Board (at least six-monthly) presenting a clear picture of staffing levels, vacancies, sickness, rota gaps, and reliance on temporary staffing across all maternity and neonatal professions. • A Statistical Process Control (SPC) based workforce dashboard showing key trends and early warning signs such as red flags, one-to-one care in labour, neonatal dependency levels, and indicators of capacity pressure. • Clear routes for escalating persistent workforce or capacity issues through governance structures, with evidence that these issues are discussed and actions tracked. • Governance meeting minutes showing routine triangulation of workforce data with incidents, complaints, outcomes, and staff and service user feedback. • A Trust risk register entry (or equivalent) reflecting any significant workforce risks, with up-to-date mitigation plans and progress updates. • Examples of Board and senior leadership discussions demonstrating understanding of the current workforce position, challenges, and improvement plans across obstetric, midwifery, neonatal, anaesthetic and perioperative teams.	**Review Prompts:** •How does the Trust bring together workforce and capacity data across maternity and neonatal services into a single view? •Is reporting focussed on assurance, risk and action, or mainly descriptive? •How are workforce risks triangulated with incidents, outcomes, staff experience and service user feedback? •Can you show how and identified workforce risk has been escalated and what action followed? •Is there clear evidence that the Board understands and is actively responding to workforce pressures? **What reviewers might expect to see:** •Integrated workforce report at least six-monthly •Coverage of all required staff groups •Dashboard and trend data •Triangulation with incidents, complaints, outcomes staff and service user feedback •Risk register and action tracking •Board/senior leadership discussion and follow-up	**1**: No clear governance route or no integrated workforce report covering the required professional groups.	**2**: Reporting occurs, but it is fragmented, descriptive, or weak on escalation and triangulation.	**3**: Six-monthly integrated reporting exists, but oversight, action tracking, or connection to wider safety intelligence is variable.	**4**: Strong integrated reporting, dashboards, escalation routes, triangulation, and clear evidence of executive / Board understanding.	**5**: Mature governance with clear line of sight from workforce and capacity risks to Board action, mitigation, resource decisions, and sustained monitoring of impact.	Bi-annual worfforce piece completed. Initial Perinatal submission rather than separate therefore this will need honing to be a consistent piece of on-going work with actions.	4

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Royal Cornwall Hospitals NHS Trust

Safety Action B - Training
Outcome: Effective Board oversight of maternity and neonatal MDT training and competency. ensuring all maternity, neonatal and anaesthetic staff are trained, assessed and supported to maintain the knowledge, skills and behaviours required for safe, high quality multidisciplinary care.

Why:
· National reviews have repeatedly identified inadequate, inconsistent or poorly embedded training as a recurrent contributory factor in avoidable harm.
· High quality multidisciplinary training, particularly scenario-based learning that integrates clinical skills, escalation, human factors and communication, improves:
- Team performance - Situational awareness - Safety culture - Escalation behaviours - Clinical outcomes
· Sustained competence requires:
- Structured, role-specific training programmes - Protected time for staff to attend - Regular assessment of competence - Clear escalation pathways - Visible governance oversight

Minimum Requirements to Achieve this Outcome
· Trusts should aim to ensure all staff have attended the required annual training listed below. A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee.

Technical Guidance
· The training requires **90% attendance at two pre-determined points during the MIS Year** (April to November 2026): **30 November (mandatory MIS checkpoint)**, and **one other Trust selected checkpoint**, at the following training where applicable dependant on staff group: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal resuscitation training

· It is the responsibility of the employing agency to provide training for their staff, so these staff will not be included in your MIS declaration. However, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust.

· It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. *(See exemptions below)*

· **At least two emergency scenario/drills should be conducted during the whole MIS reporting period**. O**ne in a hospital based clinical area, and another starting in a community / home location**. The hospital clinical area can be any area where clinical activity takes place e.g. Delivery Suite, any clinic, ED, theatre, a ward. This should not be a simulation suite. Attendance from the relevant wider professional team is strongly encouraged, including (where applicable) theatre staff, paramedics, porters, haematology services and neonatal staff. This will require shared planning and cross-agency support. Learning from recent Prevention of Future Deaths reports highlights the importance of this multi-agency approach.

· All staff that require neonatal resuscitation training should be trained and assessed in line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024).

Exempt Staff for Training Compliance
· **Fetal monitoring and surveillance** - Anaesthetic staff, Neonatal staff, Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit), MSWs, GP and Foundation Level Trainees

· **Maternity emergencies and multi-professional training (PROMPT)** - Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS Year 8 compliance assessment; Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS Year 8 compliance. Any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in your MIS declaration while they are absent from work, and for one month after their return. Staff still working in their formal induction period will not be included in your MIS declaration until their induction period is completed.

· **Rotating medical staff** - In the following circumstances, evidence from rotating resident doctors having completed their training in another maternity unit will be accepted: **1.** Staff must be on rotation. **2.** The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period.

· **Neonatal resus training** - Staff who have already attended an external neonatal resuscitation training course consistent with BAPM basic capability Neonatal Airway Capability or above (including external courses such as NLS) during MIS Year 8; NLS instructors that have taught on a course during MIS Year 8; All Obstetric and Anaesthetic Doctors (Consultants, SAS, LE Doctors and Anaesthetic Trainees) contributing to the obstetric rota; Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit); Local policy should determine whether Maternity Support Workers are included in basic neonatal resuscitation dependent on their role within the service; If Nursery Nurses work within the service, this should also be recognised in your local training needs analysis.

Reference documents:
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Supplementary-guidance.pdf
https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2585/BAPM_Airway_Standards_Full_April24.pdf
https://www.rcog.org.uk/about-us/quality-improvement-clinical-audit-and-research-projects/avoiding-brain-injury-in-childbirth-abc/

Safety Action Element	Requirement as per Safety Action/ MIS Audit Template	MIS Suggestion of "*What good might look like*"	NHSR Prompts and Evidence	NHSR Maturity	Division Supporting Narrative	Compliance Rating
B1	**Obstetric Emergency Training** · Trusts must ensure that **maternity staff attend annual multidisciplinary obstetric emergency training** that incorporates **local learning, human factors, communication, teamwork, escalation pathways and situational awareness**. · **Anaesthetists** working in maternity **are required to attend at least half of the MDT training day as a minimum**, **during which obstetric emergencies requiring anaesthetic input** (e.g. post-partum haemorrhage (PPH)), **escalation pathways, call chains, teamwork, communication and human factors are rehearsed.** · Trusts must ensure that an **impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8** (November 2026) **as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation**, aligning to the proposed ABC methodology. **There is not an expectation that all staff will have received training.**	• An annual MDT training plan that covers the required emergencies and integrates local learning, communication and teamwork principles, escalation routes and human factors. • A local training needs analysis used to identify priorities, ensure training content reflects local risks, and tailor the programme to emerging themes. • A training trajectory or forward plan outlining how the service will maintain high attendance and meet future training needs, including scheduling, workforce release planning and projected compliance. • Attendance records showing participation from maternity, neonatal, anaesthetic and theatre staff, with anaesthetists attending the required portion of the programme. • Scenario outlines demonstrating that key obstetric emergencies including PPH, maternal collapse, shoulder dystocia and cord prolapse are regularly practised, and from this year incorporating IFH. • Evidence that learning from incidents, claims, complaints and governance reviews is fed into training design. • Evidence of service user input. For example, involving MNVP representatives in shaping scenario design, highlighting communication challenges, or identifying areas where service users felt emergencies were poorly understood or explained. • Feedback summaries or debrief notes indicating that training is relevant, realistic and supports effective MDT working. • Examples of collaborative delivery involving obstetrics, anaesthetics, midwifery, neonatology and theatre teams.	**Review Prompts:** •How does the Trust ensure that >90% of relevant staff attend MDT obstetric emergency training at both checkpoints? •Is this training clearly multidisciplinary in practice, or delivered in professional silos? •How is local learning (e.. incidents, reviews themes) incorporated into training content? •Can you describe how human factors, communication and escalation are actively practised , not just taught? •Do staff describe training as realistic and reflective of challenges they experience in practice? **What reviewers might expect to see:** •Evidence of MDT training delivery across relevant staff groups •Training content including emergencies, escalation, human factors and teamwork. •Incorporation of local and national learning into training scenarios. •Attendance data and monitoring against required thresholds. •evidence of impacted fetal head scenario inclusion that aligns with ABC (or clear plan)	**1:** No clear training programme or no evidence that MDT obstetric emergency training is delivered. | **2:** Training occurs, but it is not clearly multidisciplinary, lacks key elements (e.g. human factors, escalation), or attendance is poorly monitored. | **3:** MDT training is in place and broadly aligns with requirements, but incorporation of local learning, consistency, or attendance monitoring is variable. | **4:** Strong MDT training programme with appropriate content, attendance monitoring, and incorporation of learning from incidents and reviews. | **5:** Well-embedded, high-quality MDT training with clear evidence of impact on practice, regular review and refinement, and strong governance oversight.	Overall the training is reported consostently monthly allowing for Board assurance and questions regarding trajectories. The ability to reduce pinchpoints close to the reporting checkpoints for compliance for anaesthetics remains the challenge to be able to hit the 90+% rate. There is a draft training strategy completed to further develop training based on national stanfdards and aspiration to be a platinum standard. Thius far we have reached the first pinch reporting period and are at 90% or higher across the board.	4

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B2	**Neonatal Resuscitation** As a minimum, **Trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth** (including all midwives) **complete annual neonatal resuscitation training and are assessed as meeting at least basic capability**, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS or equivalent).	• A local training register showing annual neonatal resuscitation training and capability sign-off for all relevant staff, supported by completed assessment records. • Assessments clearly mapped to the BAPM standard, demonstrating that staff meet basic capability before undertaking unsupervised primary resuscitator roles. • Scenario-based training plans reflecting local environments and escalation pathways, with updates informed by recent incidents or debriefs and service user feedback about communication during neonatal emergencies. Scenarios include community births. • A training needs analysis used to shape the annual programme and identifying any areas requiring additional support. • Evidence of neonatal resuscitation compliance and capability included in routine maternity/neonatal training reports to the Board, ensuring ongoing oversight of any gaps or risks.	**Review Prompts:** •How does the Trust assure itself that all relevant staff are competent to act as first attenders or primary resuscitators? •What evidence is there that capability (not just attendance) is assessed and maintained? •Are there any groups of staff where compliance or competence is lower, and how is this managed? •How are staff supported if the do not meet required standards? •Do front line staff feel confident in neonatal resuscitation, and does this align with reported compliance? **What reviewers might expect to see:** •Training record for relevant staff groups •Evidence of competence assessment, not just attendance •Identification and management of gaps in capability •Alignment with national standards (e.g. BAPM airway copiability) •Governance oversight of compliance and capability.	**1:** No clear assurance that staff are trained or competent in neonatal resuscitation. | **2:** Training occurs, but coverage is incomplete or competence is not clearly assessed. | **3:** Training and assessment processes are in place, but gaps remain in coverage, consistency, or assurance. | **4:** Strong evidence that relevant staff are trained and assessed, with good monitoring and follow-up of gaps. | **5:** Robust system ensuring ongoing competence, with clear assurance processes, monitoring, and learning from performance in practice.	Reported monthly and remains on track	4
B3	**Fetal Monitoring Training** Trusts must ensure that **all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training**.	• A local training register showing annual fetal monitoring training and assessment for all relevant staff, including those who may ever cover shifts in escalation. • Evidence that training content aligns with national guidance and local learning, with session plans, eLearning records or competency sign-offs available. • Scenario or case-based training reflecting local risks and recent incidents, with updates documented through governance routes. • Service user feedback, for example via MNVP input into communication elements of CTG interpretation or escalation scenarios, helping ensure the training reflects how monitoring and decision making are experienced by women and families. • A simple training needs analysis informing the annual programme and identifying staff groups requiring targeted support. • Fetal monitoring training compliance included within routine reporting to maternity/neonatal governance groups and the Board, ensuring oversight of any gaps.	**Review Prompts:** •How does the Trust ensure that all relevant staff complete annual fetal surveillance training? •Is training clearly linked to escalation pathways and decision-making in practice? •How is variation in competence identified and addressed across staff groups? •Can you show how learning from incidents or reviews has informed fetal monitoring training? •Is there evidence that training is improving understanding and reducing risk, rather than just be completed? **What reviewers might expect to see:** •Training records across all relevant staff groups •Evidence of content covering interpretation, escalation and decision making. •Monitoring of compliance and follow-up where gaps exist •Linkage to local incidents or learning themes •Governance reporting of training compliance	**1:** No clear system for ensuring fetal monitoring training is completed. | **2:** Training exists, but coverage is incomplete or poorly monitored. | **3:** Training is largely in place, but variation exists across staff groups or sites. | **4:** Strong evidence of consistent training delivery and monitoring across relevant staff groups. | **5:** Fully embedded training approach with clear impact on clinical decision-making, escalation, and safety.	Reported monthly and remains on track	4
B4	**In-situ Multi-Professional Maternity Emergencies Simulations** Trusts must deliver **at least two in-situ multiprofessional maternity emergencies simulations during the MIS reporting period**. **One that begins in a hospital area** (e.g., labour ward, obstetric theatre, triage, Emergency Department (ED), NICU) **and another that begins in a community area**. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. **These should be based on local and/or national learning and include real time practice of escalation pathways**.	• A plan outlining at least one hospital based and one community based in-situ simulation each year, with scenarios informed by local incidents, national learning and Prevent Future Deaths (PFD) themes etc. • Shared planning with relevant partners such as paramedics, ED, theatres or allied care teams to ensure realistic pathways and smooth MDT coordination. • Evidence that human factors, teamwork and communication are explicitly practised, including challenging scenarios such as language barriers or unclear escalation chains. • Participation records showing involvement from relevant professions and agencies, reflecting how teams work together in real emergencies. • Debrief notes capturing key learning, system issues, and MDT reflections, with updates to scenarios or guidance documented through governance routes. Sharing of learning. • Service user input, for example via MNVP, helping shape communication elements of scenarios or identifying where families experienced confusion during previous emergencies. • Confirmation that learning from simulations is reviewed in maternity/neonatal governance and forms part of regular assurance reporting to senior leaders and the Board.	**Review Prompts:** •Can you describe the simulations that have taken place and how they reflect real clinical environments? •Do simulations include both hospital and community settings as required? •How are different professional groups partners (e.g. paramedics, theatre) involved where relevant? •What learning has come form simulations, and how has this been acted on? •Is there evidence that simulation learning has led to changes in practice, pathways or behaviours? **What reviewers might expect to see:** •Evidence of at least two simulations (hospital and community settings). •Participation from relevant multidisciplinary teams. •Inclusion of partners where appropriate (e.g. Community, ED, Ambulance). •Documentation of learning and actions from simulations •Evidence that learning shared and acted on.	**1:** No evidence that in situ simulations have been delivered. | **2:** Simulations have taken place, but do not meet the required scope (e.g. not multiprofessional, not in situ, or limited coverage). | **3:** Simulations meet minimum requirements, but learning, participation, or follow-up is inconsistent. | **4:** Strong simulation programme with appropriate scenarios, multidisciplinary participation and clear learning outputs. | **5:** High-quality, embedded simulation approach with clear evidence of impact on systems, behaviours and practice.	One has been completed in the community and was well received. Learning shared and available for evidence. There is the additional MDT session scheduled to occur in the coming weeks. Marked as amber owing to the reliance on others to ensure the MDT aspect occurs as wanted.	3
B5	**Training Compliance Oversight *(as detailed in safety action F)*** **Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups**. Compliance **must be reported quarterly through established governance routes**, **presented in a clear trend-based format** (ideally using SPC charts), **monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance** throughout future years.	• A quarterly training report presenting clear trend-based data (e.g. SPC charts) for all maternity and neonatal staff groups, underpinned by verified local training registers. • A locally maintained dashboard that distinguishes active staff requiring training from those who are temporarily exempt, such as staff on long-term sickness, maternity leave, or those still within their documented induction period. • Monitoring arrangements for new and rotational staff, ensuring they either complete relevant training within three months of joining or can evidence that they were trained within the current year at their prior organisation. • Clear governance oversight, with compliance themes, risks and improvement actions discussed at maternity/neonatal governance and reported onwards to the Board. • Evidence of practical action where compliance falls, such as adjusting release time, increasing training availability, or targeted reminders for teams or staff groups. • A maintained trajectory toward 100% compliance, with transparent explanations where temporary dips occur (e.g. high turnover, large intake of new starters).	**Review Prompts:** •How is training compliance reported to governance and Board level, and how frequently? •Is reporting focused on trends and risk, or mainly a snapshot of compliance levels? •Are compliance issues actively escalated and addressed or simply reported? •How does the Trust track progress towards >90% and beyond (towards sustained compliance)? •Is there clear evidence that the Board understands and responds to training gaps? **What reviewers might expect to see:** •Quarterly training compliance reports •Trend-based data (i.e. trajectories, SPC where applicable) •Coverage across all relevant staff groups •Evidence of escalation where compliance falls below expected levels •Board/senior Leadership discussion and follow-up actions	**1:** No clear governance or Board oversight of training compliance. | **2:** Reporting occurs, but is infrequent, incomplete, or descriptive rather than meaningful. | **3:** Regular reporting is in place, but interpretation, escalation, or action is inconsistent. | **4:** Strong oversight with clear reporting, trend analysis, and escalation of concerns. | **5:** Mature governance with clear Board understanding, active management of risk, and sustained improvement in compliance.	Provided monthly, over and above expectation, and allows for Board scrutiny and assurance via both commentary and SPC charts.	5

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Royal Cornwall Hospitals NHS Trust

Safety Action C - Learning from Reviews and Investigations
Outcome: Effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.

Why:
· The focus of this Safety Action is to ensure that every perinatal and maternal death, and every baby with potential for severe brain injury, is consistently identified, investigated, and learned from using the appropriate national processes.
· This **includes, but is not limited to**, the **Perinatal Mortality Review Tool (PMRT) via MBRRACE-UK**, the **Maternity and Newborn Safety Investigations (MNSI)**, the **NHS Resolution Early Notification Scheme (NHSR EN)**, and a **Maternity Outcomes Signal System (MOSS) critical safety check**.
· This Safety Action aims to embed a culture in which findings are not only reported but critically analysed for their meaning and impact, focusing on the essential 'so what'. The intention is that learning translates into measurable improvements in safety, equity, and outcomes across maternity and neonatal care. This should include learning from examples of excellence when good care is identified.
· Recent national inquiries and coronial Prevention of Future Deaths (PFD) notices have consistently shown that failures to robustly investigate and learn from perinatal deaths, maternal deaths and patient safety incidents perpetuate avoidable harm. National priorities now require that review and investigation findings should result in clear actions with a demonstrable impact on outcomes and equity, and that these are tracked and reported to ensure transparency and continuous improvement.

Technical Guidance (expand in formula bar or access via MIS Supporting document, pages 32-42)
1. Reporting and review: Notify all qualifying events and deaths
Qualifying events and deaths are defined as:
- **Details of which perinatal deaths must be notified to MBRRACE-UK are available at: www.npeu.ox.ac.uk/mbrrace-uk/perinatalprogramme**
- **Notification and surveillance information must be provided for babies who die after a home birth where the care was provided by your Trust and those babies who die at home having been discharged from your Trust.**
- **All maternal deaths during pregnancy and up to one year following the end of the pregnancy (regardless of how the pregnancy ended) must be notified to MBRRACE-UK. Details of which maternal deaths, perinatal deaths and babies with brain injury must be notified to Maternity and Newborn Safety Investigations (MNSI) programme are available at: https://www.mnsi.org.uk/for-nhs/investigationoverview-for-nhs/#what-we-investigate**
- **Details of which babies with brain injury must be notified to NHS Resolution (NHSR) EN scheme are available at, we strongly recommend that reporting occurs within 14 days, this is to support NHS Resolution commence engagement with families: https://resolution.nhs.uk/services/claimsmanagement/clinical-schemes/clinicalnegligence-scheme-for-trusts/early-notificationscheme/support-for-nhs-trusts-or-memberorganisations/**

The process and timeline for event/death notification and use of the data:
· **Notifications of all the events and deaths listed above are made through the NHS England Submit a Perinatal Event Notification (SPEN) portal, which automatically directs information about the appropriate deaths/events to MBRRACE-UK, MNSI and the NHSR EN**

scheme. For the purposes of the maternity incentive scheme (MIS), all eligible perinatal deaths and events for MBRRACE-UK and MSNI must be notified via SPEN within seven working days of the death/event.
· **Neonatal deaths notified via SPEN to MBRRACE-UK continue to be automatically and immediately transferred to the appropriate local Child Death Overview Panel (CDOP) via the Cascade system.**
· **Once eligible perinatal deaths have been notified to MBRRACE-UK via SPEN, MBRRACE-UK users should log on to the MBRRACE-UK/PMRT system to complete the surveillance information; and PMRT users should log on to start the PMRT review for eligible deaths.**
· **When referring through SPEN an event that meets MNSI and NHSR EN criteria the portal will provide guidance to complete the submission as an MNSI reference number will be requested to support referral to NHSR EN.**
· **The MOSS system also automatically receives a Trust-specific data feed from the relevant events notified via SPEN.**

Reference documents:
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Supplementary-guidance.pdf
http://www.npeu.ox.ac.uk/mbrrace-uk/perinatal-programme
https://www.mnsi.org.uk/for-nhs/investigation-overview-for-nhs/#what-we-investigate
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/support-for-nhs-trusts-or-member-organisations/
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
https://link.springer.com/article/10.1186/s12913-022-08461-w
https://www.npeu.ox.ac.uk/pmrt/resources/parent-engagement-materials
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/support-for-patients-families-or-carers/translated-resources/
https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

Safety Action Element	Requirement as per Safety Action/ MIS Audit Template	MIS Suggestion of "*What good might look like*"	NHSR Prompts and Evidence	NHSR Maturity	Division Supporting Narrative	Compliance Rating
C1	**Notify all Qualifying Events** **All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal** to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis.	• A local process that ensures all qualifying events are identified quickly and submitted via SPEN without delay, supported by clear guidance and accessible instructions for staff. • Notification responsibilities that are shared across the team rather than resting with a single individual, so that reporting continues reliably during leave, sickness or out-of-hours periods. • System checks (e.g. cross-referencing SPEN submissions with incident reports, neonatal dashboards or bereavement notifications) to ensure every eligible case is captured. • Routine governance review highlighting any missed or late notifications, with actions agreed and monitored to strengthen reliability. • Inclusion of notification timeliness and completeness within maternity/neonatal governance reporting and Board-level assurance, demonstrating consistent oversight.	**Review Prompts:** •How does the Trust ensure that all qualifying events are identified quickly and notified through Submit a Perinatal Event Notification (SPEN) without delay. •Does the process rely on one person, or is the responsibility shared and resilient across the team? •How does the Trust check that no eligible cases have been missed? •Can the Trust show recent late or missed notifications and what action followed? •Is notification timeliness and completeness visible through governance and Board assurance? **What reviewers might expect to see:** •Clear local guidance or process for identifying and notifying qualifying events. •Evidence that notifications are submitted through SPEN •System checks against other sources such as incident reports, dashboard or bereavement notifications. •Review of missed or delayed notifications and resulting actions. •Governance reporting on timeliness, completeness and recurring issues.	**1:** No clear local process for identifying and notifying qualifying events, or no evidence that the Trust knows whether notifications are complete and timely. | **2:** A process exists, but it is inconsistently applied, overly reliant on one individual, or there is limited evidence of checks on timeliness and completeness. | **3:** Notifications are generally made and local arrangements are in place, but cross-checking, exception review, or governance oversight is inconsistent. | **4:** Strong evidence that qualifying events are identified and submitted promptly via SPEN, with routine cross-checking, review of late or missed notifications, and clear governance oversight. | **5:** A well-embedded, reliable notification system with shared ownership, systematic assurance of timeliness and completeness, and clear governance understanding of trends, risks and improvement actions.	In place and complain but continuing to progress ideas to strengthen evidence relating to failsafe checks and broadening out accountability so not sat with only 1 or 2 people. Clearly evidence in Board reports that checks have been completed as opposed to by exception.	4
C2	**Seek Parents' Views of Care** **For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care** and raise any questions and comments they may have **prior to the PMRT review starting**.	• A clear, sensitive process for approaching parents at appropriate times, ensuring they are offered more than one opportunity to share their views in the way that feels right for them (written, verbal, virtual or in person). • Use of supportive materials such as leaflets and discussion prompts (linking to sub-actions C4 and D1) that explain the PMRT process and encourage parents to reflect on all aspects of their care experience. • Evidence that staff record when and how opportunities were offered, ensuring the process does not rely on a single individual and remains consistent during leave, shift changes or busy periods. • Feedback from parents captured in a structured, compassionate way (e.g. using PMRT parent forms, free-text reflections or facilitated conversations) and included in the evidence provided to reviewers. • Governance oversight confirming that parent feedback is consistently sought, received and used to inform PMRT reviews, with trends or themes shared through maternity/neonatal governance and included in Board-level assurance. • Where service users (e.g. MNVP representatives) have helped shape the parent-facing materials or approach, this is reflected in meeting notes or guidance updates.	**Review Prompts:** •How are parents informed that a review will take place, and when does this happen? •Are they given more opportunities to share their views, and in different formats if needed? •How is it recorded that opportunities were offered and that parent feedback was received or declined? •How does the Trust show that parent perspectives are actually fed into PMRT review? •Is there governance oversight of whether parent feedback is being consistently sought and used? **What reviewers might expect to see:** •A clear parent engagement process for PMRT eligible deaths •Parent facing materials or prompts explaining the review process •Records of when and how parents were offered opportunities to contribute •Evidence that feedback was captured through PMRT forms, conversations or free text reflections. •Governance discussion of uptake, themes and any gaps in the process.	**1:** No clear process for seeking parents' views, or little evidence that parents are routinely offered meaningful opportunities to contribute before the PMRT review. | **2:** Some opportunities are offered, but the process is inconsistent, poorly documented, or heavily dependent on individual staff. | **3:** A process is in place and parent feedback is sometimes captured and used, but consistency, documentation, or governance oversight is variable. | **4:** Strong evidence of a sensitive, structured process with multiple opportunities for parents to contribute, good documentation, and clear use of feedback within reviews. | **5:** A well-embedded, compassionate approach in which parent voice is consistently central to the review process, supported by strong documentation, accessible materials, governance oversight and evidence of learning from themes.	In place. Revising Quarterly PMRT report to better capture parent feedback and commentary	4

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C3	**External Multi-Disciplinary Reviewers** For **a minimum of 60% of the deaths reviewed**, **external members of relevant specialties must be present** at the multi-disciplinary review **and this should be documented within the PMRT**.	• Clear arrangements for involving external reviewers from appropriate specialties (e.g. neonatology, obstetrics, midwifery, anaesthetics) to ensure the required 60% threshold is met. • A reciprocal arrangement with neighbouring Trusts or network partners so that each organisation both provides and receives external reviewers, helping maintain availability and avoid reliance on a single individual. • PMRT entries that clearly document who attended, their specialty, and whether they were external to the Trust, providing straightforward evidence of compliance. • A small, reliable pool of external clinicians identified through local networks or LMNS arrangements, with contingency options to maintain reviewer availability during leave or periods of high activity. • Governance oversight confirming external reviewer involvement, with any gaps explained and actions taken to strengthen arrangements. • Summary outputs from reviews demonstrating how external perspectives have contributed to learning, challenge, and quality improvement, and included in routine maternity/neonatal governance reporting.	**Review Prompts:** •How does the Trust ensure external reviewers are available for the required proportion of reviews? •Is there reciprocal or network-based arrangement, or does this depend on informal contacts? •Can the Trust show external attendance is documented in PMRT? •What happens if external reviewer availability becomes difficult? •Is compliance with the 60% threshold reviewed through Governance, and are gaps acted on? **What reviewers might expect to see:** •Documented arrangements for involving external reviewers from relevant specialties. •Evidence of reciprocal/network arrangements or named reviewer pool •PMRT records identifying reviewer speciality and whether that were external. •Governance review of external reviewer compliance and gaps •Evidence that external input contributes to learning equality improvement.	**1:** No reliable arrangement for external reviewers, or no evidence that the Trust knows whether it is meeting the 60% requirement.	**2:** Some external review takes place, but arrangements are ad hoc, poorly documented, or insufficient to provide confidence in compliance.	**3:** External reviewer involvement is broadly in place, but there are gaps in consistency, documentation, contingency planning or governance oversight.	**4:** Strong evidence of clear arrangements, routine documentation in PMRT, and oversight of whether the 60% threshold is being met.	**5:** A mature and reliable external review system with reciprocal arrangements, good contingency planning, clear governance oversight, and evidence that external perspectives add learning and challenge to the review process.		5
C4	**Provide Relevant Information** · **Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them**. · **Information about duty of candour must be provided for all parents where the event is eligible** for duty of candour.	• Clear, accessible written and verbal information available for parents explaining MNSI, the EN scheme and the PMRT process, offered in a sensitive and timely way. • Materials provided in different formats (including, but not limited to: 'Easy-read', translated versions, or interpreter-supported conversations, aligning with sub-action D1) to ensure families with language or communication needs can understand what is happening. • Evidence that information is offered more than once (aligning with sub action C2) so families have multiple opportunities to ask questions or share their views before the PMRT review begins. • Duty of Candour conversations and letters documented clearly, with families given time, support and contact details for follow-up. • Feedback from families (where appropriate, via MNVP or bereavement services) informing improvements to the language, tone or accessibility of parent-facing materials. • Confirmation through governance or assurance reports that families routinely receive the right information at the right time and that Boards have oversight of any gaps or improvements needed.	**Review Prompts:** •What information do families receive about PMRT, MNSI, the EN schemes and duty of candour, and when is it offered? •How does the Trust ensure this information is understandable and accessible for families with different language or communication needs? •Is the information offered more than once, recognising that families may not be ready to absorb everything initially? •How are duty of candour conversation and follow-up letters documented? •Is there any review of whether families are consistently receiving the right information? **What reviewers might expect to see:** •Written and verbal parent information on PMRT, MNSI and the EN scheme. •Accessible formats such as translated material, easy read or interpreter supported conversations •Documentation showing information was offered more than once where appropriate. •Duty of candour letters or records of conversation. •Governance or assurance reports highlighting gaps, themes or improvements in information provision.	**1: No clear evidence that families are routinely given relevant information about reviews, investigations and duty of candour in an accessible way.**	2: Information is available, but provision is inconsistent, inaccessible for some families, or poorly documented.	3: Information is broadly provided and some accessibility needs are recognised, but repeated offers, documentation or assurance are inconsistent.	4: Strong evidence that families receive clear, accessible and timely information, with good documentation and attention to language or communication needs.	5: A well-embedded, compassionate and inclusive approach with repeated opportunities for information sharing, strong accessibility support, responsive improvement of materials, and clear governance oversight of quality and consistency.		5
C5	**Offer Parents a Meeting with Relevant Specialists** **Offer parents a meeting with relevant specialists to share the findings with them** from reviews and investigations, and relevant incident reports.	• Parents are proactively offered a meeting with the appropriate specialists (e.g. neonatology, obstetrics, midwifery, bereavement leads) once review findings are available, with the offer made in a sensitive and timely way. • Evidence that offers are documented and made more than once where needed, ensuring families have opportunities to meet when they feel ready. • Meetings arranged in a setting that supports open, compassionate discussion, with clear explanations of findings and space for parents to ask questions or share reflections. • Documentation confirming who attended, what was discussed and any follow-up actions, ensuring continuity and avoiding reliance on a single team member to coordinate. • Input from service users (e.g. MNVP or bereavement services) informing how meetings are structured, how information is shared and how any communication barriers (including language needs) are addressed. • Governance oversight confirming that meetings are routinely offered, uptake is monitored and any gaps or learning about the process are acted on and reflected in reports to senior leaders.	**Review Prompts:** •How and when are parents offered a meeting to discuss findings? •Is the offer made more than once if families are not ready initially? •Who usually attend these meetings, and how is the right specialists input ensured? •How is the discussion documented and followed up? •Does the Trust review whether meetings are being routinely offered and whether the process works well for families? **What reviewers might expect to see:** •Record that meetings were offered proactively and, where needed more than once. •Evidence of involvement of relevant specialists and bereavement support. •Documentation of attendance, discussion and follow-up actions. •Examples of adjustments made for communication or accessibility needs. •Governance oversight of offer rates, uptake, learning and improvement to the process.	**1:** No clear evidence that parents are routinely offered meetings to discuss review findings.	**2:** Meetings are sometimes offered, but the process is inconsistent, poorly documented, or not clearly family-centred.	**3:** A process exists and meetings are generally offered, but repeat offers, follow-up, documentation or oversight are variable.	**4:** Strong evidence that parents are proactively and sensitively offered meetings, with good documentation, flexibility and appropriate specialist involvement.	**5:** A well-embedded, compassionate approach in which meetings are consistently offered in a family-centred way, informed by feedback and overseen through governance, with clear evidence of continuity and learning.	In place but again examining ways in which to better capture evidence from meetings with KMNVP/ bereavement team	4
C6	**Thematic Reports of Learning and Actions** ·The Trust **must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports**. Trusts must also use **demographic data to identify and understand any disparities in outcomes**. ·These **thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board <u>at least quarterly</u>**. Reports should **clearly demonstrate the measures implemented to address recurrent themes**, and **progress** with these, **including how learning has been shared** and, **where appropriate, incorporated into existing multidisciplinary training**.	• A quarterly thematic report that brings together learning and actions across all relevant sources, with clear summaries and simple evidence of progress (e.g. action trackers, completed changes, updates from risk owners). • Use of demographic data within the report to identify disparities in outcomes or experience, supported by analysis and follow-up actions where inequities are identified. • Use of recognised improvement methodology (e.g. Plan-Do-Study-Act (PDSA), driver diagrams, measurable aims) to show structured actions and demonstrable progress. • Evidence of routine discussion with the Trust's Perinatal and Board-level Safety Champions, captured through meeting notes and agreed actions. • Reports that highlight recurrent themes and show how these have been addressed, including changes to pathways, escalation processes, documentation, or workforce plans. • Clear examples of how learning has been shared across teams (e.g. safety huddles, newsletters, teaching sessions) and, where appropriate, incorporated into multidisciplinary training. • Governance records demonstrating that these thematic reports are received and reviewed at Executive Board level each quarter, with any further actions or scrutiny clearly documented.	**Review Prompts:** •Does the report genuinely triangulate information from all the required sources, or is it largely a summary of one or two? •How does the Trust track actions arising from recurrent themes and show progress overtime? •Is demographic data used to identify disparities, and is this translated into action? •How is the learning shared across teams, and where relevant, built into multidisciplinary training? •Can the Trust show that Safety Champions and the Executive Board review these reports and act on what they show? **What reviewers might expect to see:** •Quarterly thematic reports covering MNSI, EN,PMRT, PSIRF, MOSS claims score cards and national reports. •Action Trackers or other simple evidence of progress against recurrent themes. •Use of demographic data to identify disparities and associated actions. •Evidence of recognised improvement methodology where appropriate. •Discussion with Perinatal and Board Level Safety Champions •Executive Board papers or minutes showing review, challenge and follow-up. •Examples of learning shared through huddles, newsletters teaching or training updates.	**1:** No clear thematic reporting bringing together learning, actions and progress across the required sources.	**2:** Some thematic reporting exists, but it is partial, descriptive, or weak on triangulation, action tracking or governance oversight.	**3:** Quarterly thematic reporting is in place, but analysis, equity focus, improvement methodology, or evidence of impact is inconsistent.	**4:** Strong thematic reporting with clear triangulation, action tracking, use of demographic data and evidence of governance discussion and follow-up.	**5:** A mature learning system with high-quality quarterly thematic reports, clear line of sight from learning to action to impact, strong equity analysis, meaningful discussion with Safety Champions and Executive Board, and clear evidence that learning is shared and embedded into practice and training.	In place and the Safety Report, including SPC/ thematic review is available. Again examining ways in which to better capture and share learning where particualr themes are not evident.	4

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Safety Action D – Service-user Voice and Equity
Outcome: The voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes.

Why:
· National inquiries and reviews have repeatedly shown that failures to listen to (and act on) women and families experiences contribute directly to avoidable harm, poor experience, and widening inequalities. Ockenden (2020 and 2022), Kirkup, MBRRACE, CQC reports, Prevention of Future Death (PFD) reports, and NHS England equity guidance all highlight the same themes: communication gaps, missed concerns, inequitable experiences, and limited involvement of families in shaping care.
· This safety action incentivises maternity and neonatal services to place service user voice at the centre of improvement. Its purpose is to ensure that insights from women and families across all demographic groups directly influence local decision making, drive meaningful and measurable change, and support the delivery of safe, equitable, and high-quality care for every woman, baby, and family.

Reference documents:
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Supplementary-guidance.pdf

Safety Action Element	Requirement as per Safety Action/ MIS Audit Template	MIS Suggestion of "*What good might look like*"	NHSR Prompts and Evidence	NHSR Maturity	Division Supporting Narrative	Compliance Rating
D1	**Communication Equity, Language Support and Accessible Information** · Trusts should **demonstrate continued progress towards ensuring that women and families,** including those who may require translation, interpreting support, or reasonable adjustments, **are supported to understand their care, options, and decisions at key points in the perinatal journey**. · Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.	• Clear local processes ensuring timely access to professional interpreters (face-to-face, telephone or video), with usage evidenced in clinical records rather than reliance on relatives or friends. • Accessible information provided in formats suited to individual needs. For example (and not limited to) translated materials, Easy read versions, visual prompts or communication aids, with records showing how these were offered. • Staff routinely checking understanding, documenting how consent discussions were supported (e.g. interpreter present, communication aids used) and escalating concerns if communication barriers remain. • Evidence of reasonable adjustments being made, such as adapted appointment formats, longer consultation times or additional follow-up for those with language or communication needs. • Service user insight, for example via MNVP or community engagement, informing improvements to communication materials and identifying where families experienced barriers or misunderstandings. • Governance oversight showing that any communication risks, interpreter usage and themes around informed consent are routinely monitored and included in reports to senior leaders and the Board. • Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress. • Evidence for Board assurance, including audit, spot checks, incident/complaint themes and service user feedback, demonstrates that	**Review Prompts:** •How does the Trust ensure women and families can understand their care, options and decision at key points in the journey? •Are professional interpreters and accessible formats routinely available in practice, or does this depend on local workarounds? •How is understanding checked and documented, particularly where there are communication barriers or reasonable adjustments needs? •Can the Trust show how service user feedback or community insight has informed improvements to communication materials or approaches? •Is there governance oversight of communication risk, interpreter use, informed consent themes and action taken where gaps are identified? **What reviewers might expect to see:** •Interpreter access process and evidence of use in practice •Documentation that understanding and consent support are checked and recorded. •Reasonable adjustments where needed •Service user input into communication improvements •Governance reporting on communication risks, themes and mitigation.	**1:** No clear evidence that the Trust has a structured approach to communication equity, language support or accessible information. | **2:** Some arrangements are in place, but they are inconsistently applied, poorly evidenced, or there is limited assurance that women and families are supported to understand their care. | **3:** Local arrangements are broadly in place and some monitoring is evident, but documentation, reasonable adjustments, or governance oversight is inconsistent. | **4:** Strong evidence of clear communication equity processes, timely interpreter access, accessible information, and governance oversight of risks, themes and improvements. | **5:** A well-embedded and consistently applied approach, with strong assurance that women and families are supported to understand their care, clear evidence of improvement informed by service user feedback, and active Board understanding of communication-related risks and inequities.	Pocket Talk remians new in real tersm but in place and being used. Requires audit of use as good practice. Learning involving PEG available. This has remained a strong theme in triangulation. Thematic review of incidents occur to identify if there is additional learning needed. This has been reported to Board regularly.	4
D2	**Service-user Voice Driving Safety and Quality Improvement** · **Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans**. · **Trusts must use demographic data to understand their local population** and **demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service**. · **Progress** with this work **should be monitored through established governance routes quarterly** to ensure that actions lead to measurable improvements in safety, quality, or experience.	• Multiple, accessible routes for women, families and carers to share their experiences. For example, through MNVP engagement, listening events, surveys (including Picker), 15 steps type exercises, friends and family tests, community outreach or digital platforms, with evidence that feedback is recorded and reviewed. • Insights collected from a diverse range of demographic groups, using translation, interpreting support, targeted outreach or community partnerships to ensure under-represented voices are heard. • A service improvement plan that clearly incorporates service-user feedback, showing how views and suggestions have shaped priorities, actions or pathway changes. • Routine use of demographic data (e.g. ethnicity, deprivation, protected characteristics, language needs) to identify disparities in experience or outcomes, with associated actions documented and tracked. • Governance minutes and regular reports demonstrating that progress is monitored, with improvements or gaps escalated as needed. • Examples of how service-user themes have influenced practice, such as changes to communication materials, adjustments to antenatal or postnatal pathways, or updates to training scenarios. • Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress. • Board-level assurance reports highlighting key service-user themes, equity issues and actions taken, demonstrating that their voices inform decision	**Review Prompts:** •How does the Trust service user insight from women, families and carers across maternity and neonatal services? •Are there multiple and accessible ways for people to contribute, and is there evidence that under-represented groups are being actively included? •How is demographic data used to understand who is being heard, where disparities exist, and what needs to change? •Can the Trust show clear examples of where service users or feedback have shaped priorities, pathway changes, training or communication? •Is progress monitored through governance routes quarterly, with Board visibility of key service user equity issues and the actions taken in response? **What reviewers might expect to see:** •Multiple routes for gathering service user feedback •Evidence of outreach of different demographic groups •Service improvement plan informed by service user insight •Demographic data used to identify disparities and actions •Governance monitoring of progress and escalation of gaps •Examples of service user themes influencing practice or priorities •Board-level reporting on service user voice, equity issues and action taken.	**1:** No clear evidence that service user insight is systematically captured or used to inform safety and quality improvement. | **2:** Some service user feedback is gathered, but it is limited, poorly connected to improvement activity, or there is little evidence that under-represented groups are being heard. | **3:** Service user insight is being captured and some improvement activity is linked to it, but the use of demographic data, governance oversight, or evidence of measurable impact is inconsistent. | **4:** Strong evidence that service user voice is actively captured through multiple routes, used to shape improvement priorities, and monitored through governance with attention to equity and demographic differences. | **5:** A mature and well-embedded approach in which diverse service user voices clearly shape priorities, actions and pathway changes, demographic data is routinely used to identify and address inequities, and Board-level assurance shows that service user insight informs decision-making at every level.	Strong evidence of collecting and collating. Excellent support from KMNVP. Continue to demonstrate learning in to action to achieve the platinum standard. Demographics now being better captured and mindful of how best to support from this (i.e., WREN, Porth team)	4

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Safety Action E – Care Bundles

Outcome: Board oversight of progress with implementation of Saving Babies' Lives Care Bundle (SBLCBv3.2), a plan to implement the Maternal Care Bundle by March 2027, and assurance that a guideline for neonatal pulse oximetry testing has been developed in line with national guidance.

Why:

- MBRRACE UK reports continue to highlight avoidable variation and persistent inequalities contributing to maternal and neonatal deaths. Consistent implementation of the Saving Babies' Lives Care Bundle and the Maternal Care Bundle is essential to reduce preventable harm, standardise best practice, and ensure equitable, safe care for all families.
- The Saving Babies' Lives Care Bundle has been part of the Maternity Incentive Scheme since its' inception, achieving high levels of compliance and driving meaningful improvements. As services move towards embedding this as business as usual, incentivisation of progress will help demonstrate impact.
- Equivalent incentivisation is now required for the introduction of the recently announced Maternal Care Bundle to ensure uniform adoption across Trusts, reduce unwarranted variation, and support targeted interventions where improvement is most needed. This iterative approach will ensure measurable assurance that avoidable harm is being actively mitigated against, and that both bundles are delivering the impact they were designed to achieve.
- In addition to this, CAG identified the need to promote and support neonatal pulse oximetry testing, which supports earlier detection of conditions associated with hypoxaemia that may not be apparent on clinical examination, helping ensure timely and equitable care for newborns.

Reference documents:

https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Supplementary-guidance.pdf
https://www.rcog.org.uk/media/b15mznah/intergrowth-estimated-fetal-weight-charts_10-december.pdf

Safety Action Element	Requirement as per Safety Action/ MIS Audit Template	MIS Suggestion of "*What good might look like*"	NHSR Prompts and Evidence	NHSR Maturity	Division Supporting Narrative	Compliance Rating
E1	**Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board** The **provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation**. **Quarterly reports should demonstrate how the Trust has prioritised the requirements** of the SBLCB **based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents.** In light of the recent NHSE and RCOG fetal growth chart safety communication, **Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance**, **confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions** relating to fetal growth restriction (FGR) detection as highlighted.	• A clear quarterly report to the Board summarising progress against each SBLCB v3.2 element, using indicators or dashboards (e.g. the national implementation tool where in use) to show implementation status, gaps and recent improvements. • Evidence that local safety intelligence (e.g. incident themes, PSIRF findings, audit results or learning from MNSI/MBRRACE) is used to prioritise which Care Bundle elements need the most immediate focus locally. • A short update confirming that fetal growth charts and surveillance pathways comply with current SBLCB v3.2 guidance, with any risks or actions around FGR detection clearly described. • Documentation showing how actions arising from SBLCB audits or reviews are tracked, escalated and monitored through maternity governance. • Board-level minutes demonstrating active discussion of SBLCB progress, areas of concern, and decisions about resourcing or improvement priorities. • Examples of how SBLCB learning has been incorporated into training, communication materials or local pathways, particularly where FGR detection or monitoring processes have been strengthened.	**Review Prompts:** •Is there clear quarterly reporting to the Board on SBLCBv3.2 implementation? •How does the Trust prioritise which elements require focus based on the local safety intelligence? •Is there evidence that fetal growth surveillance aligns with current national safety advice, with risks identified? •Are actions from audits or learning tracked, escalated and monitored through governance? •Do Board minutes show discussion, challenge and decision making in relation to SBLCB progress **What reviewers might expect to see:** •Quarterly Board reports on SBLCBv3.2 progress •Prioritisation based on local safety intelligence •Confirmation of actions from audits or reviews •Tracking of actions from audits or reviews •Board discussion and oversight of progress and risks	**1: No clear evidence of SBLCBv3.2 reporting or oversight at Board level.** | 2: Some reporting is in place, but it is limited, descriptive, or lacks clarity on progress, risks or priorities. | 3: Regular reporting is occurring, but prioritisation, use of safety intelligence, or evidence of impact is inconsistent. | 4: Clear quarterly reporting to the Board, with evidence of prioritisation based on local safety intelligence, identified risks, and tracked improvement actions. | 5: A well-established and consistently applied approach, with meaningful Board oversight, clear prioritisation, and demonstrable improvements informed by safety intelligence and Care Bundle implementation.	Reported quarterly. Will be looking to better review and assure prior t submission now that the LMNS are no longer involved with a viewe to ensuring that any actions identified in audit can be clearly viewed as being completed.	4
E2	**Maternal Care Bundle – Implementation Plan** In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. **Progress with implementation is reviewed quarterly** through established governance routes.	• A Board-approved implementation plan setting out clear milestones, responsibilities and timescales for achieving full Maternal Care Bundle delivery by March 2027. • Evidence of collaborative planning with all relevant services (e.g. maternity, anaesthetics, emergency medicine, critical care, community services) reflected in meeting notes or agreed action logs. • A simple quarterly update that shows progress against each element of the bundle, highlights risks or delays, and outlines the actions being taken to address them. • Governance oversight demonstrating that progress is monitored through existing maternity/neonatal safety groups, with escalation routes clearly documented. • Board papers or minutes showing regular discussion of implementation status, resource needs and any required changes to support timely delivery. • Examples of how learning from incidents, reviews or national guidance has shaped the local implementation approach.	**Review Prompts:** •Is there a Board-approved implementation plan with clear milestones and responsibilities? •Has the plan been developed collaboratively across all relevant services? •How is progress against the plan monitored and reported through governance? •Are risk, delays or resource requirements identified and addressed? •Do Board Papers or minutes show regular discussion of implementation progress? **What reviewers might expect to see:** •Board approved implementation plan with millstones •Evidence of collaboration across relevant services •Regular updates through governance routes •Identification and management of risk or delays •Board oversight and discussion of delivery.	**1: No clear evidence of a Maternal Care Bundle implementation plan or Board oversight.** | 2: A plan exists but is incomplete, lacks Board approval, or there is limited evidence of oversight or progress monitoring. | 3: A Board-approved plan is in place, but collaboration, governance oversight or progress reporting is inconsistent. | 4: A clear, Board-approved plan with defined milestones, collaborative input and routine governance monitoring of progress and risks. | 5: A well-developed and actively managed implementation plan, with strong multidisciplinary collaboration, clear governance oversight, and demonstrable progress towards delivery.	There remains on-going discussions as a region/ nationally regarding the system/ promary care aspects of the implementation plan	3
E3	**Neonatal Pulse Oximetry Testing** · **Trusts must develop a standardised, equitable, and governance approved guideline for neonatal pulse oximetry testing**, aligned to the BAPM framework. · The **guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings** (including homebirths) to ensure that every baby receives **pulse oximetry screening between 2 and 24 hours of age, with clear escalation processes** for babies in the amber and red pathways.	• A single Trust-wide guideline, or an adopted regional guideline adapted locally if needed, describing consistent screening and escalation processes across all birth settings. • Clear inclusion of when testing should occur (2–24 hours of age), how results should be documented and how amber/red pathways should be escalated. • Evidence that the guideline has been approved through maternity/neonatal governance, with a plan in place for implementation and staff awareness. • Routine review through governance to ensure the guideline remains aligned with BAPM expectations and that progress towards implementation continues.	**Review Prompts:** •Is there a single, standardise guideline for neonatal pulse oximetry testing across all birth settings? •Does the guideline clearly describe timing, documentation and escalation processes? •Has the guideline been approved through governance and communicated to staff? •Is there evidence of implementation across all settings, including home births? •Is progress or compliance reviewed through governance arrangements? **What reviewers might expect to see:** •Trust-wide or adopted guideline aligned to BAPM •Clear processes for timing, documentation and escalation •Evidence of governance approval •Implementation across all birth settings •Governance review of progress and compliance	**1:** No clear evidence of a guideline or approach to neonatal pulse oximetry testing. | **2:** A guideline exists but is incomplete, not standardised, or lacks evidence of approval or implementation. | **3:** A guideline is in place and approved, but implementation, consistency or governance oversight is limited. | **4:** A clear, governance-approved guideline is in place, with consistent processes and evidence of implementation and monitoring. | **5:** A fully embedded and consistently applied approach, with strong governance oversight, clear compliance with BAPM expectations and ongoing review of effectiveness.		5

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Safety Action F – Board Oversight, Governance, Culture and Leadership
Outcome: The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.

Why:
- Independent investigations into maternity and neonatal services have repeatedly shown that safety issues are often not identified, escalated or addressed until significant harm has already occurred. Governance structures and the cultures that underpin them remain highly variable across Trusts.
- Trusts with consistent oversight, reliable escalation processes and compassionate, connected and visible leadership are better able to identify risks early and act decisively. A positive safety culture supports staff wellbeing, strengthens multidisciplinary working and reduces the likelihood of avoidable harm. Strong Board engagement and challenge ensure that risks are not only recognised but resourced, prioritised and mitigated, contributing to safer care and a more supportive working environment.

Reference documents:
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Core-standards.pdf
https://resolution.nhs.uk/wp-content/uploads/2026/03/MIS-Year-8_Supplementary-guidance.pdf
https://www.england.nhs.uk/long-read/perinatal-quality-oversight-model/
https://www.england.nhs.uk/publication/maternity-outcomes-signal-system-standard-operating-procedures/
https://www.england.nhs.uk/publication/maternity-and-neonatal-voices-partnership-guidance/

Safety Action Element	Requirement as per Safety Action/ MIS Audit Template	MIS Suggestion of "*What good might look like*"	NHSR Prompts and Evidence	NHSR Maturity	Division Supporting Narrative	Compliance Rating
F1	**Board Oversight of Maternity and Neonatal Quality and Safety** · **Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety**. This assessment should cover training, workforce, staff and service user experience, and progress **against the care bundles at the frequencies outlined in Safety Actions A–E**. · **Trusts must also ensure that findings arising from detailed scrutiny** at the Quality Governance Committee (or equivalent) **are formally escalated to the Executive Board**, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). **Where Trust level mitigation to concerns is insufficient, escalation to Regional Midwifery Officer teams should be documented**, alongside PQOM aligned actions.	• Regular Board-level maternity and neonatal quality and safety reports bringing together key themes from training, workforce, incidents, complaints, service-user feedback, clinical outcomes and care bundle progress. • Evidence that the Quality Governance Committee (or equivalent with delegated authority) undertakes detailed scrutiny of these reports, with key metrics, themes, risks and required actions formally escalated to the Executive Board through established governance routes. • Executive Board minutes showing active discussion, curiosity, challenge and follow-up, including requests for further assurance where needed, and decisions relating to resourcing, risk mitigation, targeted improvement work and alignment with wider strategic priorities and future planning. • A consistent governance cycle ensuring all required information (e.g. from Safety Actions A–E) is reported at the correct frequency, supported by dashboards or trend analyses (ideally SPC-based) to demonstrate performance over time. • Clear documentation of how deep-dive findings or emerging risks identified at the Quality Governance Committee level are escalated, recorded and tracked for impact at Executive Board level. • Examples of improvements or policy changes made in response to Board scrutiny, demonstrating that oversight leads to measurable changes in safety, quality and experience.	**Review Prompts:** •Does the Board receive regular, comprehensive reports covering maternity and neonatal safety and quality? •Are findings from governance committees clearly escalated to the Board? •Is there evidence of triangulation across workforce, incidents, outcomes and service user experience? •Do Board minutes show discussion, challenge and follow up actions? •Is the oversight aligned to PQOM and escalation routes clearly defined where risks remain? **What reviewers might expect to see:** •Regular Board level maternity and neonatal safety reports •Escalation from Quality Governance Committee or equivalent •Reporting that brings together indecent, outcomes, workforce and service user feedback •Board minutes showing discussion, challenge and actions •Evidence of escalation where risks require further support	**1: No clear evidence that the Board receives or reviews maternity and neonatal quality and safety information.** | 2: Some reporting is in place, but it is limited, fragmented or lacks evidence of Board engagement or oversight. | 3: Regular reporting is occurring, but escalation, triangulation of data or Board response is inconsistent. | 4: Clear, routine reporting to the Board with evidence of escalation from governance committees, triangulated data and Board discussion of risks and actions. | 5: A well-embedded and effective oversight approach, with strong Board visibility, scrutiny, challenge and demonstrable impact on safety, quality and experience.	In place but need to further improve the capture and sharing of minutes to evidence actions, assurance, etc to show that the report has been considered as per MIS.	4
F2	**Maternity Outcomes Signal System** **Trusts must evidence that the critical safety check** (Annex 1 of the MOSS standard operating procedures) **was completed in the event of signals, or that a test drill** (Annex 9) **was carried out if no signals occurred**. **An accountable trust board executive** (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) **must approve completed checks, including drills**. **This will be externally validated through regional assurance - services must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team** at england.moss@nhs.net	• A clear local process ensuring that whenever a MOSS signal is triggered, the critical safety check is promptly completed using the Annex1 template, or a structured test drill (Annex 9) is undertaken as part of routine annual practice as per the standard operating procedures. • Completion of Annex 1 showing timely completion of checks or drills, with the responsible executive reviewing and approving each one, and their approval clearly recorded. • Checks and drills are not reliant on a single individual - perinatal leadership teams complete through co-production with staff working on the labour ward. • Routine submission of each completed critical safety check or drill to the regional chief nurse, midwife, obstetrician and medical director (as per the standard operating procedures), and the regional assurance team. • Perinatal leadership teams can arrange a meeting with the national MOSS project team at NHS England to discuss any aspect of MOSS. Half-hour slots are available on Mondays between 1.30pm-3pm. Please contact england.moss@nhs.net to arrange. • Local governance oversight confirming that safety issues identified through MOSS checks are escalated for discussion to the next public trust board meeting for acting on. • Continued trust board oversight and active engagement to ensure changes or improvements are made at the required speed, with examples of these highlighted at trust board meetings.	**Review Prompts:** •Is there clear processes for completing MOSS safety checks or test drills? •Are checks completed promptly and approved by an appropriate Board Executive? •Is there evidence of submission to regional assurance processes? •Are findings escalated and discussed at Board level? •Is there evidence of multidisciplinary involvement in completing checks or drills? **What reviewers might expect to see:** •Completed MOSS safety checks of test drills •Executive approval clearly recorded •Submission through regional assurance routes •Escalation of findings through governance to Board •Evidence of multidisciplinary involvement.	**1:** No clear evidence of MOSS processes, checks or drills. | **2:** Limited evidence of checks or drills, with gaps in timeliness, approval or submission. | **3:** Checks or drills are completed, but consistency, governance oversight or executive approval is variable. | **4:** Clear processes in place, with timely completion of checks or drills, executive approval and governance oversight. | **5:** A well-established process, with consistent completion, strong executive oversight, and clear evidence that MOSS findings are escalated and lead to timely improvement.	Reported via safety report but verifiction regarding testing and review of perinatal understanding and sharing of information regarding MOSS.	4
	Maternity and Neonatal Board Safety Champions **Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team** (including the MNVP Lead where they are in commissioned in line with MNVP guidance), **in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board** where any concerns are identified.	• Regular contact between Board Safety Champions and the perinatal leadership team (including MNVP representatives), with clear evidence of two-way communication about safety themes, service-user concerns and improvement priorities. • Attendance or involvement of Safety Champions at key maternity and neonatal meetings, walk-arounds, listening events or MNVP sessions, demonstrating visible leadership and active engagement with staff and families. • A clear process for escalating risks, concerns or emerging themes from frontline teams and service users to the Executive Board, supported by brief notes or agreed actions. • Documentation showing Safety Champions influencing priorities. For example, by supporting resource requests, endorsing improvement work, or ensuring alignment with wider Trust strategy. • Inclusion of Safety Champion updates within regular governance and Board reports, demonstrating their ongoing role in oversight, assurance and the promotion of a positive safety culture. • Examples of improvements or changes made as a result of Safety Champion involvement, showing impact rather than representation alone.	**Review Prompts:** •Are Board Safety Champions engaged with perinatal leadership teams and MNVP representatives (where in place)? •Is there evidence of regular communication and involvement in safety related activities? •Do safety champions support escalation of risks and concerns to the Board? •Is there evidence that they influence priorities or resource decisions? •Are their contributions visible within governance and Board Reporting? **What reviewers might expect to see:** •Documented engagement between safety champions and perinatal teams •Evidence of attendance at meetings, walkarounds or engagement activity •Examples of risks or concerns escalated to the Board •Evidence of Influence on priorities, resource decisions or improvement work. •Inclusion of Safety Champion activity in Governance or Board reporting.	**1: No clear evidence of Board Safety Champion role or involvement.** | 2: A role is identified but with limited engagement or evidence of impact. | 3: Some engagement is evident, but communication, visibility or impact is inconsistent. | 4: Active involvement of Safety Champions, with regular engagement, communication and evidence of influence on priorities. | 5: A well-embedded role with visible leadership, strong two-way communication and clear impact on safety culture and improvement.	Good engagement and well attended. Look at further improvements to share learning from walk abouts as next steps (i.e., Teams Channel, etc). Fresh Eyes walk about a comprehensive piece.	5

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F4	**Perinatal Culture Improvement Plan** **Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact**, and is **reviewed by the Trust Board at least six monthly**.	• A clear perinatal culture improvement plan that draws together insights from staff surveys, focus groups, staff walkarounds, service-user feedback (including MNVP), incident and audit findings, workforce data, and safety intelligence, user feedback (including MNVP), incident and audit findings, workforce data, and safety intelligence. • Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress. • Evidence that staff and service users are engaged in shaping priorities, with themes reflected in the plan and tracked over time. • Regular updates through maternity/neonatal governance showing what has improved, what remains challenging, and what actions are underway. • Inclusion in quarterly Board reports (aligning with sub-action F1) demonstrating scrutiny, discussion and follow-up actions, including requests for further assurance where needed. • Examples of changes made in response to the plan, such as improvements to teamwork, communication, psychological safety, or escalation behaviours, showing real cultural impact.	**Review Prompts:** •Is there a clearly defined perinatal culture improvement plan? •Does the plan raw on multiple data sources, including staff and service user insight? •Is recognised improvement methodology used to support delivery? •How is progress tracked and reported through governance? •Is there evidence of Board review and oversight at least six monthly? **What reviewers might expect to see:** •Documented perinatal culture improvement plan •Evidence the plan is informed by staff feedback, service user insight and safety data, •Use of recognised improvement approaches (e.g. aims, actions, tracking) •Regular governance updates on progress •Evidence of Board review and oversight	**1: No clear evidence of a perinatal culture improvement plan.**	2: A plan exists but is limited in scope, not clearly informed by data or lacks oversight.	3: A plan is in place with some data and engagement, but progress tracking or Board oversight is inconsistent.	4: A clear plan informed by multiple data sources, with structured improvement actions and regular governance reporting.	5: A well-embedded approach with strong triangulation, active staff and service user involvement, and clear evidence of measurable cultural improvement over time.	Steering group has met to draft plan that incorporates all aspects of perinatal work, including CQC picker survey, culture reviews and indic=vidual feedback. It is key that we ahave a baseline to work from which will be the basis of the initial plan.	4

Neave,Lynsey
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Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 13.2

Title of Report: Learning from Deaths Q1

Executive Director Lead: Dr Meridith Kane, Chief Medical Officer

Author and Job Title: Dr Ray Sinclair Clinical Director Safety, Quality & Clinical Effectiveness, Jill Tozer Associate Director for quality Governance 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 was included in Executive Leadership Team papers prior to scrutiny by the Quality Assurance Committee on 22 September.

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?				

Mandy Kynsey 30/10/2026 09:31:09

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	Learning from deaths helps identify health inequalities and informs targeted prevention strategies, enabling proactive interventions to improve population wellbeing and reduce disparities.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The LeDeR programme ensures RCHTs service quality and reduces inequalities by reviewing deaths of people with intellectual disabilities aged 4+, identifying care gaps, and implementing improvements through standardised reviews and governance processes.
Sustainable and efficient use of NHS resources by RCHT	Learning from deaths helps RCHT identify systemic issues, reduce preventable deaths, and improve care quality, thereby optimising resource allocation and efficiency.

Recommendation(s):

The Board is recommended to:

- **discuss for assurance** Discuss for assurance the Q1 Learning from Deaths assurance report

Neave,Lynsey
30/10/2026 09:31:09

Learning from Deaths Quarter 1 (April 2026 – June 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 April 2026. It also includes Crude Mortality up to July 2026.

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 NHFD case-mix adjusted mortality rate following fractured neck of femur remains above the national average (5) at 6.4 and is above the 95% (2SD) control limit for the year up to and including the most recent quarter. It is recognised by the NHFD that this may be as a result of statistical variation, and most units in this position return below the control limit in the following quarter, hence whilst the NHFD does not consider RCHT to be an 'outlier', the data and NHFD KPIs are being scrutinised, with a response and updated action plan to be returned to the NHFD by 25 September 2026.

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)

2 deaths have been reporting at RCHT for Q1 in this patient group

1.3.1.2 Deaths subject to a 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.

0 deaths in this group have been closed with learning and embedded actions.
5 deaths have 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.

2 deaths have been reported in Q1 in this patient group.

Alyson Linsey 30/11/2026 08:31:09

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.

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

1.3.1.5 Learning from 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.

1 death has been reported in this group.

1.3.1.7 Deaths following concerns raised by clinicians

1 death have been reported in this group.

1.4 Structured Judgement Reviews

53 SJRS were completed in Q1, with most care rated good. 1 case identified as possibly avoidable with investigation taking place.

1.5 Medical Examiner

In Q1, the Medical Examiner reviewed 80.56% of deaths.

1.6 Learning and feedback from Inquests

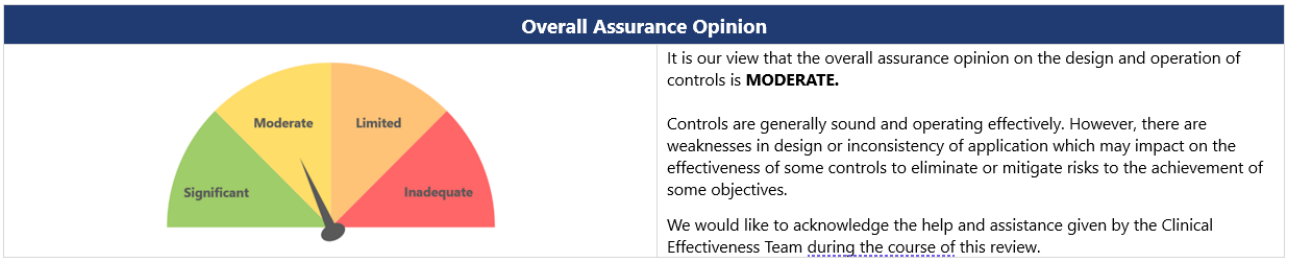
In Q1, 29 inquests generated learning on documentation and completion of nursing assessments and systemic delays (ambulance, admission into hospital).

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1.7 Divisional Governance Mortality Review process

ASW Assurance undertook an internal audit of Mortality. This was done to assess the effectiveness of the Trust's mortality governance framework, in ensuring that deaths are appropriately identified, reviewed and investigated, and that learning is targeted to improve patient safety and outcomes in line with national guidance.

The outcome of this review is moderate assurance.



Mortality review processes are being strengthened following divisional restructure, with work underway to standardise Mortality and Morbidity (M&M) meetings and improve governance, both reporting to Mortality Review and Oversight Committee (MROG and embedded learning at specialty/divisional level.

1.8 Health Inequalities

A significant proportion of patients who died during Q1 lived in areas of high socioeconomic deprivation, highlighting the importance of considering health inequalities and wider determinants of health alongside clinical factors when reviewing mortality and identifying opportunities for improvement.

1.9 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 Urology, Paediatrics, Haematology Rheumatology.

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.

3. Assessment

Overall Hospital Mortality Data

3.1 RCHT Hospital Standardised Mortality Ratio (HSMR)

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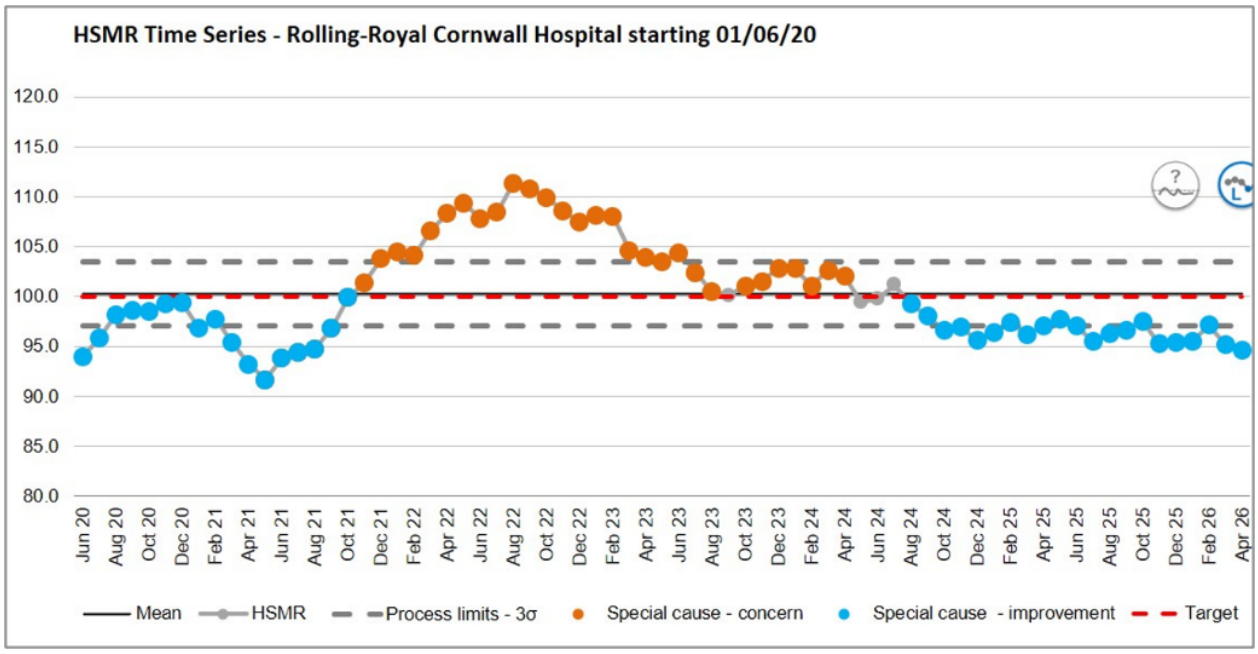
Healthcare Evaluation Data (HED) uses national NHS data on hospital admissions and deaths, which is automatically provided through NHS England systems rather than entered locally.

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.

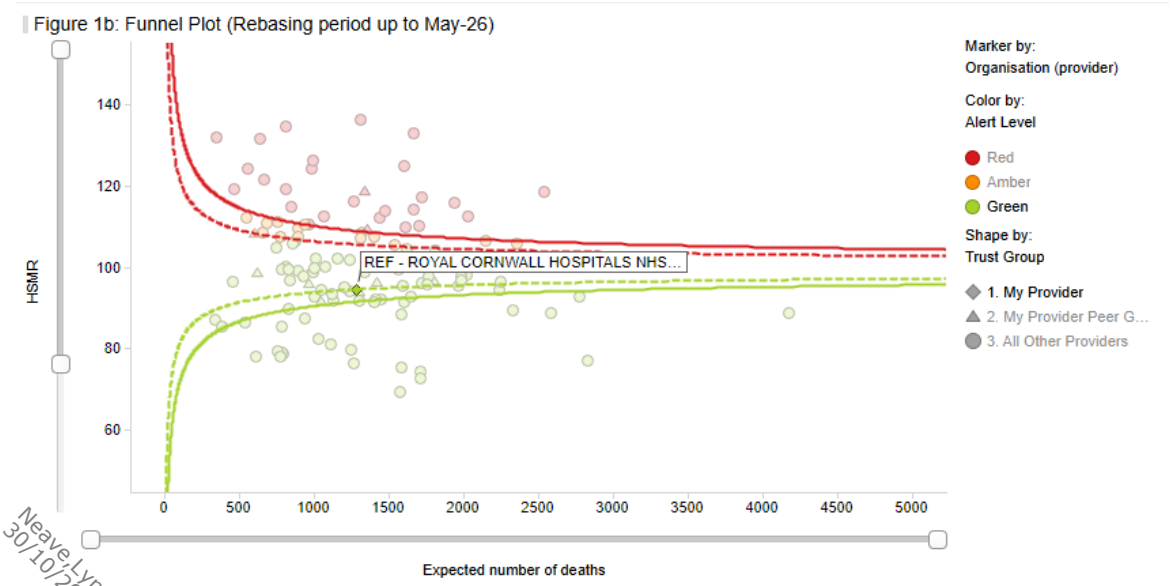
HSMR Status

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 94.64; a sustained downward trend since August 2022.



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



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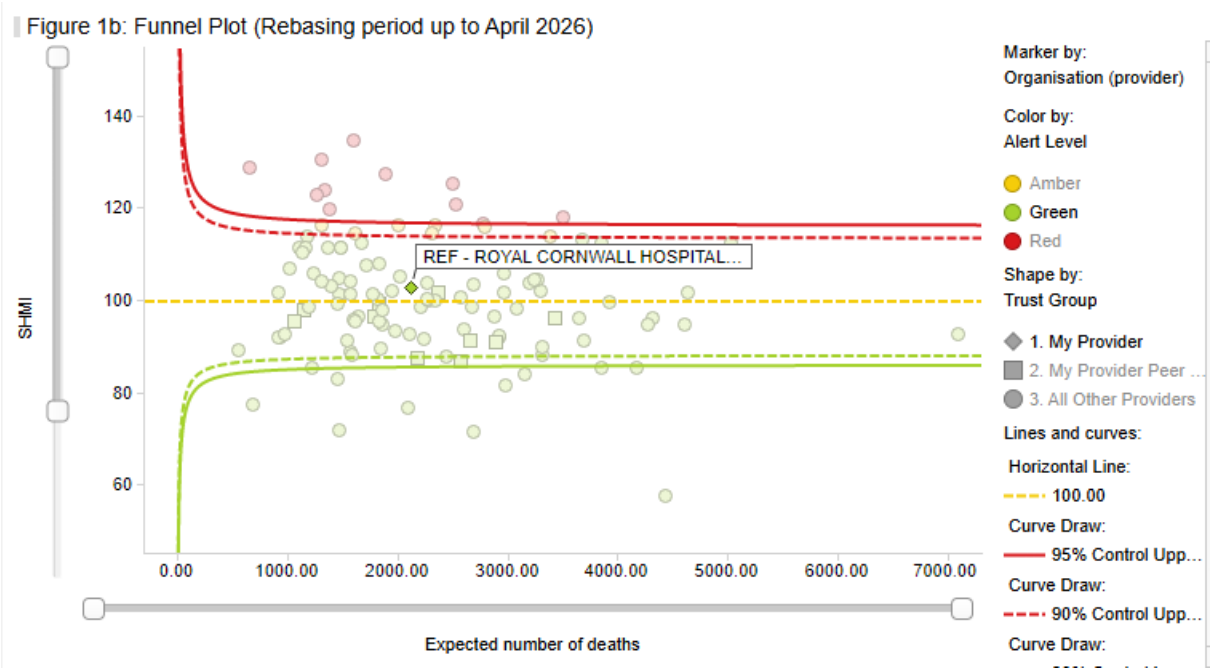
3.2 Summary Hospital Mortality Indicator (SHMI)

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 April 26 is 102.94
The data are represented as both a funnel plot and SPC chart.

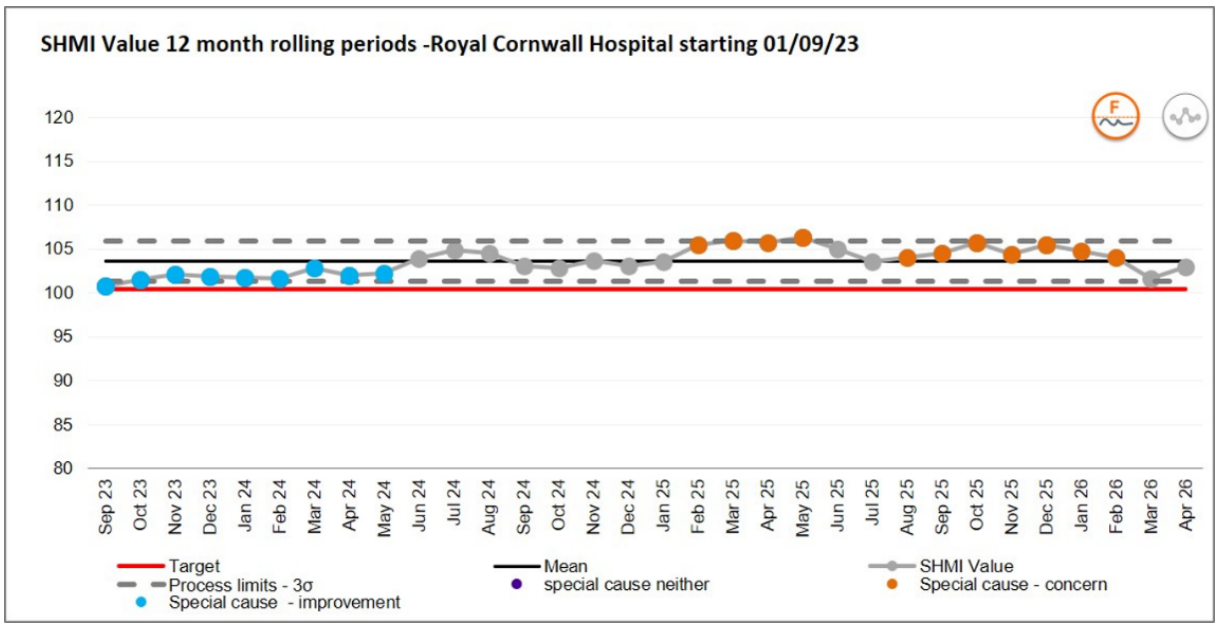
Figure 1b: Funnel Plot (Rebasing period up to April 2026)



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 April 2026.

Neave,Lynsey
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A recent review identified that some patients admitted via Medical Rapid Assessment and Treatment Service (MRATS) and Same Day Medical Assessment (SDMA) were incorrectly recorded as elective rather than emergency admissions. This has affected SHMI reporting by reducing expected mortality and consequently overestimating the SHMI mortality index. Additional training and guidance are being provided to staff to improve coding accuracy; however, it is too early to determine whether these actions have impacted the figures. We will continue to monitor the data as reporting lag works through the system.

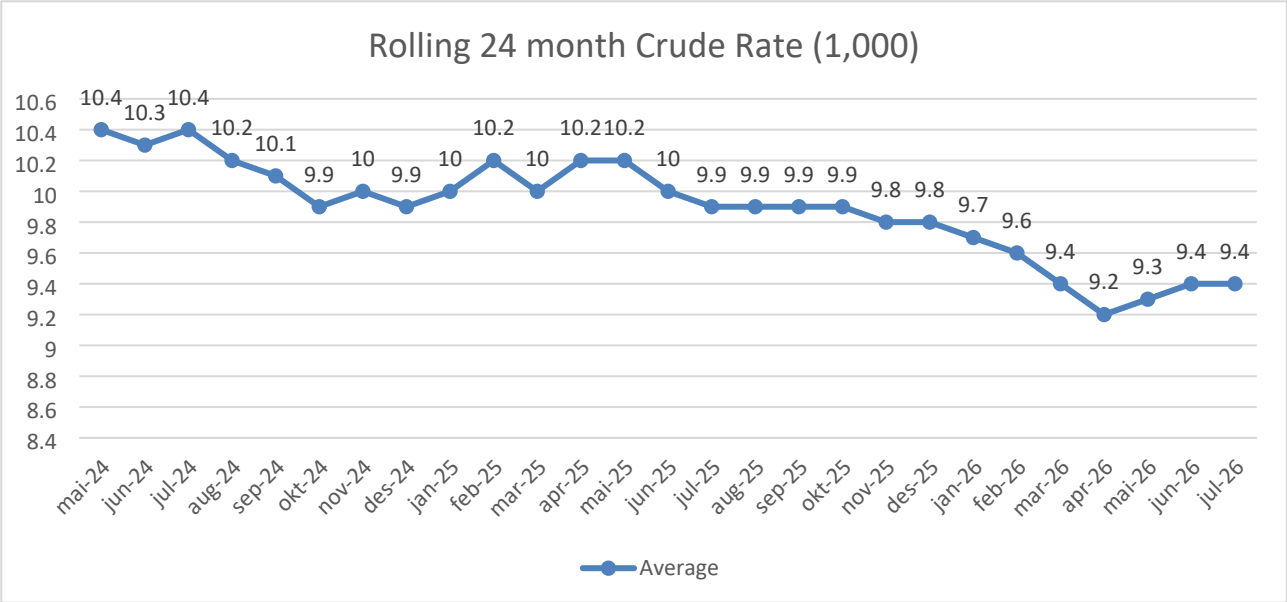
3.3 Crude Mortality

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 10.4 per 1000 admissions in Mat 2024 to 9.4 per 1000 admissions in July 2026 with a stable trend.

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3.4 Mortality Alerts

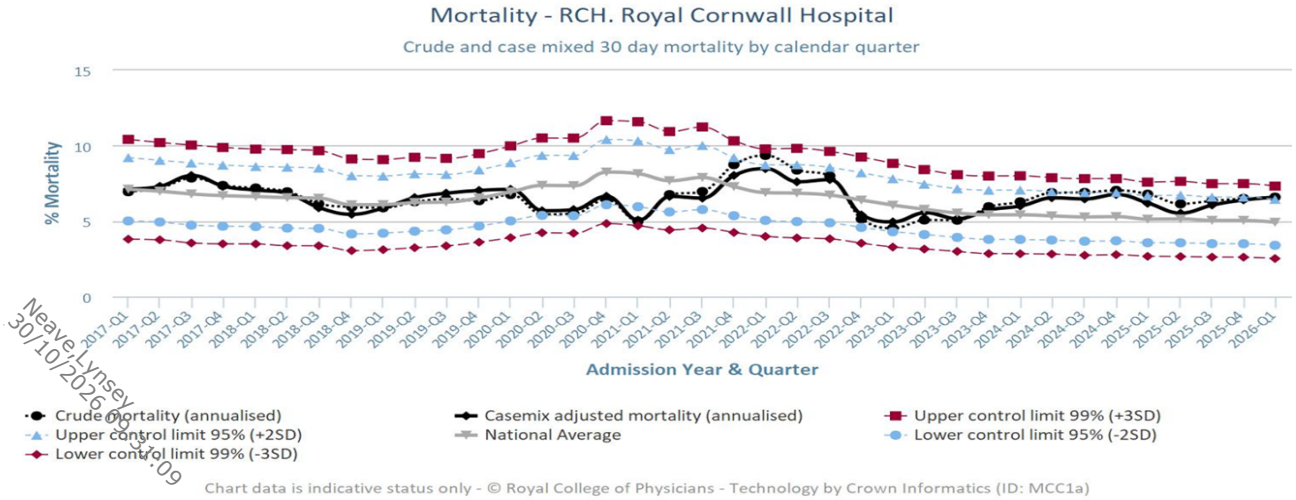
3.4.1 Fractured Neck of Femur

3.4.1.1 National Hip Fracture Database (NHFD)

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.

- The NHFD case-mix adjusted mortality rate following fractured neck of femur remains above the national average (5) at 6.4 and is above the 95% (2SD) control limit for the year up to and including the most recent quarter.

It is recognised by the NHFD that this may be as a result of statistical variation, and most units in this position return below the control limit in the following quarter, hence whilst the NHFD does not consider RCHT to be an 'outlier', the data and NHFD KPIs are being scrutinised, with a response and updated action plan to be returned to the NHFD by 25 September 2026.



Neave,Lynsey 30/10/2026 09:47:09

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 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

Between May 2025 and April 2026, 1,210 patients died as inpatients at RCHT and 734 died within 30 days of discharge.

The majority of deaths were expected or related to life-threatening illness that did not respond to treatment.

Learning is identified through review of the patient journey and translated into actions through specialty clinical governance and mortality review processes.

All deaths are also scrutinised by the Medical Examiner's Office, which can independently escalate concerns and request a Structured Judgement Review where criteria are met.

Mortality review pathways report into the monthly Mortality Review Oversight Group (MROG), which provides quarterly assurance to QAC. The MROG structure has been strengthened over the past six months and aligned to the new divisional model.

Learning from deaths linked to patient safety incidents is tracked through Patient Safety Incident Review Oversight Group (PSIROG) for PSR2 and PSII reviews, and through the weekly Executive Quality and Safety Huddle for lower-level PSR1 incidents, with actions monitored to completion.

HED mortality indicators and clinical audit data are used to identify variation, benchmark against peers and focus deeper review where mortality appears higher than expected.

Because robust investigation and action planning often extend beyond a single quarter, this report includes all mortality review processes live during Q1 and will track cases through to completion, sign-off and embedded learning.

3.5.1 Priority Deaths

Priority deaths are defined by the 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).

Stacey Cynsel
30/07/2026 09:31:09

In Q1 2026-27 there have been 2 deaths in this group

Patient 1 –

An 82-year-old lady was admitted with limb weakness and possible facial droop. She was diagnosed with a Stroke and despite active treatment she was moved to end of life care. She was reviewed by a Stroke consultant and Stroke Clinical Nurse Specialist in the emergency department.

Patient 2 –
A 58-year-old man who was admitted with right sided weakness and facial droop. The patient was reviewed by the Stroke consultant in the emergency department.

The Structured Judgement Reviews have been reviewed at MROG.

3.5.6 Learning from Patient Safety Reviews

There are no PSR 2 and PSII completed incident reports relating to the death of a patient with the Patient Safety Incident Review Oversight Group oversight of safety action plans. There are 5 ongoing and 2 new. All are on track to complete; some will require up to 4 months to embed and audit efficacy. See appendix 1 for more details of each case.

3.5.7 Learning from Complaints

Two patients who died at RCHT had family complaints raised following their deaths. These cases were reviewed by the Trust Mortality Lead, who concluded that there were no concerns regarding the clinical care provided. The issues identified within the complaints primarily related to communication with the families. As communication concerns are not routinely captured through the Structured Judgement Review (SJR) methodology, these issues were not identified during the mortality review process.

3.5.8 Severe Mental Health

There was 1 patient who died with severe mental illness. On completion, this 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.

3.5.9 Learning from Child Deaths

There were no child deaths reported in RCHT in Q1.

3.5.10 Perinatal and Neonatal Mortality

The Q1 2026 Perinatal Mortality Review considered one term stillbirth at 40+2 weeks in a woman with identified risk factors including smoking, socioeconomic deprivation, previous PPH and previous postnatal depression.

See appendix 2 for updates from Child Death Overview Panel (CDOP) action plan and Prevention of Future Death (PFD) Action plan previously presented in Q4 25-26 LFD Report.

Alexander Kinsey
30/1/2026 09:32:09

3.6 Deaths reporting concerns raised

There was 1 death in this category. This SJR was requested by the patient safety team. A PSR was also completed, and final decision was no harm.

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.

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

23 SJRs completed for Quarter 1 (April 2026 – June 2026). 22 of these were Critical Care SJRs which sit outside of the formal mandated LFD process.

Of the 53 SJRs, 11 were a priority death and 3 SJRs are outstanding. The expected completion date for these is end of September 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 Q1.

SJR Score	Total Number of SJRs	Avoidability*	Total Number of SJRs
1 – Very Poor Care		1 – Definitely Avoidable	
2 – Poor Care	2	2 – Strong evidence of avoidability	
3 – Adequate Care	5	3 – Probably avoidable (50:50)	1
4 – Good Care	24	4 – Possibly avoidable but not likely (<50:50)	1
5 – Excellent Care	22	5 – Slight evidence of avoidability	4
		6 – Definitely not avoidable	47

In this quarter 2 cases were identified using SJR where poor care was judged to have taken place, one of these cases with probable evidence of avoidability. An investigation is ongoing into the second case to determine whether this was an avoidable death.

Breakdown of activity for quarter 1 is shown here. This does not include reports provided from the legal services department to the coroner (summary reports).

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	Deaths in Q1	ME Datixes in Q1	Priority death SJRs requested	Priority death SJRs completed	Nonpriority death SJRs requested	Nonpriority death SJRs completed	New inquests Opened	Inquests Heard
Medicine Division	326	1	6	4	1	1	15	30
Surgical Division	43	0	0	0	0	0	16	15
Clinical Support and Cancer	23	0	0	0	0	0	2	3
Women and Children	1	0	0	0	0	0	0	1
Corporate	0	0	0	0	0	0	0	1
Unknown**	0	0	0	0	0	0	19	23
Total		1	6	4	1	1	48	66

*48 new inquests in Q1 broken down by Division above. Some cover multiple Divisions.
** Legal team provided a summary of their care report for these new requests

3.8 Medical Examiner

In Quarter 1 2026-2027, the Medical Examiner office reviewed 432 deaths - 80.56% of RCHT deaths. The remaining 19.44% (84 deaths) were referred to the coroner.

22 deaths were reported to the patient safety team for further review of inpatient care (5.09% 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).

A clinical guideline has been created to support hospital teams in navigating the bereavement process in a structured, compassionate, and timely manner. It ensures that patients and their families remain the central focus throughout, and that all required documentation, communication, and referrals are appropriately completed before, during, and after death.

3.9 Learning and Feedback from Inquests

In Q1 there were 66 Inquests. Out of these, 18 inquests were attended by 28 trust witnesses. 14 out of these 18 inquests were represented by our in-house Legal team and the remaining 4 were represented by our panel firm solicitors. Out of these 18 Inquests attended we previously attended Pre-Inquest Review Hearings for 5 of these cases in previous quarters. One hearing was listed for 3 days.

In Q1 the Trust also attended 9 Pre Inquest Review Hearings.

- Documentation and completion of nursing assessments
- Systemic delays (ambulance, admission into hospital) continue to feature in inquests being heard.

There were no PFDs issued in Q1.

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The learning identified from Inquest is reported in the Legal Services Quarterly Report.

3.10 Divisional Governance Mortality Review Process

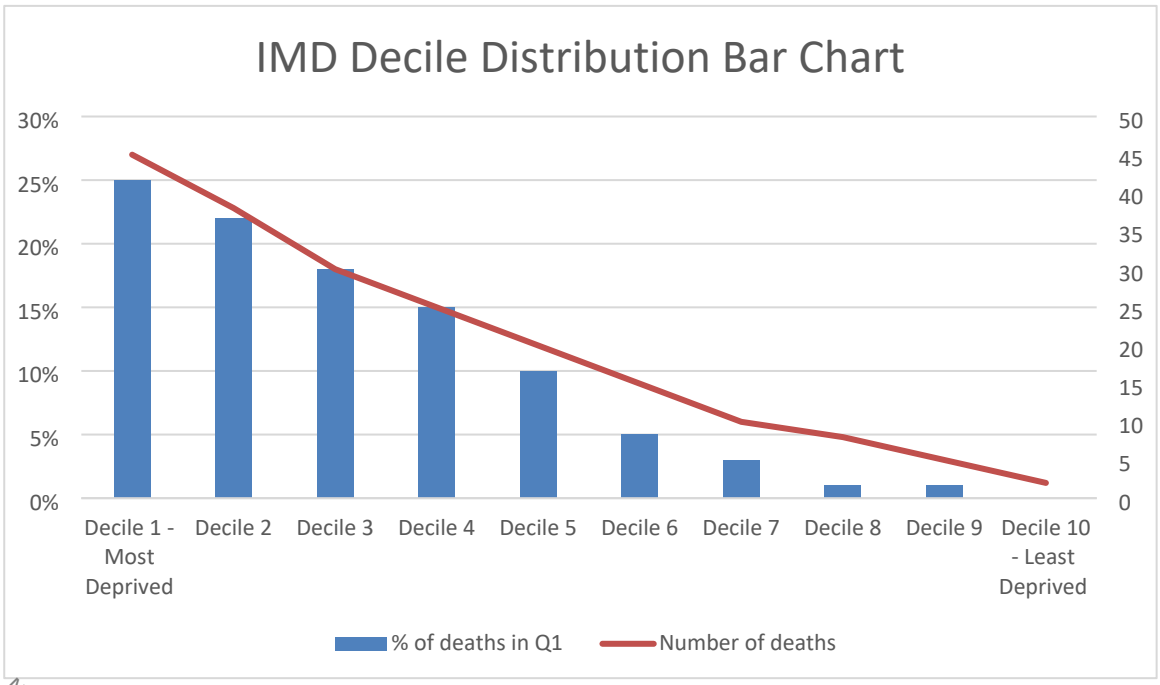
Following divisional restructure, we are strengthening the quality and impact of its mortality review processes, focusing on governance, clinician engagement and learning.

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. Each specialty mortality lead will attend MROG every 4- 6 months on a rolling program. See appendix 4 for meeting details.

3.11 Health Inequalities - About our patients that have died received

Review of deprivation data for patients who died during Q1 identified that many patients lived in areas experiencing high levels of socioeconomic deprivation. A substantial number were from neighbourhoods ranked within the lower IMD (index of Multiple Deprivation) deciles nationally, indicating greater deprivation. This highlights the impact that wider determinants of health can have on patient outcomes and serves as a reminder of the importance of considering health inequalities alongside clinical factors when reviewing deaths and identifying opportunities for improvement.



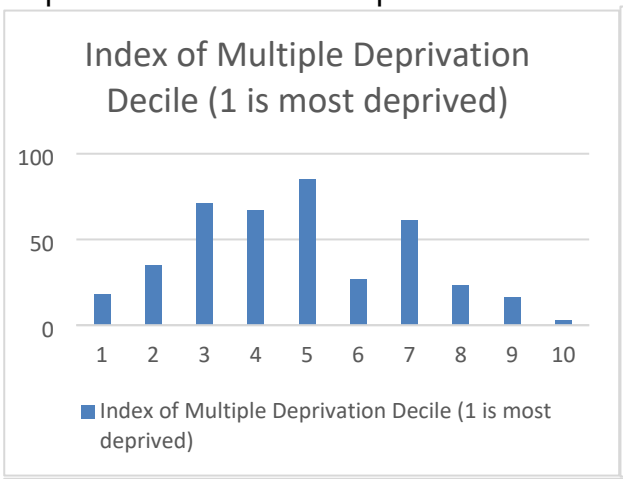
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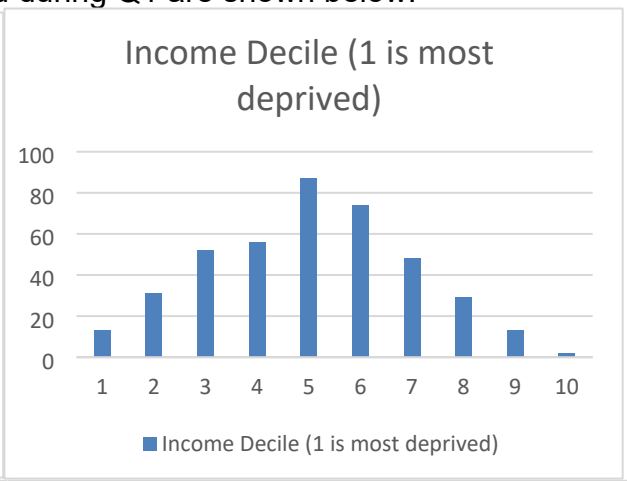
Nearly two-thirds of patients who died during Q1 were resident in areas within the three most deprived national IMD deciles, highlighting the significant impact of deprivation and wider determinants of health on the population served by the Trust.

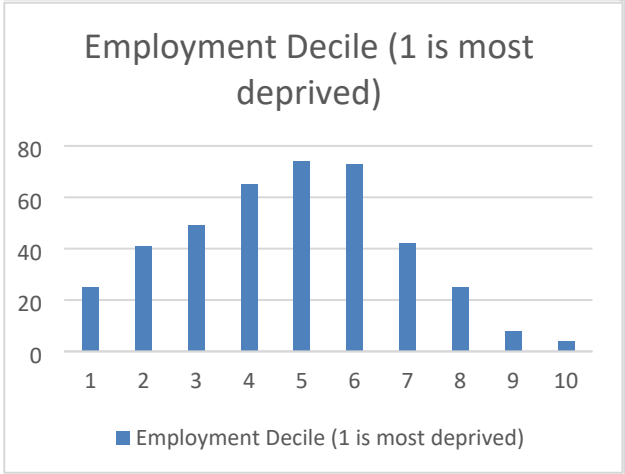
Area	Relative Concentration
Camborne/Redruth	● High
Penzance	● High
St Austell	◑ Moderate-High
Helston	◑ Moderate
Bodmin	◑ Moderate
Truro	○ Lower

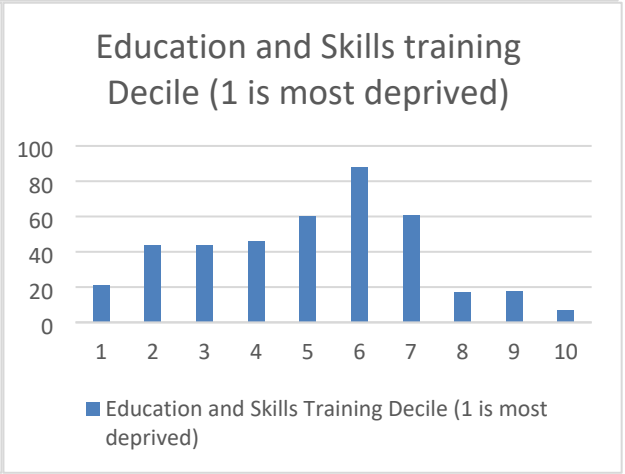
Analysis of deprivation data for patients who died in Q1 demonstrates that deaths were disproportionately concentrated amongst residents living in more deprived communities. Clusters were observed in areas of West Cornwall and former mining communities where deprivation remains higher than the Cornwall average. These findings reinforce the importance of considering wider determinants of health and health inequalities when reviewing mortality outcomes and service delivery.

Deprivation details for the patients who died during Q1 are shown below.

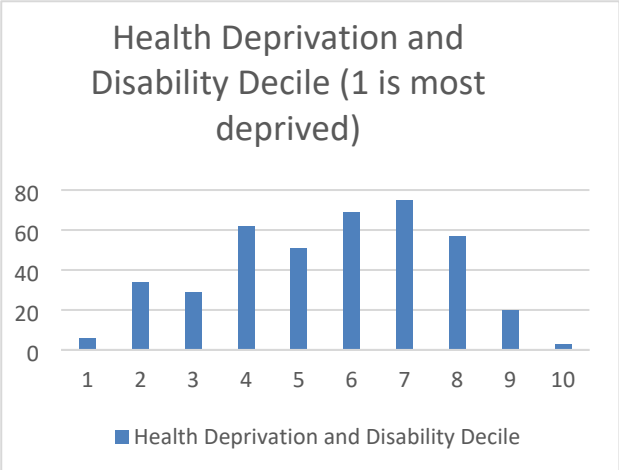


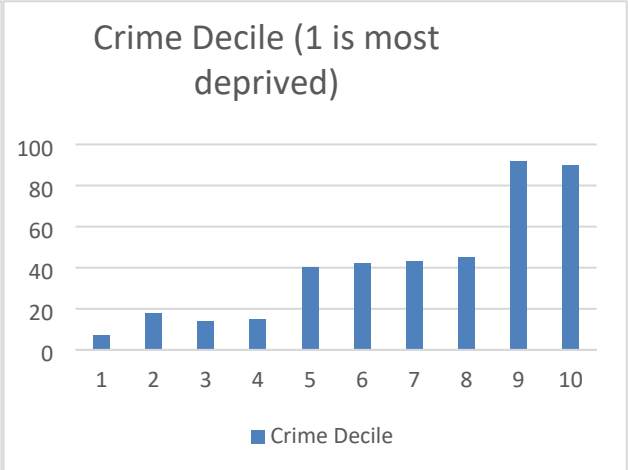


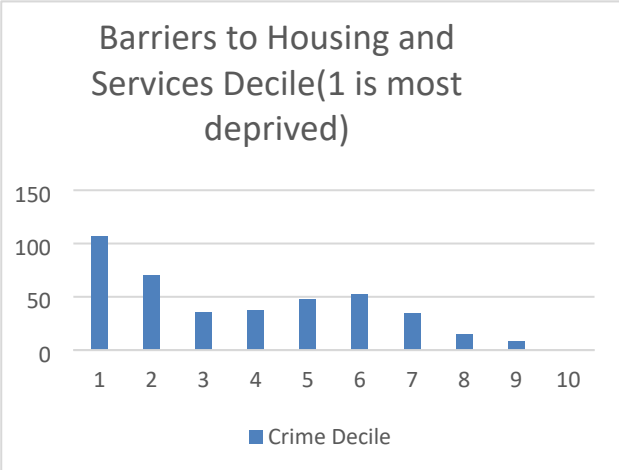


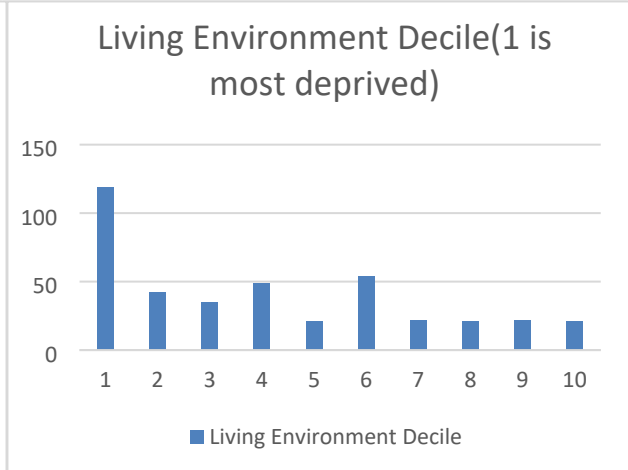


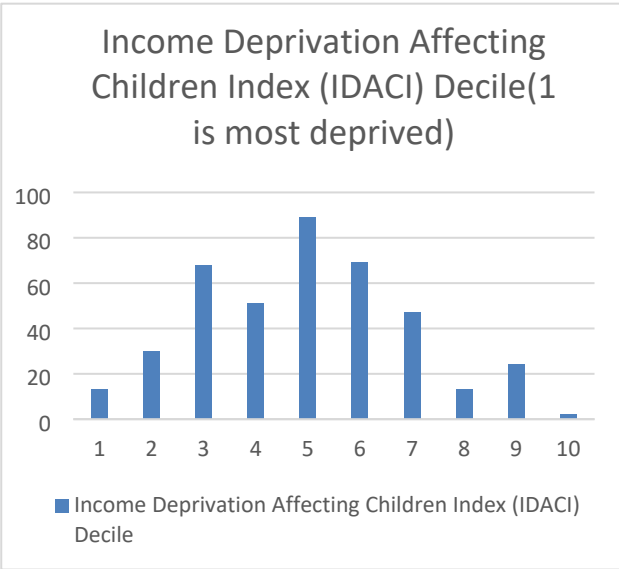
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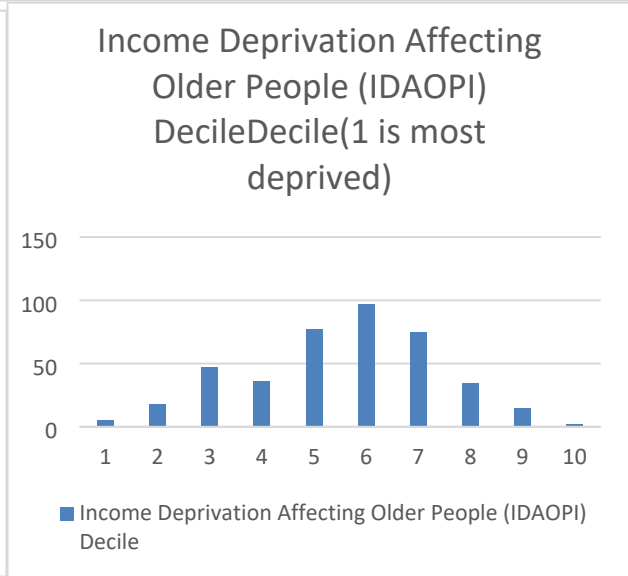




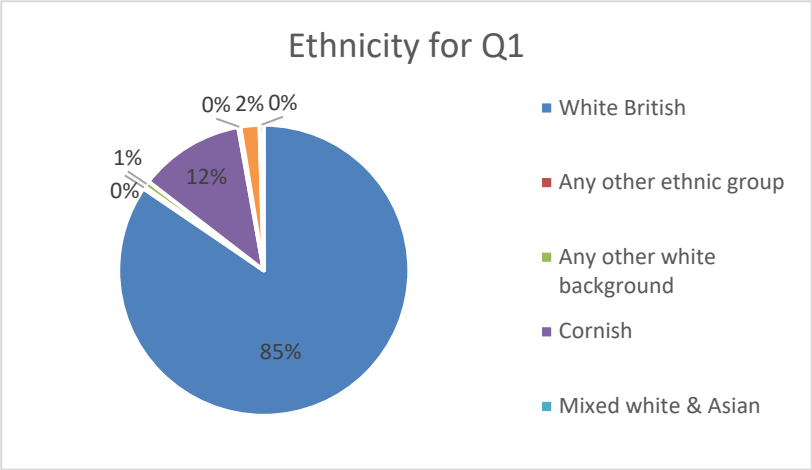








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3.12 Quality Improvement

The Quality Improvement portfolio demonstrates a wide range of projects focused on improving patient safety, documentation, communication, and clinical pathways. Initiatives include improvements to clinical records, handovers, falls prevention, treatment escalation planning, and care pathways for specific patient groups. Ongoing work also supports staff development and patient wellbeing.

3.12 National Audits and Indicators of Care

National audit reports are reviewed bi-monthly by the Clinical Effectiveness Group (CEG) and reported to QAC. Mortality-related concerns are monitored through CEG, with learning and actions confirmed through the relevant governance processes. RCHT participates in all 77 national clinical audits, with particular scrutiny of audits where alerts are raised or RCHT is identified as an outlier. Key findings include:

- National Prostate Cancer Audit: No mortality-specific KPIs.
- National Kidney Cancer Audit: Death within 30 days of Systemic Anticancer therapy (SACT) was 4.4% compared to a national average of 3%; all cases reviewed with no concerns identified.
- Epilepsy12: Sudden unexplained death in epilepsy (SUDEP) discussions documented in 78% of cases, above the national rate of 68%.
- National Audit of Non-Hodgkin's Lymphoma: One-year survival 80% (national 80%); two-year survival 72.2% (national 72.7%).
- Fracture Liaison Service Audit: No mortality-specific metrics.

4. Risk

The Board Assurance Framework (BAF) Standard 1:

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

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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:

- Discuss for assurance the Q1 Learning from Deaths assurance report.

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Appendix 1 – Learning from Patient Safety Reviews

Patient 1 - The patient had a failed discharge (with no one being at home to let them in). On re-admission the patient spent time between the discharge lounge and Roskear ward. The patient had multiple falls. It took 18 days for them to get a bed in care of the elderly ward.

Learning from SJR - The patient received generally good basic nursing care and documentation while on the respiratory ward for approximately two months; however, there was limited evidence of holistic senior medical review, consideration of longer-term outcomes, or documented Mental Capacity Act (MCA) assessment despite ongoing confusion. Earlier transfer to the Eldercare team may have enabled more timely assessment, decision-making, discharge planning and management of falls risk. Although Best Interest processes were followed, documentation from senior clinicians prior to transfer was minimal. In addition, discharge arrangements were initially clearly documented, but these later changed to a complex discharge process without a documented change in clinical status or clear rationale for the decision. The patient was subsequently transferred back to Roskear Ward, where he remained for a further month.

Patient 2 - Unwitnessed fall. Patient had been set up by night staff to have a wash. He decided that he needed to use the bathroom and so moved from the bedside. He stated that he was struggling with the curtain and then lost his balance. Patient states he fell onto his left hip and shoulder. The patient suffered a fractured neck of femur. He went to surgery to but passed away very soon post op.

Patient 3 – The patient attended Resus with an acute exacerbation of COPD and a Neck of Femur fracture. Following initial stabilisation, the patient underwent a CT scan. Approximately 10 minutes after returning from CT, a student nurse requested urgent review as the patient had become cyanosed. On assessment, the patient was blue, cyanosed, and displaying agonal breathing. An airway assessment was performed using a jaw thrust manoeuvre. It was identified that there was no oxygen flow from the non-rebreathe mask; the mask was connected to wall oxygen and oxygen therapy recommenced immediately. The Waters circuit was removed to provide airway support. A colleague subsequently took over airway management. No pulse was detected and CPR was commenced while the emergency alarm was activated. The medical team attended promptly and, following assessment, a decision was made to cease resuscitation efforts.

Lessons Learned:

- Early recognition and escalation of patient deterioration by the student nurse and Resus Practitioner enabled a rapid emergency response.
- The incident highlighted risks associated with the use of portable oxygen during patient transfers and the importance of confirming oxygen delivery on return to the clinical area.
- Departmental overcrowding and adult Resus operating at full capacity were recognised as contributory system factors.

Actions and Improvement implemented:

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- Learning has been shared with the staff involved and will be disseminated through Emergency Department (ED) governance processes.
- Oxygen safety processes have been strengthened, including:
    - Daily documented oxygen and equipment checks.

    - Verification that oxygen cylinders are full and available at each bed space.
    - Mandatory reconnection to wall oxygen following patient transfers.
    - Introduction of a "stop and check" process after transfer to confirm oxygen therapy and equipment functionality.
    - Clear accountability for monitoring patients immediately following transfer.
- Reinforcement of NEWS monitoring and escalation requirements.
- Review of ED flow and capacity pressures, with ongoing work to improve patient flow and safer decant processes from Resus.
- Development of simulation and education programmes focusing on oxygen safety, patient transfers, and recognition and escalation of deteriorating patients.

Patient 4 - PSR2 - A medically fit post-operative hip fracture patient was transferred to an escalation Planned Care Unit awaiting discharge. On 4 January, their condition deteriorated, with NEWS2 rising to 5–6 and suspected infection. Although reviewed by a locum doctor, antibiotics were not started and escalation to specialist teams was unclear or delayed. Documentation of actions and senior review was limited, and Critical Care Outreach Team were not triggered. Observations decreased overnight despite earlier deterioration, with no monitoring between 23:43 and death at 03:10 on 5 January. Key concerns include delayed treatment, poor escalation, and inadequate monitoring. This is ongoing.

Patient 5 – The patient was discharged from Wellington Ward on 30/10/2025 with a plan for an outpatient echocardiogram. The echocardiogram, completed on 14/11/2025, demonstrated a severely reduced ejection fraction (20-25%), severe aortic stenosis (AS), and a dilated aortic root. The report was reviewed and correspondence sent to the GP on 25/11/2025; however, the presence of severe AS was not highlighted and no referral to Cardiology was made. The correspondence requested GP review of medications only.

The patient subsequently had two further admissions to RCHT with shortness of breath, during which severe AS was documented, but no Cardiology referral was initiated. During the patient's most recent admission, referral was made to the inpatient Rapid Access Heart Failure Clinic (RAHFC). The ward team was advised to refer the patient to Cardiology for assessment of severe AS; however, it was subsequently confirmed that the patient was being transitioned to palliative care. This is ongoing.

Patient 6 - PSII & External MNSI (Maternity and Newborn Safety Investigations) - A first-time mother with an IVF pregnancy, initially disengaged from antenatal care, declined recommended monitoring, induction, and planned a freebirth at home beyond 42 weeks. Despite counselling on increased risks, she continued with this plan. When midwives attended in labour, they were unable to detect a fetal heartbeat and arranged urgent transfer. On arrival to hospital, intrauterine death was confirmed, and the baby was delivered stillborn shortly after. Care largely followed pathways, but gaps were identified around engagement, risk assessment for freebirth, and care planning for those declining recommended interventions. This is ongoing

Patient 7 – PSII - A patient in their late 50s with multiple long-term medical conditions was admitted to hospital on 31 August 2025 with persistent vomiting, dehydration and abdominal symptoms. The clinical presentation was complex, with several potential diagnoses considered, including acute kidney injury, infection, cardiac pathology and bowel obstruction. During admission, the patient developed worsening physiological deterioration and an enlarging umbilical hernia. An abdominal X-ray demonstrated dilated

small bowel and a CT scan was requested; however, the scan was not completed after being recorded as declined by the patient, and this was not promptly communicated to the treating clinical team. The patient subsequently suffered a cardiac arrest and died despite resuscitation attempts. Post-mortem examination identified aspiration pneumonia secondary to small bowel obstruction caused by an obstructed umbilical hernia as the cause of death.

The investigation found that clinical monitoring and medical review were undertaken throughout the admission, but identified opportunities to:

- Reassess the working diagnosis as the patient's condition evolved.
- Escalate concerns regarding possible bowel obstruction and seek surgical review.
- Strengthen senior clinical review and escalation processes for deteriorating patients.
- Improve communication and follow-up of cancelled or incomplete urgent investigations.
- Enhance communication and shared understanding with patients and families during periods of diagnostic uncertainty and deterioration.

This PSII is ongoing. Further learning and recommendations will be incorporated into the final investigation report and subsequent organisational improvement plans.

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Appendix 2 – Perinatal Mortality Review

The review highlighted several aspects of good care, including excellent continuity from the community midwifery team and high-quality, individualised bereavement care delivered in line with the National Bereavement Care Pathway.

Review findings concluded that there were no significant care issues that contributed to the outcome, with care graded A/B and no cause of death identified at the initial review pending further investigations.

The key learning identified was the importance of contemporaneous completion of the Reduced Fetal Movements (RFM) proforma whenever the RFM pathway is initiated, to ensure comprehensive documentation of assessment, clinical findings, decision-making and management plans.

As a result, a reminder will be shared with all maternity staff through the Joint Perinatal Newsletter to reinforce compliance with local RFM documentation requirements.

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Updates from CDOP Action plan

CDOP Review date	Theme	Issue/focus	Recommendations	Cornwall / IoS – Action taken / re-assurances	ICB Cornwall	Timeline	Update
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	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.	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.	The guidance remains in place and reviewed and it remains that we would not normally guide on car seats. Confirmed that there are no new training needs.
18/09/2024	support for professiona	Recognising the psychological impact of	Any professional involved with the	RCHT/CFT MIU learning. CIOS	CIOS health there is support available for	28/02/2026	Confirmed with the TriM team that there is

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CDOP Review date	Theme	Issue/focus	Recommendations	Cornwall / IoS – Action taken / re-assurances	ICB Cornwall	Timeline	Update
	Is after the death of a child	a child death on professionals. Lack of support for staff, especially those working with acute trusts after a child dies.	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.	ICB have undertaken a sepsis mapping exercise and are looking to implement any changes needed.	practitioners including counselling, OT. Line manager and specialist supervision. CIOS complete.		24 access to TriM support. At weekends, which was the query, there would not normally complete a TRiM session with a team member but if a query was made then arrangements would be made. I have a copy of the trained TRiM people but have been asked not to share but keep promoting the central contact which continues to be done via Trust comms. Happy to close

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Updates from PFD Action plan

Concern / recommendation	Action	Update
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. 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.	This has been shared and shared and remains a standard query from a W+C perspective. Case has been presented at Patient Experience Group (PEG) subsequently
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. Pocketalk Devices 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	Pocket Talk is now used across Maternity services for several months. This has been confirmed with the Board/ PSIROG

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	• 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 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 3 – Medical Examiner

Number of cases reviewed by medical examiner team in Q1 - 432
Number of incidents reported by medical examiner team – 22

Department/Ward	Number and type of incidents
Emergency Department = 3	1 – Discharge – inappropriate 1 – Care plan/assessment missing/inadequate/illegible 1 – Delayed diagnosis
Respiratory Medicine = 3	1 – Discharge – inappropriate 2 – Discharge – planning failure
Gastro = 2	2 – Delay/failure to monitor
Oncology = 1	1 – Lack of/delayed availability of beds
Discharge Lounge = 1	1 – Notes lost
Renal = 2	1 – Delay/failure to monitor 1 – Communication failure
Radiology = 1	1 – Delay/failure to monitor
Eldercare = 2	1 – Communication failure within team 1 – Inadequate handover of care
SWAST = 2	2 – Delay in admission
Discharge Lounge = 1	1 – Inappropriate discharge
Medicine = 2	1 – Notes lost 1 – Inappropriate discharge
Cardiology = 2	1 – Delay in system output 1 – Delay in acting on complication of treatment

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Appendix 4 - Specialty M&M

Specialty	Frequency	Jan 26	Feb 26	March 26	April 26	May 26	June 26
Cardiology	Monthly	Yes	Yes	Yes	Not required	Not required	Not required
Endocrine	Monthly	Yes	Yes	Yes			
Respiratory	Quarterly	Not required	Yes	Not required	Not required	Not required	
Renal	Bimonthly	No	No	No	No	No	No
Breast	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Gen. Surg.	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Haem.	Quarterly	Yes	Not required	Not required	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	Not required	Not required	Yes			
ENT	Monthly	Not required	Not required	Not required	Not required	Yes	Yes
Gastro	Quarterly	Not required	Not required	Yes	Not required	Not required	No
Oral/maxfax	Monthly	Not required	Not required	Not required	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	Not required	Yes	Not required	No	No	No
ED	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Eldercare	Monthly	Yes	No	Yes			
Gynae.	Weekly	No	Yes	Yes	Yes	Yes	Yes
Maternity	Weekly	Yes	Yes	Yes	Not required	Yes	Not required
Neonatal	Monthly	Yes	Yes	Yes	Not required	Yes	Not required
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: 05 November 2026

Item Number: 13.3

Title of Report: Voluntary Services Strategy 2026-2029

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Tamsin Zee, Strategy and Innovation Lead, Dom Whitting, Lead for Chaplaincy and Voluntary Services and Purva Shrivastava, Patient Experience Manager

Email Address: t.zee@nhs.net, dom.whitting@nhs.net, purva.shrivastava1@nhs.net

Purpose of the Report:

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

To seek approval of the Voluntary Services Strategy 2026-2029

Consultation:

The strategy has been developed through

- Review of the previous Voluntary Services Strategy.
- Engagement with volunteers through the Trust's first Volunteer Conference.
- Volunteer survey feedback.
- Consultation with staff, partner organisations and community stakeholders including Volunteer Cornwall, Friends organisations, education providers, Pets as Therapy and other VCSE partners.
- Review and feedback from a Non-Executive Director perspective.
- Volunteer Steering Group, Executive Leadership Team and Quality Assurance Committee approval.

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			An Equality Impact Assessment has been completed. The Strategy promotes equality, diversity and inclusion by supporting accessible volunteering opportunities, encouraging participation from underrepresented groups, and addressing barriers to volunteering where identified
Quality Impact Assessment completed?	x			The Strategy does not introduce changes that adversely affect clinical services, patient safety or quality of care.
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	Supports community participation, reduces social isolation, promotes volunteering opportunities for diverse populations and strengthens community resilience.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Enhances patient, family and visitor experience by providing additional support alongside clinical and operational teams.
Sustainable and efficient use of NHS resources by RCHT	Provides additional non-clinical support that complements existing services and strengthens partnerships with the voluntary and community sector.

Natalie Kelsey
30/01/2026 09:31:09

Recommendation(s):

The Board **is recommended to:**

- **Approve** the Voluntary Services Strategy 2026-2029 for implementation across the Trust.

Neave,Lynsey
30/10/2026 09:31:09

1. Situation / Executive Summary

The Voluntary Services Strategy 2026-2029 sets out a three-year framework to strengthen volunteers' contribution to patient experience, staff support and community wellbeing, aligned with the Trust Strategy 2026-2035.

Informed by volunteer and stakeholder engagement, it prioritises recruitment, retention, development and recognition; inclusive, accessible opportunities; and stronger community partnerships. Volunteers will complement, not replace, paid staff, supported by appropriate training, safeguarding and governance.

Delivery will be monitored by the Patient Experience Group and Volunteer Steering Group against agreed objectives and success measures. The strategy is presented for Trust Board approval.

The Executive Leadership Team endorsed the strategy on **16th September 2026 and the Quality Assurance Committee on 27th October 2026** for progression for approval to the Trust Board.

The strategy is attached in appendix one.

2. Background

Volunteers support patients, visitors, families and staff across RCHT. The refreshed Voluntary Services Strategy 2023-2026 aligns with the Trust Strategy 2026-2035, supporting Outstanding Care for One and All through modern, inclusive and sustainable volunteering. It positions volunteers as a strategic asset for patient experience, community engagement, wellbeing, prevention and partnerships across Cornwall and the Isles of Scilly.

3. Assessment

Informed by the previous strategy review, volunteer engagement and stakeholder consultation, the three-year framework supports volunteer recruitment, retention, development and recognition, expanding opportunities to improve patient experience, community engagement and partnerships.

The programme will:

- Strengthen volunteer engagement, development and recognition.
- Expand Trust-wide volunteering opportunities.
- Support patient experience and high-quality care.
- Strengthen community and voluntary sector partnerships.
- Promote an inclusive, accessible and diverse volunteer workforce.
- Develop volunteering as a strategic asset for healthcare delivery and community wellbeing.

The Patient Experience Group and Volunteer Steering Group will monitor strategy and implementation plan delivery against agreed objectives and success measures.

Cheryl Lisney 30/10/2026 09:21:09

The strategy was presented to the Volunteer Steering Group on **30th September 2026**. The Friends organisation Chair suggested minor terminology and acronym changes and clearer quarterly implementation milestones showing progress from current to future objectives.

The Executive Leadership Team endorsed the strategy on **16th September 2026 and the**

Quality Assurance Committee on 27th October 2026 for progression for approval to the Trust Board.

Discussion emphasised integrating volunteers within Divisions, strengthening voluntary and community sector links, and promoting Trust-wide opportunities, with promotion through EDT meetings agreed.

Feedback has been incorporated into the final strategy and action plan before submission for approval.

4. Risk

Failure to implement the Voluntary Services Strategy may limit the Trust's ability to maximise the contribution of volunteers to patient experience, staff support, community engagement, and delivery of the Trust Strategy. The strategy includes appropriate governance, training, safeguarding, and volunteer management arrangements to ensure volunteers complement, rather than replace, paid staff.

5. Accountability

The Acting Chief Nursing Officer is the Executive Lead for Voluntary Services. Operational responsibility for delivery of the strategy sits with the Lead for Chaplaincy and Voluntary Services and the Voluntary Services Team. Progress will be monitored through the Patient Experience Group and Volunteer Steering Group.

6. Recommendations

- **Approve** the Voluntary Service Strategy 2026-2029 for implementation across the Trust.

Neave,Lynsey
30/10/2026 09:31:09

Royal Cornwall Hospitals NHS
NHS Trust

Voluntary Services Strategy

2026-2029

Outstanding Volunteers for One and All



Neave,Lynsey
30/10/2026 09:31:09

Author
Version: 1
3/9/2026

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Neave,Lynsey
30/10/2026 09:31:09

1. Introduction

Volunteers have been part of the Royal Cornwall Hospitals NHS Trust for many years, making a positive difference to patients, families, visitors and staff through their commitment, compassion and generosity. As we look towards the future, volunteering has an even greater role to play in helping us deliver our vision of **Outstanding Care for One and All**.



The Trust's Strategy 2026-2035 sets out an ambitious vision for the future of healthcare across Cornwall and the Isles of Scilly. It recognises that the needs of our population are changing and that we must respond by delivering care that is safe, person-centred, digitally enabled and increasingly provided closer to home. The strategy highlights the importance of partnership working, prevention, community involvement and reducing health inequalities, whilst continuing to provide excellent acute care for those who need it most.

Volunteering is uniquely positioned to support these ambitions. Volunteers bring valuable lived experience, local knowledge, compassion and community connections that help bridge the gap between healthcare services and the communities we serve. They enhance patient experience, support wellbeing, reduce isolation, strengthen links with voluntary and community organisations, and help people access the right support at the right time.



Volunteering creates value not only for patients, staff and communities, but also for volunteers themselves. It provides opportunities to build social connections, improve wellbeing, develop new skills and maintain a sense of purpose and belonging. Through volunteering, individuals contribute to better health outcomes for others while often experiencing positive benefits to their own physical, mental and social wellbeing.

As healthcare evolves over the next decade, volunteering must evolve too. This strategy moves beyond a traditional model focused solely on supporting hospital services and instead positions volunteering as a strategic asset that contributes to improving population health, supporting neighbourhood-based care, enabling digital inclusion, developing future NHS careers and strengthening community resilience. In doing so, volunteers will continue to support outstanding patient care while helping the Trust achieve its wider ambitions for prevention, partnership and sustainable healthcare.

Neave Kinsey
30/10/2026 09:11:09

The Trust Strategy recognises the important contribution made by volunteers and commits to strengthening connections between hospital volunteers and the wider Voluntary, Community and Social Enterprise (VCSE) sector to better support patients, staff and volunteers themselves. This Voluntary Services Strategy builds on that commitment and outlines how we will grow, develop and modernise volunteering over the next three years.



This strategy has been informed by the achievements, learning and feedback gathered through the delivery of the previous Voluntary Services Strategy. While much has been accomplished, we recognise there is an opportunity to expand the impact of volunteering, attract people from a broader range of backgrounds, create new volunteering opportunities, and strengthen the contribution volunteers make across our hospitals and communities.

Our ambition is to create a modern, inclusive and forward-looking Voluntary service where people feel welcomed, valued and empowered to contribute. We will develop volunteering opportunities that reflect the changing needs of our communities, support innovation and improvement, and create meaningful pathways into careers and lifelong involvement in health and care. Whilst ensuring volunteers work alongside, but not in replacement of paid employees.

Guided by the Trust's four strategic objectives of **Safe, High-Quality Care: Supported and Valued People; Improving Together; and Partnering with Purpose**, this strategy sets out how volunteering will contribute to delivering outstanding care, improving experiences and strengthening the health and wellbeing of Cornwall and the Isles of Scilly. Together, we will create a volunteering service that not only supports our hospitals, but helps shape healthier and more connected communities for the future

Neave,Lynsey
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Royal Cornwall Hospitals NHS
NHS Trust

2. Trust Strategy

The new Trust strategy details how we can achieve Outstanding Care for One+All by building on our values, partnering the system and wider community and improving together. The volunteer service is mentioned throughout the wider Trust strategy demonstrating the importance of this service. It states “We will recognise the value and contributions of our team of dedicated hospital volunteers; connecting our volunteers into other VCSE teams for support and strengthening how we can therefore more holistically support our volunteers, patients and our staff.”. Voluntary Services will work with the trust to ensure we support their ambition for our service.



Neave,Lynsey
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The Trust strategic objectives are outlined below, and these will form the basis for the Voluntary Services strategy, supporting the service to deliver Outstanding Voluntary Services for One + All.

Safe, High-Quality Care – We will continue to work alongside our clinical colleagues to help deliver the high-quality care for our patients. We will be a valued member of the wider healthcare system working to enhance the experience of our local population.

Supported and Valued People – We will strengthen our career opportunities by developing clear progression pathways from Volunteer to NHS Career. Our volunteers will feel supported in development opportunities with equality and diversity embraced across our services.

Improving Together – We will embrace learning and improvements within the volunteer services, supporting our teams to continuously develop and improve together. We will develop plans to support environmental sustainability within the volunteer services and work alongside colleagues to encourage green improvements.

Partnering with Purpose – We will build partnerships within the system and wider voluntary services network to support each other and learn together.

3. Developing the Service Strategy

This Voluntary Services Strategy has been developed through a comprehensive programme of review, engagement and co-production involving volunteers, staff, partner organisations and community stakeholders such as; Friends RCHT, WCH and SMH, Volunteer Cornwall, CHBN, Pets as Therapy and higher/further education institutes. The aim was to ensure that the strategy reflects both the ambitions of the Trust Strategy and the experiences, insights and aspirations of those who contribute to and benefit from volunteering across Royal Cornwall Hospitals NHS Trust.

Neave,Lynsey
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As a first step, a full review of the previous Voluntary Services Strategy action plan was undertaken to assess progress against agreed priorities, identify areas of success and understand where we needed further development. This review demonstrated significant achievements over recent years, including the expansion of volunteer roles, the introduction of innovative volunteer-led initiatives, improved volunteer management processes, and stronger foundations for future growth.

The review also highlighted that the wider landscape for volunteering and healthcare has evolved significantly. Since the publication of the previous strategy, there has been increasing emphasis on prevention, neighbourhood health, digital inclusion, reducing health inequalities and partnership working across health and care systems. These themes now sit at the heart of the Trust Strategy and have informed the priorities of this refreshed Voluntary Services Strategy.

Learning from Our Previous Strategy
Listening to Our Volunteers

A significant milestone in the development of this strategy was the Trust's first ever Volunteer Conference, held in July 2026.

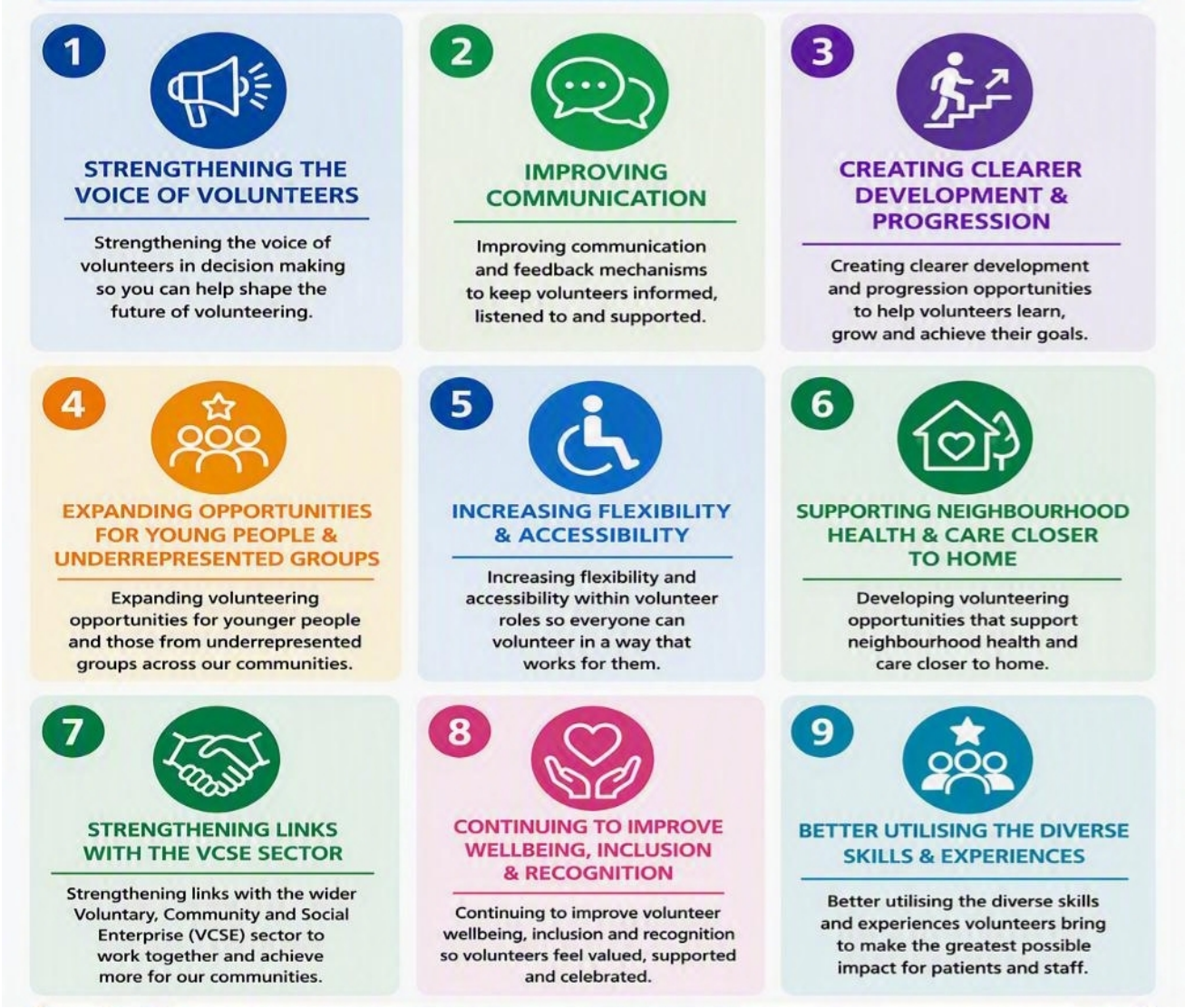
This landmark event brought together volunteers, Trust leaders, staff, patient representatives and partner organisations to celebrate the contribution of volunteers and help shape the future direction of volunteering at RCHT. The conference provided an opportunity to share the ambitions of volunteers, showcase their impact and explore how volunteering can evolve to support future models of healthcare delivery. Interactive workshops and discussions were held throughout the day, providing volunteers with the opportunity to contribute directly to the development of this strategy.

Recognising that volunteers are at the heart of the service, a volunteer survey was also undertaken to understand current experiences, identify areas for improvement and inform future priorities.

Both the survey and conference explored volunteer engagement, communication, development opportunities, training, accessibility, recognition and experience. Overall, the results demonstrated high levels of commitment, pride and satisfaction amongst volunteers, with many describing volunteering as a rewarding opportunity to support patients, staff and the wider community.

Neave,Lynsey
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Alongside these positive findings, the survey highlighted several important themes for improvement:



These themes will help form the priorities of this strategy and how the future of volunteering will look. Participants also expressed a strong ambition for volunteers to be recognised not only as supporters of hospital services, but as active partners in improving health, wellbeing and community resilience across Cornwall and the Isles of Scilly.

Co-producing Our Future

The findings from the full strategy review, volunteer survey and inaugural Volunteer Conference have been combined with the ambitions of the Trust Strategy 2026-2035 to create a refreshed and ambitious vision for volunteering. Together, these insights have informed a strategy that seeks to modernise volunteering, broaden its impact and strengthen its contribution to delivering Outstanding Care for One and All.

Neave Saxton 30/10/2025 09:31:09

This strategy reflects a shared ambition for volunteering to play a greater role in supporting patients, communities and staff; helping to reduce social isolation, improve experiences of care, strengthen partnerships, support prevention and create meaningful opportunities for people to contribute to the health and wellbeing of Cornwall and the Isles of Scilly.

4. Where Are We Now?

During our recent volunteer conference, we asked the volunteers what their favourite thing about volunteering is in one word, the results are shown below:



This summarises nicely why people take the time they do to help others.

As of August 2026, the Trust has 250 registered volunteers, supported by a Voluntary Services Manager, Volunteers Co-Ordinator and a Voluntary Services Administrator: Key achievements since the previous strategy began include:

- Development of Butterfly Companion Volunteers – specially trained volunteers supporting patients who are in the last days and hours of their lives
- Working towards Investing in Volunteers accreditation
- Refreshed uniform for all RCHT volunteers
- New programme of essential mandatory volunteer training delivered to all volunteers
- Improved administrative procedures for required volunteering checks
- Emergency Department volunteers to help with increased pressures

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- Mobile Shop trolley launched in partnership with Friends of RCH
- First Volunteer Conference planned and delivered
- First Volunteer Survey launched and responses received

Moving forward, the recognised challenges facing the service include:

- Improving visibility of the service with limited dedicated space
- Meeting the support needs of volunteers
- Recruitment of new volunteers linking to NHS Careers
- Ensuring inactive volunteers feel part of the cohort and encouraged to return to volunteering if possible
- A small staff team to look after 250 volunteers
- Some volunteers heavily involved (e.g. volunteering multiple times a week) in order to ensure running of services
- Ensuring Trust staff understand and recognise the role of volunteers and the team which supports them
- Ensuring the volunteer cohort is diverse in all areas – including acknowledgment of the rising retirement age
- With financial pressures, volunteers do not replace paid staff
- Ensuring volunteers are trained in EDI matters given the changing demographics and diversity in Cornwall

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A survey conducted in development of this strategy was completed by 69 volunteers and returned the following headlines:



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5. Our Future Service

Outstanding Volunteers for One + All

Supporting the delivery of the RCHT Strategy through the power of Volunteering



Supported & Valued People

- We will create a welcoming, inclusive and rewarding volunteering experience where people feel valued, supported and able to develop their skills, confidence and future career aspirations.

Neasa Lynsey
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Safe, High Quality Care

- We will work alongside clinical and operational teams to improve patient, family and visitor experiences, providing compassionate support that contributes to safe, high-quality care and wellbeing for all.

Improving Together

- We will embrace innovation, learning and continuous improvement, using the insight of volunteers, patients and staff to shape services and support climate resilience and health creation.

Partnering with Purpose

- We will build meaningful, partnerships across health, care, voluntary and community sectors, helping to reduce inequalities, strengthen community resilience and improve wellbeing across Cornwall and the Isles of Scilly.

6. Delivering the RCHT Voluntary Services Strategy

Supported and Valued People				
Priority Area	**Action**	**Lead**	**Timescale**	**Success Measure**
Communication	Quarterly volunteer newsletter, management updates and clearer communication on service developments. Share Volunteer newsletter with wider trust.	Voluntary Services Team	Q3 2026	Improvement in communication score and reduced complaints/comments
Volunteer Voice & Engagement	Establish quarterly Volunteer Voice Forums and annual volunteer listening events. Introduce "You Said, We Did" communications.	Voluntary Services Manager	Q4 2026	10% improvement in consultation score in next survey
Reward and Recognition	Establish annual awards ceremony to celebrate volunteers	Lead for Chaplaincy and Voluntary Services	Q1 2027	Awards ceremony established
Development & Progression	Introduce volunteer development pathway, role shadowing opportunities such as HCA and volunteering skills workshops. Access to training opportunities through the trust.	Voluntary Services Manager	Q4 2027	Volunteers participating in development opportunities
Better Use of Volunteer Skills	Undertake volunteer skills audit and develop specialist volunteering opportunities matching volunteer expertise.	Voluntary Services Manager	Q4 2027	Skills database completed and utilised during recruitment
Inclusion & Accessibility	Review volunteer role descriptions for accessibility. Develop additional low-mobility and remote volunteering opportunities.	Voluntary Services Team	Q4 2027	Increase in volunteers with accessible role options
EDI	Increase volunteer visibility from under-represented groups.	Voluntary Services Manager	Q4 2028	Increase in volunteers from under-represented groups

Neave, Lynsey
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Safe, High Quality Care				
Priority Area	**Action**	**Lead**	**Timescale**	**Success Measure**
Local Department Support	Introduce volunteer guidance for leaders in volunteer areas. Include volunteer support within ward/service manager expectations.	Voluntary Services Manager	Q4 2026	Reduction in negative perception of volunteers.
Establish bases for volunteers at SMH and WCH	Meet with Directorate Manager to discuss the need/benefits. Work with the Space Utilisation Group to identify and apply for appropriate space.	Lead for Chaplaincy and Voluntary Services	Q1 2027	Dedicated space assigned to voluntary services at SMH and WCH
Introduce Digital Technology Volunteers	Introduction of specific volunteers to assist patients who may be struggling with technology and contacting friends and relatives	Voluntary Services Manager	Q1 2027	Patients supported on wards with digital technology
Expand volunteering opportunities at SMH, WCH and SASH	Work alongside Directorate Managers to review volunteering needs and opportunities at St Michael's Hospital (SMH) West Cornwall Hospital (WCH) and St Austell Surgical Hub (SASH). Advertise new opportunities, targeting required audiences.	Voluntary Services Manager	Q1 2028	New volunteers recruited and in place across all three satellite sites.

Newquay Meeting 30/10/2025 09:31:09

Improving Together				
Priority Area	**Action**	**Lead**	**Timescale**	**Success Measure**
Green spaces Volunteering	Increase opportunities for gardening and green spaces volunteering. This is being supported by a "Green Ranger" who is being funded through Volunteer Cornwall.	Voluntary Services Team	Q1 2027	Introduction of gardening volunteers and increase in opportunities relating to green spaces.
Volunteer & Community Impact Centre	Continue to engage with Women and Children's hospital build to identify if any space can be utilised for a Volunteer Hub.	Lead for Chaplaincy & Voluntary Service	Q4 2028	Volunteer & Community Impact Centre location agreed and opened.
Sustainability	Sustainability Lead to engage with volunteers on sustainable ideas and, where possible, support to embed these ideas such as improved recycling, coffee grounds to share, potential for bird houses.	Voluntary Services Team Sustainability Lead	Ongoing	Clear engagement following annual conference and interest in sustainable approaches.

Neave,Lynsey
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Partnering with Purpose				
Priority Area	**Action**	**Lead**	**Timescale**	**Success Measure**
Nurture our partner network	Engage in networking opportunities to promote the work of the RCHT Voluntary Services and build relationships with new partners Maintain regular contact with existing partners, keeping them informed of activities and opportunities, and ensuring their value as a partner organisation is appreciated. Invite to annual conference as appropriate	Voluntary Services Manager	Ongoing	Increased number of partner organisations reportable at each annual conference
Develop relationship with Volunteer Cornwall	Closer working relationship with Volunteer Cornwall utilising the Non-Executive Director relationship and sharing knowledge, opportunities and skills	Voluntary Services Manager	Ongoing	Key relationships to be established
Attract more volunteers	Work with colleges and higher education institutes to attract more volunteers. Connect with local groups, especially underrepresented to encourage volunteering.	Voluntary Services Team	Ongoing	Maintain volunteer numbers and expand underrepresented groups
Volunteer Community & Recognition	Deliver annual conference, virtual engagement opportunities and Volunteer Week activities across all sites.	Voluntary Services Team	Ongoing	Increased attendance and positive event feedback

Neave Viney
30/10/2026 06:31:09

Appendix 1. Governance Information

Document Title	RCHT Voluntary Services Strategy		
This document replaces (exact title of previous version):	RCHT Voluntary Services Strategy 2023-2026		
Date Issued/Approved:	*Date signed off by Directorate Committee*		
Date Valid From:	2026		
Date Valid To:	2029		
Directorate / Department responsible (author/owner):	Voluntary Services , Chaplaincy, Corporate Nursing		
Contact details:	Voluntary Services Manager 01872 253737		
Brief summary of contents	RCHT Voluntary Services Strategy 2026-2029 including service vision, strategic objectives, service priorities and implementation plan		
Suggested Keywords:	Voluntary Services, Volunteers, Volunteering, Strategy		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Chief Nursing Officer		
Approval route for consultation and ratification:	Patient Experience Group Executive Leadership Team Quality Assurance Committee		

Neave,Kynsey
30/10/2026 09:31:09

General Manager confirming approval processes	Head of Safety, Risk and Patient Experience			
Name of Governance Lead confirming approval by specialty and care group management meetings	TBC			
Links to key external standards	None required			
Related Documents:	None required			
Training Need Identified?	No			
Publication Location (refer to Policy on Policies –Approvals and Ratification):	Internet & Intranet		Intranet Only	✓
Document Library Folder/Sub Folder	*e.g. Clinical / Infection Prevention & Control*			

Neave,Lynsey
30/10/2026 09:31:09

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
September 2026	*V1.0*	*Initial issue*	*Taz Zee, Strategy Programme Manager*

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager

Neave,Lynsey
30/10/2026 09:31:09

Appendix 2. Equality Impact Assessment Form

Section 1: Equality Impact Assessment Form					
Voluntary Services Strategy 2026-2029					
Directorate and service area: Voluntary Services			**Is this a new or existing Policy?** Refresh of previous strategy		
Name of individual/group completing EIA Taz Zee, Strategy Programme Manager			**Contact details:** t.zee@nhs.net		
1. Policy Aim Who is the strategy / policy / proposal / service function aimed at?	Volunteers, RCHT employees and other external stakeholders of RCHT voluntary services including existing and future partner organisations				
2. Policy Objectives	Provide a structured plan for the evolution of RCHT voluntary services over the next 3 years				
3. Policy Intended Outcomes	Continuation and expansion of the existing excellent elements of the voluntary services, harnessing of opportunities for improvements in other areas in line with our overarching Trust strategy				
4. How will you measure the outcome?	Implementation plan progress reportable to Patient Experience Group quarterly				
5. Who is intended to benefit from the policy?	Patients, staff, volunteers and general public				
6a). Who did you consult with?	Workforce	Patients	Local groups	External organisations	Other
	Yes			Yes	Yes (volunteers)
b). Please list any groups who have been consulted about this procedure.	**Please record specific names of groups:** Pets 4 Therapy				
c). What was the outcome of the consultation?	Endorsement of our strategic objectives and input into the detailed priorities which should underpin them over the next 3 years, which were duly incorporated into this plan.				

Neave,Lynsey 30/10/2026 09:31:09

7. The Impact
Please complete the following table. If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have a positive/negative impact on:

Protected Characteristic	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age	✓			Positive impact – the intention to support more people to return to volunteering is likely to benefit the older population who have faced barriers to returning post-pandemic. Similarly, the intention to recruit more young volunteers as part of their career pathways will have a positive impact
Sex (male, female non-binary, asexual etc.)		✓		No intended impact
Gender reassignment		✓		No intended impact
Race/ethnic communities /groups		✓		No intended impact
Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)	✓			Positive impact - The intention to support more people to return to volunteering could lead to more people who currently face barriers relating to disability to be supported in returning
Religion/ other beliefs		✓		No intended impact
Marriage and civil partnership		✓		No intended impact
Pregnancy and maternity		✓		No intended impact
Sexual orientation (bisexual, gay, heterosexual, lesbian)		✓		No intended impact

If all characteristics are ticked 'no', and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.
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:	

If you have ticked 'yes' to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net

Alaina Lynsey 30/09/2025 09:31:10

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 04 November 2026

Item Number: 13.4

Title of Report: Thirlwall Inquiry – Report and Recommendations

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Bernadette George, Acting Chief Nursing Officer, Iain Davidson, Chief Pharmacist, Zoe Cooper, Head of Safeguarding Services, Lisa Sandy, Project Team Manager

Email Address: bernadettegeorge@nhs.net zoe.cooper2@nhs.net iain.davidson7@nhs.net l.sandy@nhs.net

Purpose of the Report:

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

This paper provides the Board with:

1. The final report published by the Thirlwall Inquiry on 15 September 2026.
2. The Trust-level gap analysis and action plan produced in response to the report recommendations.
3. A summary of the Safe Storage of Insulin review and required actions.
4. The outcome of the gap analysis against existing safeguarding arrangements across Royal Cornwall Hospitals NHS Trust (RCHT) and Cornwall Partnership NHS Foundation Trust (CFT).

Consultation:

The Thirlwall Inquiry report, recommendations and initial Trust actions were discussed at the 25 September Maternity, Obstetric and Neonatal Safety Champions Board Meeting.

The gap analysis and action plan was co-produced by members of the Thirlwall Inquiry Task and Finish Group, including representation from the Neonatal team, the Women and

Treave.Lynsey 30/10/2026 09:31:0

Children senior leadership team, Chief Pharmacist, Head of Safeguarding, Medical Examiners Office, and the Associate Director of People Services.

The Safe Storage of Insulin report was completed by the Chief Pharmacist, in consultation with the Neonatal, Security and Pharmacy teams, with guidance from the Regional Neonatal Network.

The Safeguarding Gap Analysis was completed by the Safeguarding team based on a review of the Inquiry findings, existing Trust safeguarding arrangements, governance structures, policies and assurance processes.

The report has been discussed at the Executive Leadership Team meeting 28th October and Quality Assurance Committee 27th October.

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		No adverse equality impacts identified. The paper supports safeguarding arrangements that apply equitably across all protected groups.
Quality Impact Assessment completed?		x		No adverse impacts identified. The arrangements described strengthen quality, safety, and governance oversight of safeguarding.
Data Protection Impact Assessment completed?		x		No adverse impacts identified. The paper does not introduce new data processing or changes to existing information governance arrangements.

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').

Alayne Kynsey 30/10/2025 09:31:39

Considerations	Summary of considerations (if one or more does not apply state 'not

	applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Implementation of recommendations in the Thirlwall report based on the learning from neonatal deaths at the Countess of Chester hospital.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Implementation of recommendations in the Thirlwall report based on the learning from neonatal deaths at the Countess of Chester hospital.
Sustainable and efficient use of NHS resources by RCHT	Not applicable.

Recommendation(s):

The Board **is recommended to:**

- **Discuss and reflect** on the Thirlwall Inquiry report findings and recommendations.
- **Approve** the Trust gap analysis and action plan, noting the immediate or urgent actions taken in relation to:
    - Safe Storage of Insulin – essential actions include the installation of CCTV into the drug treatment room on the Neonatal Unit and Delivery Suite by 30 November 2026.
    - Sudden Unexpected Death in Infancy and Childhood (SUDIC) process communications to Board members and neonatal staff.
- **Take assurance** that safeguarding arrangements across RCHT and CFT are robust and substantially aligned with the safeguarding themes arising from the Thirlwall Inquiry.
- **Endorse the** delivery of the identified safeguarding improvement actions and receive progress updates through existing safeguarding assurance reporting arrangements.

Neave,Lynsey
30/10/2026 09:31:09

Thirlwall Inquiry - Report of the Public Inquiry into Events at the Countess of Chester Hospital, 2015 to 2018

1. Executive Summary

The final **Thirlwall Inquiry** report, published in September 2026, made 17 recommendations to strengthen safeguarding, patient safety, governance and escalation processes within neonatal services. NHS England has subsequently requested assurance from all neonatal services on five immediate actions arising from the report. Assurance will be coordinated through the regional Neonatal Critical Care Operational Delivery Network (ODN), with Trust returns submitted to NHS England by December 2026.

The Trust has completed a multidisciplinary review of the Inquiry recommendations and developed a comprehensive gap analysis and action plan. This review confirms that the Trust is **fully compliant with the majority of recommendations**, including:

- Board oversight of neonatal and child deaths.
- Mortality surveillance, reporting and governance arrangements.
- Escalation processes for concerning trends and patterns.
- MBRRACE and Child Death Review processes.
- Data reporting requirements and designated clinical leadership arrangements.
- Communication and implementation of the SUDIC process.
- Clinical guidance and laboratory processes relating to insulin testing and escalation.

The review identified a limited number of areas where the Trust is **not yet fully compliant**:

- CCTV coverage of neonatal medicines storage areas, required by **30 November 2026**.
- Biometric-controlled access to insulin storage to meet enhanced GIRFT requirements by **31 March 2027**.
- Safeguarding training compliance across all staff groups.

The Trust is **largely compliant** with insulin management requirements and **substantially compliant** with the safeguarding themes arising from the Inquiry. A safeguarding assurance review found robust governance, leadership, escalation, multi-agency working and organisational learning arrangements, with no significant safeguarding gaps requiring immediate action.

An action plan is in place to address the remaining compliance gaps within the required timescales. Executive oversight will be provided by the Acting Chief Nursing Officer and Chief Medical Officer, with progress monitored through a dedicated Task and Finish Group and existing governance arrangements.

2. Background

The final report of the Thirlwall Inquiry, published in September 2026, examined the circumstances surrounding the deaths and collapses of babies at the Countess of Chester Hospital and made a series of recommendations to strengthen patient safety, safeguarding, governance and escalation processes within neonatal services.

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Following publication of the report, **NHS England Specialised Commissioning** requested

assurance from neonatal services on five immediate actions relating to Board oversight, implementation of the SUDIC process, progress with the National Bereavement Care Pathway, compliance with insulin storage and access control requirements, and safeguarding training and escalation arrangements. Assurance returns will be coordinated through the regional Neonatal Critical Care Operational Delivery Network (ODN) and submitted to NHS England in December 2026.

The Government is currently reviewing the inquiry's recommendations, alongside wider maternity and neonatal improvement work, with a national response expected in December 2026. No immediate actions are required at this stage pending further national guidance.

3. Inquiry Report Summary and Recommendations

The Thirlwall Inquiry identified significant shortcomings in leadership, governance, safeguarding and escalation processes within neonatal services. The final report contains 17 recommendations directed at national bodies and NHS trusts to strengthen patient safety and organisational oversight.

Following publication of the report, NHS England wrote to all NHS trusts and Integrated Care Boards, requiring Boards to consider the Inquiry findings at a public Board meeting and, where relevant, ensure awareness and application of the Sudden Unexpected Death in Childhood (SUDIC) protocol within neonatal services.

4. Trust Gap Analysis and Action Plan

Following publication of the Thirlwall Inquiry report, the Trust undertook a multidisciplinary review of all recommendations and developed a gap analysis and action plan.

The review confirms that the Trust is **fully compliant** with a number of the recommendations, including:

- Board-level oversight and monitoring of neonatal and child deaths.
- Established escalation routes for concerning trends or patterns.
- MBRRACE, Child Death Review and mortality governance processes.
- Designated clinical leadership and reporting arrangements for mortality surveillance.
- Data reporting requirements, including identified lead reporters and routine review of national datasets.
- Communication and implementation of the SUDIC protocol, with awareness confirmed for Board members and relevant neonatal staff.
- Updated clinical guidance and laboratory processes relating to insulin and C-peptide testing and escalation of abnormal results.
- Board level safeguarding training

The review identified a small number of areas where the Trust is **partially compliant and further action is required**, specifically:

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- Installation of CCTV within neonatal medicines storage areas to meet the November 2026 requirement.

- Implementation of enhanced insulin security arrangements, including biometric-controlled access, to achieve full compliance with GIRFT standards by March 2027.
- Improvement of safeguarding training compliance across all staff groups and Board members, particularly at higher competency levels.

These areas align with the five immediate assurance requirements identified by **NHS England Specialised Commissioning**. Assurance will be coordinated through the regional Neonatal Operational Delivery Network (ODN), with Trust returns submitted to NHS England by December 2026. The Trust's action plan has been developed to address the outstanding areas of non-compliance and support achievement of full compliance within the required timescales.

5. Safe Storage of Insulin - Immediate Actions Required

The Trust is **largely compliant** with the Thirlwall and GIRFT requirements for insulin management within neonatal services. Existing controls are in place and only a small number of actions remain to achieve full compliance with the minimum standards.

The Trust is **not yet compliant** with the requirement to install CCTV covering neonatal insulin storage areas. CCTV installation is required within both the Neonatal Unit and Delivery Suite medicines storage areas by **30 November 2026** and is being progressed through the Trust's business case process.

The Trust is also **not yet compliant** with the enhanced GIRFT standard requiring biometric-controlled access to insulin storage. To achieve full compliance by **31 March 2027**, implementation of an Omnicell Automated Dispensing System (or equivalent) is required and is currently under review.

Beyond these identified gaps, the Trust has appropriate arrangements in place for the storage, management and monitoring of insulin within neonatal services. A wider review of insulin storage arrangements across Women's and Children's services will be undertaken following completion of the priority neonatal actions.

Overall, the Trust is compliant with the majority of the requirements, with clear plans and timelines in place to address the remaining compliance gaps.

6. Safeguarding Gap Analysis and Assurance Review

The safeguarding review concluded that the Trust is **substantially compliant** with the safeguarding themes and recommendations arising from the Thirlwall Inquiry. Strong assurance was identified across safeguarding governance, executive oversight, escalation processes, management of allegations against staff, multi-agency working, information sharing, organisational learning, and specialist safeguarding leadership. No significant gaps requiring immediate action were identified.

The Trust is **not fully compliant** with safeguarding training requirements across all staff groups, particularly at higher competency levels, and further work is required to improve training compliance rates. Opportunities have also been identified to strengthen professional curiosity, challenge and safeguarding supervision.

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A targeted improvement plan is in place to address these areas and to support implementation of forthcoming NHS England guidance which will be monitored throughout

safeguarding reporting governance arrangements. Overall, the review provides assurance that safeguarding arrangements are robust, with identified improvements focused on strengthening existing arrangements rather than addressing fundamental gaps in compliance.

7. Risk

The Trust is **largely compliant** with the Thirlwall recommendations, with robust safeguarding arrangements and clear plans in place to address the remaining gaps.

Areas not yet fully compliant relate primarily to insulin storage and access controls. While the Neonatal Unit largely meets current requirements, some clinical areas used by neonatal staff, particularly Delivery Suite, do not yet meet GIRFT minimum storage standards and require further review and improvement. Delivery of CCTV and enhanced access controls will address these gaps.

Key implementation risks include balancing enhanced medicines security with timely access to emergency medicines, and estate constraints that may affect the introduction of biometric-controlled storage solutions.

The Trust is **substantially compliant** with safeguarding requirements; however, safeguarding training compliance, particularly at higher competency levels, requires improvement. A targeted improvement plan is in place, supported by enhanced supervision and Board oversight.

The Trust also recognises the importance of maintaining a culture that promotes professional curiosity, speaking up and constructive challenge. Ongoing work through training, supervision and the Culture Programme will support continued improvement in these areas.

8. Accountability

Executive oversight of the Trust's response to the Thirlwall Inquiry will be provided jointly by the Acting Chief Nursing Officer and Chief Medical Officer.

A dedicated Task and Finish Group has been established to oversee delivery of the immediate actions arising from the Inquiry recommendations and associated action plan. Ongoing monitoring and assurance will subsequently be embedded within existing governance arrangements.

Responsibility for medicines management compliance sits with the Chief Medical Officer and Chief Pharmacist, with progress against the Thirlwall, GIRFT and NHS England recommendations reported through the relevant clinical governance committees and escalated to the Quality Assurance Committee as required.

The Acting Chief Nursing Officer will oversee delivery of the safeguarding improvement actions, with ongoing assurance provided to the Board through established safeguarding governance and reporting processes.

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9. Recommendations

The Board is recommended to:

- **Discuss and reflect** on the Thirlwall Inquiry report findings and recommendations.

- **Approve** the Trust gap analysis and action plan, noting the immediate or urgent actions taken in relation to:

    - Safe Storage of Insulin – essential actions include the installation of CCTV into the drug treatment room on the Neonatal Unit and Delivery Suite by 30 November 2026.

    - Sudden Unexpected Death in Infancy and Childhood (SUDIC) process communications to Board members and neonatal staff.

- **Take assurance** that safeguarding arrangements across RCHT and CFT are robust and substantially aligned with the safeguarding themes arising from the Thirlwall Inquiry.

- **Endorse the** delivery of the identified safeguarding improvement actions and receive progress updates through existing safeguarding assurance reporting arrangements.

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NHS England South West
South West House
Blackbrook Park Avenue
TAUNTON
TA1 2PX

To: South West Chief Nursing Officers
South West Chief Medical Officers

20 October 2026

Dear Colleague,

Assurance of Actions Following the Thirlwall Inquiry Report

Following the recent national communication regarding the findings of the Thirlwall Inquiry, NHS England Specialised Commissioning will be seeking assurance on progress against the five immediate actions identified for implementation within neonatal services.

These actions are:

1. Review of the Thirlwall report and consideration of its findings by Trust and ICB boards.
2. Communication and implementation of the Sudden and Unexpected Death in Infancy and Childhood (SUDIC) process within neonatal services.
3. Progress towards implementation of the National Bereavement Care Pathway for stillbirth and neonatal death.
4. Compliance with requirements relating to the safe storage, access control and surveillance of insulin within neonatal units.
5. Assurance of safeguarding training compliance and escalation processes for concerns relating to babies and children.

To support a consistent approach to assurance, this process will be coordinated through the regional **Neonatal Critical Care Operational Delivery Network (ODN)**. The ODN will shortly issue a self-assessment spreadsheet to all neonatal units, requesting information relating to each of the five actions.

We would be grateful if neonatal teams could complete and return the self-assessment to their ODN by **2 December 2026**. ODNs will review and collate responses before submitting to NHS England Specialised Commissioning.

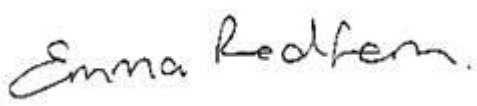
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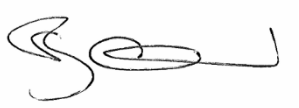
The purpose of this exercise is to provide assurance that the actions outlined in the national communication are being progressed at pace and to identify any areas where additional support may be required. We recognise the significant work already underway across neonatal services to strengthen safety, governance, safeguarding and bereavement care, and we appreciate your engagement with this process.

Given the importance of the findings of the Thirlwall Inquiry, we would be grateful for your support in ensuring that the self-assessment is completed comprehensively and within the required timescales.

Please do reach out if you have any questions.

With thanks and regards,





Emma Redfern
Medical Director
Specialised Commissioning

Sarah Zanoni
Deputy Director of Nursing & Quality
Specialised Commissioning

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Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 14

Title of Report: Finance and Performance Committee Assurance Report to the Board – September and October 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

- Approval of the Theatre Recovery and Theatre Roof Replacement Business Case (£1.23m) and appointment of the preferred contractor.
- Consideration of a formal Board/NED sustainability lead role.
- Consideration of the revised Provider Capability Self-Assessment prior to submission.
- Continued endorsement and oversight of the Financial Recovery Plan and associated quality guardrail arrangements.
- Recommended Board approval of PDC funding.

Issues for escalation or notification to the Trust Board

- **Financial Recovery**
  - Significant financial challenge remains to deliver 2026/27 and medium term revenue budgets, with delivery of the Financial Recovery Plan and associated quality guardrails requiring continued Board oversight.

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    - Limited assurance on financial recovery, including the forecast risk and forecast FSP shortfall; the continued need for close oversight of the ambitious RTT recovery programme;
- **Trust segmentation** has reduced to Segment 3, with financial recovery, UEC performance and staff survey improvement identified as the key recovery priorities.
- **Women's and Children's Programme**
    - Remains on track for the March 2027 OBC, with continued scrutiny required regarding revenue affordability and Hospital 2.0 design decisions.
    - Movement of the Women's and Children's Hospital capital funding risk from Amber to Red due to potential risks associated with enabling schemes.
    - Governance implications associated with final approval of the business case.
- **Capital Programme**
    - Capital programme for 2026/27 and 27/28 and beyond remains highly challenged. FPC receive monthly updates on commitments and prioritisation process – assurance requested on the remaining fire programme
    - Capital programme delivery remains high risk and dependent on significant mitigations, with additional pressure from emerging nationally mandated infrastructure requirements.
- Committee questioned whether the Provider **Capability Self-Assessment** is overly optimistic and requested further refinement before submission.
- **eCare programme** status has improved from Red to Amber and remains on track for April 2027 go-live, with training, operational readiness and benefits realisation remaining key risks.
- **Annual Plan delivery** remains off track across a number of key metrics, with implications for both operational performance and strategic delivery.
- A clearer roadmap is required for achieving the Trust's **University Hospital ambition.**
- Delivery of the **Green Plan** and net zero ambitions remains significantly challenged by funding and infrastructure requirements; consideration should be given to establishing a Board/NED sustainability lead.
- Further clarity is required regarding governance and accountability arrangements for the emerging **neighbourhood and integrated** care agenda.
- Future committee agenda structure should be reviewed to ensure sufficient scrutiny of the **Integrated Performance Report** and reduce duplication across agenda items.

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Summary of assurance and risk

The Committee received a verbal update on **neighbourhood and integrated care** developments. Members noted progress in developing system-wide approaches to frailty, end-of-life care and neighbourhood workforce transformation, together with the establishment of the Integrated Health and Wellbeing Partnership CEOs Group to provide strategic leadership across partner organisations. The Committee discussed the importance of clear governance, accountability and reporting arrangements as the integration agenda develops, particularly where service changes may have organisational, financial or quality implications. The Committee requested further visibility of the emerging governance framework and Terms of Reference as these mature and noted the update for assurance.

The Committee received the **Month 5 Revenue and Financial Sustainability Programme Report** and noted a year-to-date deficit of £6.6 million and a forecast year-end financial risk of £25.35 million. Members discussed temporary staffing expenditure, escalation costs, delivery of the Financial Sustainability Programme and the significant challenge posed by the low level of recurrent savings. The Committee welcomed the development of strengthened divisional delivery arrangements, enhanced financial controls and progress in developing the 2027/28 financial sustainability plan. Members also welcomed the positive cultural shift being achieved through FSP engagement activities and the introduction of data-driven productivity tools. The Committee requested further reporting on cash flow, recurrent savings and medium-term financial sustainability and noted the report for assurance. Members highlighted the level of risk and the focus on delivery.

The Committee received the **Month 5 Capital Report** and noted that whilst the £42.4 million capital programme remained balanced, delivery continued to rely upon significant mitigations and remained subject to a high level of risk. Members discussed funding dependencies, scheme deliverability, emerging national infrastructure requirements and the impact of unplanned operational pressures, including urgent sewage repairs. The Committee received assurance regarding ongoing forecasting and programme management arrangements and approved the reprioritisation of estates capital funding to support essential sewage infrastructure works. The Committee also noted the importance of maintaining oversight of medium-term capital affordability and future funding risks, including those associated with eCare, Women and Children's and nationally mandated capital requirements.

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The Committee received the **2026/27 Financial Recovery Plan** and undertook detailed scrutiny of the proposed recovery actions. Members recognised the significant scale of the financial challenge and noted that the current plan represents a best-case scenario which will require continued refinement and robust delivery. The Committee discussed workforce controls, agency reduction, recurrent savings, cash flow, medium-term financial sustainability and the need to reduce expenditure whilst maintaining quality and safety. Particular emphasis was placed on ensuring that quality guardrails are established to monitor any unintended consequences arising from recovery actions. The Committee received assurance that strengthened financial controls and accountability arrangements are being implemented across the Trust and requested further reporting on cash flow, quality impacts, recovery delivery and the implications for the 2027/28 financial position. The Committee noted the report and supported ongoing development of the recovery plan ahead of Board consideration.

The Committee received the **Theatre Recovery and Theatre Roof Replacement** Business Case and was advised that procurement had been completed and the scheme remained within the approved capital budget. The Committee noted that replacement of the roof would reduce the risk of weather-related theatre cancellations and improve operational resilience during the winter period. Following consideration of the proposed contingency arrangements and delivery approach, the Committee approved the commitment of £1.23 million project funding and the appointment of the preferred contractor.

The Committee received the **eCare** (EPR) Assurance Report and welcomed the improvement in overall programme status from Red to Amber. Members noted positive progress across reporting, diagnostics, workflow design and data migration activities, with no significant issues identified that threaten delivery. The Committee discussed training, workforce readiness and post-go-live support arrangements in detail, emphasising the importance of operational readiness, productivity recovery and benefits realisation. Assurance was provided that the programme remains on track for the planned go-live date of April 2027, although risks relating to training, mandatory reporting, data quality and capital affordability continue to require close management. The Committee requested further assurance on training and post-implementation support through future reports.

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The Committee received the **Bi-Annual Strategy Implementation Report** and noted encouraging early progress against delivery of the Trust's 2026-2035 Strategy, including implementation of the new operating model, launch of the culture programme, commencement of robotic-assisted surgery, progress in neighbourhood development and approval of the Commercial Strategy. Members recognised, however, that delivery remained uneven and that operational performance, RTT recovery and financial sustainability continued to present significant risks to achievement of strategic objectives. The Committee discussed the need for a clearer roadmap towards University Hospital status, greater visibility of the Isles of Scilly within strategic planning, and enhanced communication of strategic progress across the organisation. The Committee noted progress against Year 1 milestones and ongoing strategic development

The Committee received the **Green Plan Biannual Report** and welcomed the improved oversight and assurance provided following the appointment of the Sustainability Manager. Members noted progress in workforce engagement, sustainable models of care, local procurement and climate adaptation activities, whilst recognising that delivery of the Trust's net zero ambitions remains significantly challenged by the scale of investment required. The Committee discussed opportunities to strengthen grant-funding capability, the importance of partnership working and the need for a robust decarbonisation pipeline to maximise future funding opportunities. Members also supported consideration of a formal Non-Executive Director lead for sustainability. The Committee noted progress, discussed the principal delivery risks and received assurance regarding the ongoing management of the Green Plan programme.

The Committee received an update on the **Major Capital Programme** and noted the significant scale of capital activity currently being delivered across the Trust. Members were advised that tender and procurement cost pressures were emerging across a number of schemes, although these were considered manageable at this stage and were being actively reviewed. The Committee also noted the impact of the recent sewage infrastructure failure, which required essential remedial works to maintain operational continuity. Members supported plans to further streamline future reports to focus on strategic programme delivery, risks and assurance. The Committee noted progress across the capital portfolio and ongoing management of associated delivery and affordability risks.

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The Committee received an update on the **Women's and Children's Programme** and noted continued positive progress towards delivery of the March 2027 Outline Business Case. Members were advised that RIBA Stage 2 design work was nearing completion, that Hospital 2.0 design exemptions had been successfully progressed, and that preparations were underway to commence RIBA Stage 3. The Committee discussed digital infrastructure requirements, long-term revenue affordability, the future of the Silent Hospital initiative, and opportunities for local influence within the national design framework. The Committee received assurance that the programme remains on a challenging but achievable critical path and requested continued reporting on revenue implications, programme milestones and business case development.

The Committee received the **Annual Plan Monitoring** Report, which provided a consolidated assessment of delivery against the Trust's 2026/27 Annual Plan. Members noted that overall performance remained off track across a number of key measures and agreed that the report provided a clear and candid overview of the organisation's current position. The Committee discussed the strategic implications of continued underperformance and recognised that failure to recover key operational and financial metrics could constrain future strategic opportunities. The Committee noted the Month 5 position, associated risks, and the implications of non-delivery, and supported escalation of the report to the Board for further consideration

The Committee received the **Quarter 1 NHS Oversight Framework Segmentation** Report and noted the Trust's reduction to Segment 3. Members discussed the principal drivers of segmentation, including financial performance, workforce indicators, experience of care measures, emergency care performance and elective recovery. The Committee supported the focus on addressing the underlying causes of underperformance through a Divisional Delivery Board and recovery programmes rather than pursuing individual NOF metrics in isolation. Members highlighted financial recovery, staff survey improvement and urgent and emergency care performance as the three key priorities requiring sustained organisational focus. The Committee noted the report and received assurance regarding the planned recovery approach.

The Committee received the **Integrated Performance Report** and noted the Finance and Performance sections for assurance. Members welcomed the revised format, which provides clearer alignment between Board priorities and committee responsibilities. Due to the significant time devoted to consideration of the Financial Recovery Plan, detailed scrutiny of the IPR was limited. The Committee noted the importance of ensuring sufficient future scrutiny of the report and supported consideration of bringing the IPR earlier in future agendas, with subsequent papers focusing on key exceptions and areas requiring deeper examination.

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The Committee received the emerging **Provider Capability Self-Assessment** and considered the proposed Amber-Green ratings across the six capability domains. Members recognised the Trust's strong governance, leadership and strategic foundations, but questioned whether the overall assessment fully reflected the current financial, operational and performance challenges facing the organisation. The Committee emphasised the importance of demonstrating organisational self-awareness and ensuring the assessment accurately reflects both strengths and areas requiring improvement, including partnership working and tackling health inequalities. Feedback from the Committee will be incorporated into the revised assessment prior to Board consideration and submission to NHS England.

The Committee received the **Board Assurance Framework** report, which was taken as read due to time constraints. No specific questions or concerns were raised, and the Committee noted the report without further discussion or action.

Received the following reports:

- Approved the Estates and Facilities Senior Leadership Team Terms of Reference
- National Costs Collection Post-Submission

Finance and Performance Committee - October 2026

The Committee received an update on the development of **integrated health** and wellbeing discussions. Members explored the financial implications of shifting care into the community, recognising that benefits may not translate immediately into reduced RCHT expenditure. The Committee agreed that 2027/28 financial and business planning should explicitly reflect the implications of neighbourhood and integrated care, including transition costs and system benefits.

The Committee welcomed the **Integrated Performance Report and RTT Recovery** (deep dive). Members noted significant improvement in ambulance handovers and improving Type 1 Emergency Department performance, whilst noting that 12-hour waits remained a significant challenge. Diagnostic performance was improving slowly and Community Diagnostic Centre capacity remained underutilised, with work underway to increase community-based activity. The Committee scrutinised the ambitious RTT recovery programme, particularly theatre productivity, long waits, waiting-list growth and Trauma and Orthopaedics. Daily RTT huddles and additional scrutiny are in place, with theatre activity increasing towards the required 450 cases per week. RTT recovery will continue to be monitored through the IPR, supported by further deep dives where required, and 12-hour ED performance will be added to the summary dashboard. Overall, the Committee considered that continued close scrutiny was required rather than full assurance at this stage. Routine reporting to be provided to Committee on the RTT recovery arrangements.

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The Committee received the monthly **Financial Report** which included the **Financial Sustainability Programme** and members noted limited assurance on the financial position. At Month 6 the Trust reported a £7.69m year-to-date deficit, £2.23m adverse to plan, with the underlying run-rate and forecast indicating a full-year risk of approximately £21m. FSP delivery was £15.56m against £15.81m planned, but only 16% of savings were recurrent and the full-year forecast indicated a £10.5m shortfall against the £42.5m requirement. Members strongly challenged whether existing recovery measures were sufficient to achieve break-even, particularly given continuing pay pressures, bank and agency expenditure and the limited recurrency of savings. Management confirmed that full assurance could not currently be given on delivery of break-even and that further controls, including potential divisional control totals, were being considered. More detailed reporting on both in-year recovery and the emerging 2027/28 programme will return to the Committee, with greater alignment between finance, workforce and planned-care recovery.

The Committee considered the monthly **capital report** noting continuing pressures across the capital programme and supported the proposed £1.258m reprioritisation and additional PDC funding requests proceeding to Trust Board. Funding for ambient voice technology was supported subject to completion of the supporting business case and benefits analysis. Members highlighted significant competing demands upon the capital programme, including estates and infrastructure pressures, and requested that future reporting more clearly set out the remaining mitigation requirement and future commitments, including fire remediation.

The Committee noted a **cash report** which set out a balance of £29.2m at the end of September but recognised the significant relationship between future liquidity and successful delivery of the financial recovery plan. Both the central mitigated and worst-case financial scenarios would result in the Trust falling below the four operating-day cash threshold later in the financial year, whilst even delivery of break-even provides limited headroom. Members sought assurance regarding the process for accessing external cash support should this become necessary and were advised that an application cannot be made until the relevant cash threshold is reached. The Committee welcomed the forward-looking analysis and agreed that quarterly cash deep dives should continue.

The Committee noted the **biannual procurement** report and welcomed the introduction of monthly non-pay oversight groups to strengthen divisional scrutiny and control of expenditure. Members sought clarification on significant contractual arrangements, including the managed laboratory service and dermatology provisions, and emphasised that any changes to outsourcing arrangements should be considered carefully in the context of wider system and left-shift objectives.

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The Committee received limited assurance on the **eCare Programme,** which remains rated Amber and is progressing towards the planned go-live date of 4 April 2027. Particular attention was given to the potential impact upon operational productivity before, during and after go-live, including current pressures arising from staff being required to support the programme and manual workarounds associated with clinic-template restrictions. Members also challenged whether sufficient clinical and operational resource would be available for stabilisation and optimisation following go-live. The £1.6m sustainment team provision has been agreed, although other post-go-live resource requirements remain under consideration. These risks will continue to require close scrutiny as the programme moves into its formal readiness assessments.

The Committee noted the **Women's and Children's Hospital Programme** report and the continued progress through the design stages but recognised that the timetable remains highly compressed and that several significant financial and enabling issues remain to be resolved. Particular concern was raised regarding the movement of the capital funding risk from Amber to Red, which the Committee agreed should be explicitly highlighted to Trust Board. Members also challenged the governance arrangements, future-proofing of the proposed building and its longer-term revenue implications. A specific update on revenue implications will return to the Committee in December, and the Committee requested early visibility of the planned Board/NED development and assurance arrangements ahead of future major decisions.

The Committee noted positive progress within **Estates and Facilities**, including leadership and culture, whilst recognising that the Estates portfolio remained more challenged due to workforce, backlog and increasing infrastructure pressures. Potential additional FSP measures, including changes to retail catering discounts and car-parking arrangements, were discussed. Members cautioned that measures affecting staff should be considered carefully in the context of the Trust's wider culture work and supported by appropriately aligned executive decision-making and communications.

The Committee strongly welcomed the refreshed **Board Assurance Framework** and considered it a clearer and more effective strategic assurance tool. Members supported the explicit incorporation of risk appetite, tolerable risk ranges and target trajectories, whilst requesting continued work to strengthen the golden thread with the Corporate Risk Register and consistency in the assessment of actions as on or off track. The Committee supported the BAF progressing to Trust Board, subject to the identified refinements, and supported consideration of the BAF earlier in future Committee agendas so that principal risks and gaps in assurance inform subsequent scrutiny.

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Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 14.1

Title of Report: Trust Finance Report 2026-27: Part A: Month 6 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 30th September 2026 (Month 6).

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 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	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.

Recommendation(s):

The Board is recommended to:

- **Note** the September (month 6) financial position which represents the halfway point of the 26/27 financial year position.

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Summary of the Financial Performance for 2026-27: September ’26 – Month 6

1. Situation / Executive Summary

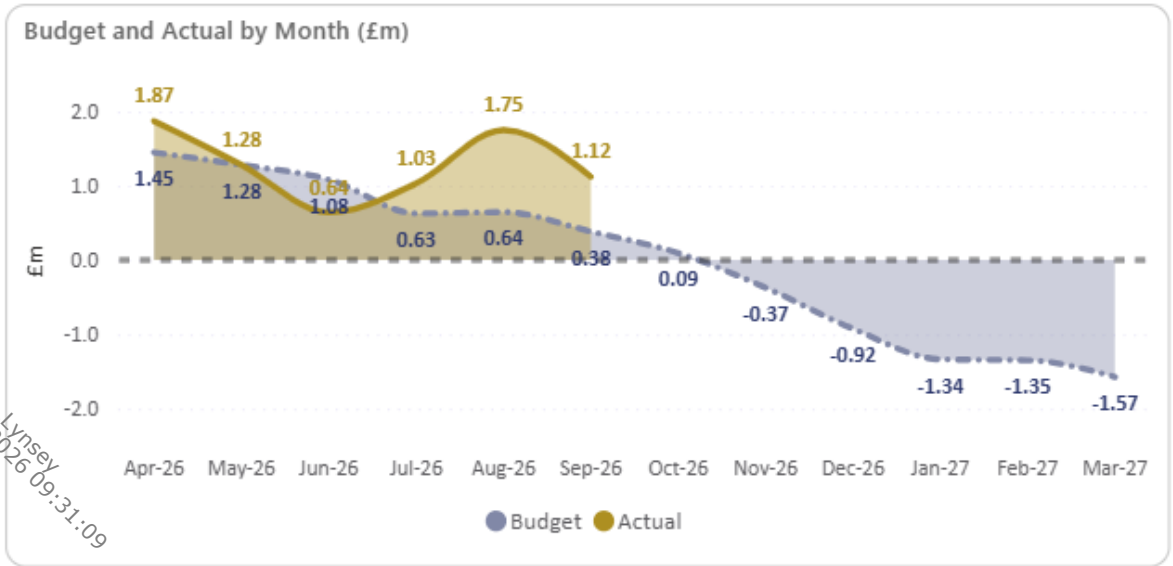
KPI	Status	Actual	Comment
YTD Position	🔴	£2.2m	September was £0.73m adverse; the YTD variance is £2.23m adverse.
Forecast Outturn	🔴	£21.4m	Forecast improved by £3.9m yet pressure continues in divisional budgets and efficiency targets.
FSP Delivery	🟠	98.4%	FSP delivery is £3.9m, £0.75m above the £3.15m target; the YTD shortfall has reduced to £0.26m.
Recurrency	🔴	15.8%	Recurrent delivery remains at 15.8% vs target, forecast increased to c.27% (£11.6m vs £42.5m target)
Agency Spend	🔴	£3.5m	Agency spend continues to exceed both in-month and YTD plans.
Cash Balance	🟢	£29.2m	Cash balance was £0.6m below forecast of £29.8m but remained £7.7m above plan.

The Trust reported a deficit of £1.12m in September, which was £0.73m adverse to plan. Year to date (Months 1-6), the Trust has reported a £7.69m deficit, £2.23m adverse to the planned deficit of £5.47m. The adverse position continues to reflect sustained pressures across pay and non-pay budgets, driven by ongoing expenditure on variable staffing and escalation measures, alongside the increasing requirement to deliver efficiency savings.

The month 6 forecast has now been completed and continues to indicate a significantly material year-end risk of approximately £21.4m although this has improved from last months forecast of £25.4m. The forecast risk reflects continued concerns regarding the deliverability and recurrency of the Financial Sustainability Programme, with a potential FSP shortfall of £10.5m, alongside £10.9m of additional cost pressures, including escalation expenditure and other emerging financial risks. These risks will require considerable mitigation if the Trust is to achieve its planned financial position. The full financial recovery plan, produced in month 5 continues to be monitored.

Trust Summary £000 - M1-M6

Current Mth Actual	Current Mth Budget	Current Mth Variance	YTD Actual	YTD Budget	YTD Variance
1,116.01	383.13	732.88	7,691.57	5,465.97	2,225.60



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The Financial Sustainability Programme (FSP) remains a significant area of risk, particularly regarding the quality and sustainability of delivery. In September, a number of non-recurrent items, including activity-related reserve reviews and additional income, increased reported delivery to £3.9m, reducing the year-to-date variance to £0.26m behind plan. However, the programme continues to rely heavily on non-recurrent measures, with only 16% of YTD savings being delivered recurrently compared to a planned 72.5%.

Temporary staffing remains a key area of concern. Agency expenditure was £0.6m in September and has remained broadly consistent since June. While agency spend in non-medical areas, particularly nursing, has reduced, this has been offset by increased medical agency expenditure. Agency expenditure was £3.48m at the midpoint of 2026/27, £0.37m adverse to plan. A further £2.6m is forecast in the second half of the year, taking the projected year-end adverse variance to approximately £1.18m without mitigation.

Bank expenditure increased to £2.97m in September, although this is partly attributable to the move from a four-week to a five-week month. Medical bank expenditure, which is reported on a calendar-month basis, reduced in September and continues to show a downward trend, but remains above planned levels. Bank expenditure was £17.5m at the midpoint of 2026/27, £4.88m adverse to plan. A further £12.16m is forecast in the second half of the year, taking the projected year-end adverse variance to approximately £6.71m.

Income was £0.17m favourable to plan in September, improving the year-to-date position to £0.52m favourable. However, there remains a risk that under-delivery of variable activity during Months 1 to 6. If not recovered by year end this will create a pressure that is not currently reflected in either the reported position or the forecast.

Overall, the Month 6 position has seen the Trust move further adverse to plan and continues to face a material full-year risk. The key issues for the Board are therefore the recovery of the reported position through the agreed recovery plan, delivery of recurrent savings, reduction in escalation and temporary staffing costs, resolution of income risks, and sustained control of non-pay expenditure.

2. Recommendations

- **Note** the September (month 6) financial position which represents the sixth month of the 26/27 financial year position.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board

Date of Meeting: 5 November 2026

Item Number: 14.2

Title of Report: Trust Finance Report 2026-27: Part B: Month 6 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 the Trust Board with an update on delivery of the 2026/27 capital programme as at 30 September 2026 (Month 6), and to seek approval for the proposed reprioritisation and receipt of the EEMAC and Truro UEC Public Dividend Capital funding.

The paper also seeks approval for the acceptance of additional PDC funding which will enable the implementation of Ambient Voice Technology.

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			x	

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
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	The proposed decisions support the health and wellbeing of the population by helping to ensure that the highest-priority capital investment set out in the programme can be delivered within the available funding.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The proposed decisions support service quality by helping to maintain delivery of the capital investment required for safe and effective services.
Sustainable and efficient use of NHS resources by RCHT	The proposed reprioritisation supports the sustainable and efficient use of NHS resources by aligning planned expenditure with the funding available and reducing the remaining mitigation requirement.

Recommendations:

The Trust Board is recommended to:

- **Note** the financial position for the capital programme for the period to 30 September 2026 (Month 6) including the update on planned and actual mitigations.
- **Approve** following FPC support, the proposed reprioritisation of £1.258m of 2026/27 capital funding identified in section 7, reducing the remaining mitigation requirement to £1.406m before any capitalisation of revenue spend.
- **Approve** following FPC support, the receipt of £0.999m and £0.150m of Public Dividend Capital for the EEMAC and Truro UEC schemes.
- **Approve** following FPC support, the acceptance of £1.042m of additional Public Dividend Capital (PDC) for Ambient Voice Technology via the Frontline Productivity Programme.
- **Note** that the capital planning for 2027/28 has now started with a significant gap between the request for investment and available funding. The Finance and Performance Committee will receive a capital planning report in November 2026.

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30/10/2026 09:31:19

Trust Finance Report 2026-27: Part B: Month 6 Capital Position Update

Executive Summary

Key messages

- The Trust has total capital funding of £42.445m for 2026/27, comprising £25.251m of Capital Departmental Expenditure Limit (CDEL) funding and £17.194m of non-CDEL funding, excluding donations.
- At the date of this report, the Trust has a balanced capital programme, but only through the inclusion of £10.035m of mitigations. The opening target for capital brokerage and over-programming is £6.664m. Of this, £1.500m of brokerage has been secured, NHSE is seeking a further £2.500m of eCare funding, and £1.258m of reprioritisation is proposed. Subject to confirmation of the eCare funding and approval of the reprioritisation, the remaining target would be £1.406m.
- At Month 6 (30 September 2026) CDEL spend totals £9.302m and is £1.926m behind plan; overall capital expenditure is £5.818m behind plan.
- There is currently no contingency within the capital plan.
- Capital risk (risk register item 8521) has been reviewed and is 20 (Extreme) given that the failure to achieve a statutory financial duty could constitute failure to achieve a key financial metric.

Key areas for review

- A detailed forecasting exercise was completed in September and is reported in section 7. After allowing for £1.500m of secured brokerage, £2.500m of potential eCare funding and the proposed £1.258m reprioritisation, the remaining mitigation target would be £1.406m. The potential eCare funding remains unconfirmed.
- A request to accept an additional £1.042m of public dividend capital which will enable the implementation of Ambient Voice Technology. A business case will be developed as part of the implementation which will set out the ongoing costs and benefits of using the new technology.

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1. Situation

This paper provides an update on delivery of the 2026/27 capital programme as at 30 September 2026 (Month 6), including the current position against CDEL and non-CDEL funding, key variances, and associated risks.

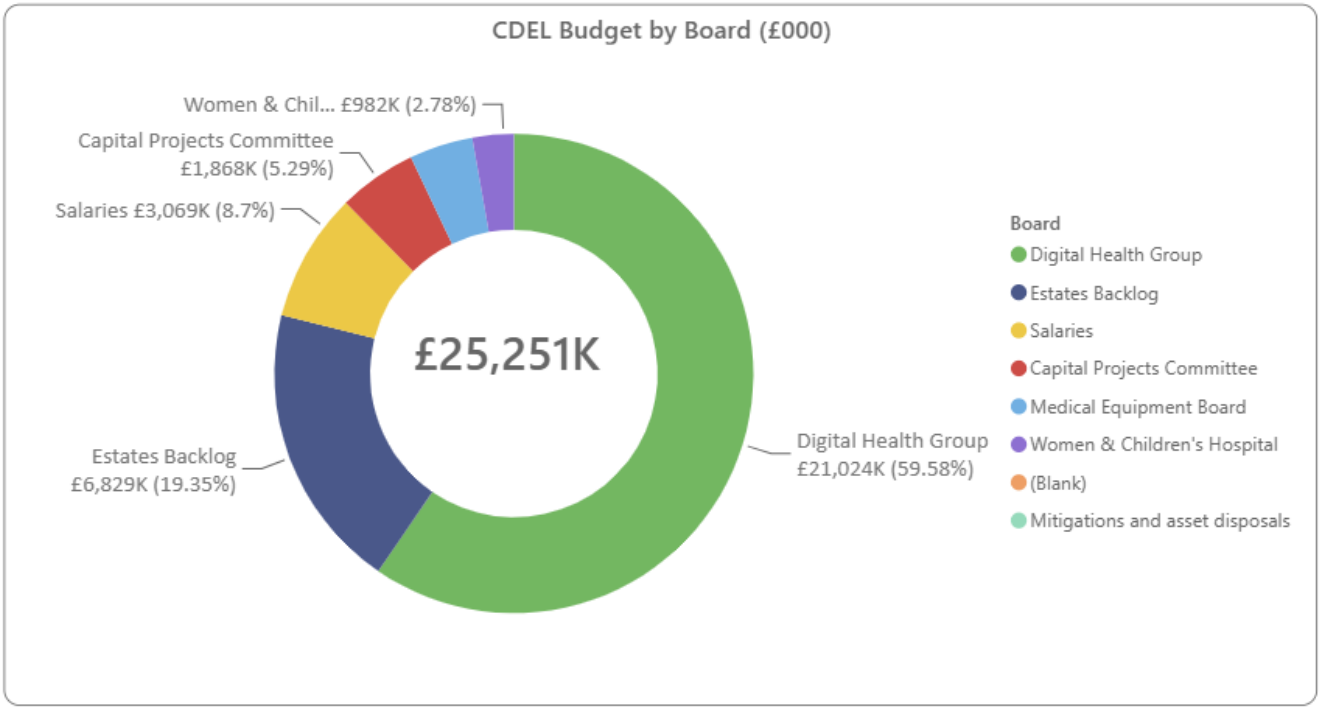
2. Introduction and CDEL funding

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 £25.251m. This has increased by £0.038m since Month 5 due to equipment disposals.

The chart below shows the split of the capital programme by capital sub-group.

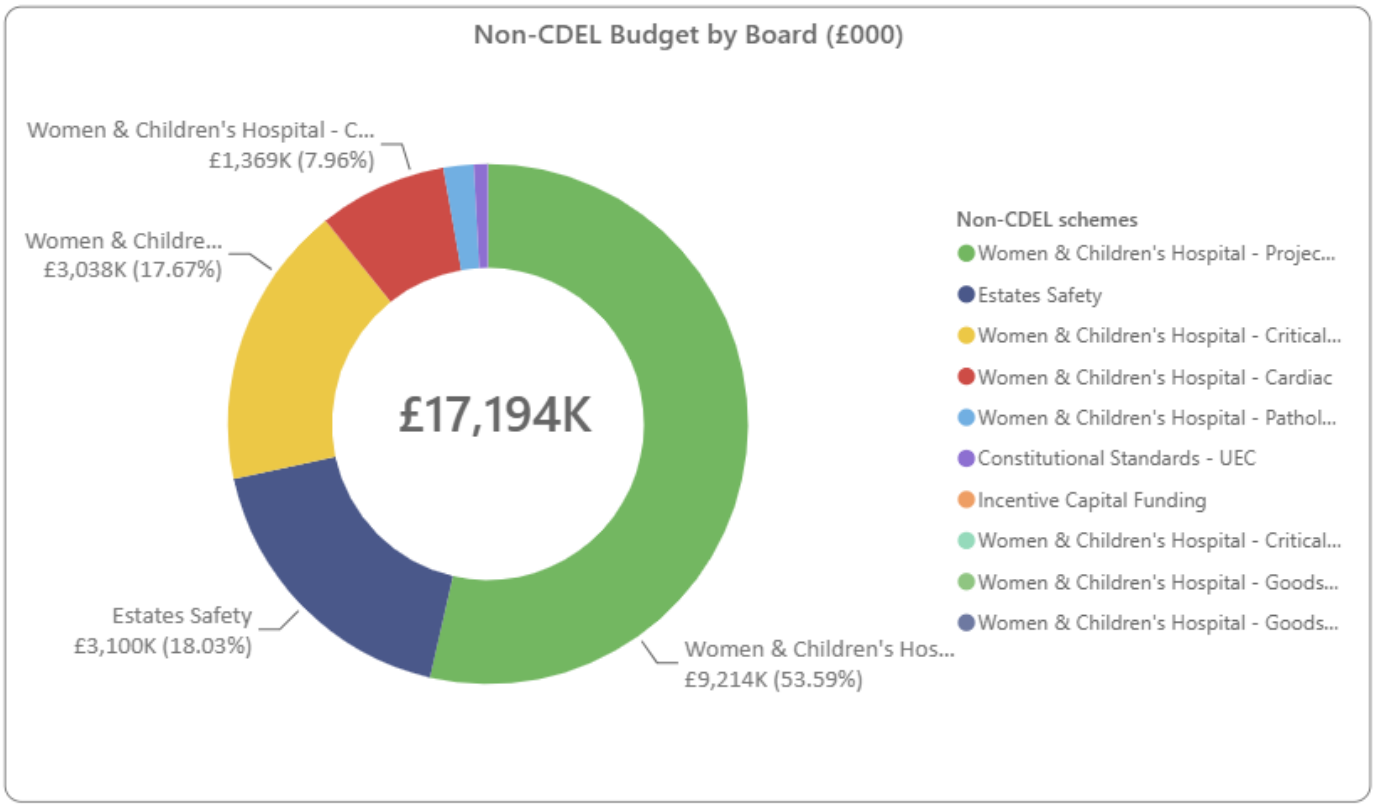


3. Non-CDEL Funding

Non-CDEL funding totals £17.194m, comprising Public Dividend Capital (PDC) funding. This has remained the same since Month 5.

The total capital funding available for the year is therefore £42.445m excluding donations.

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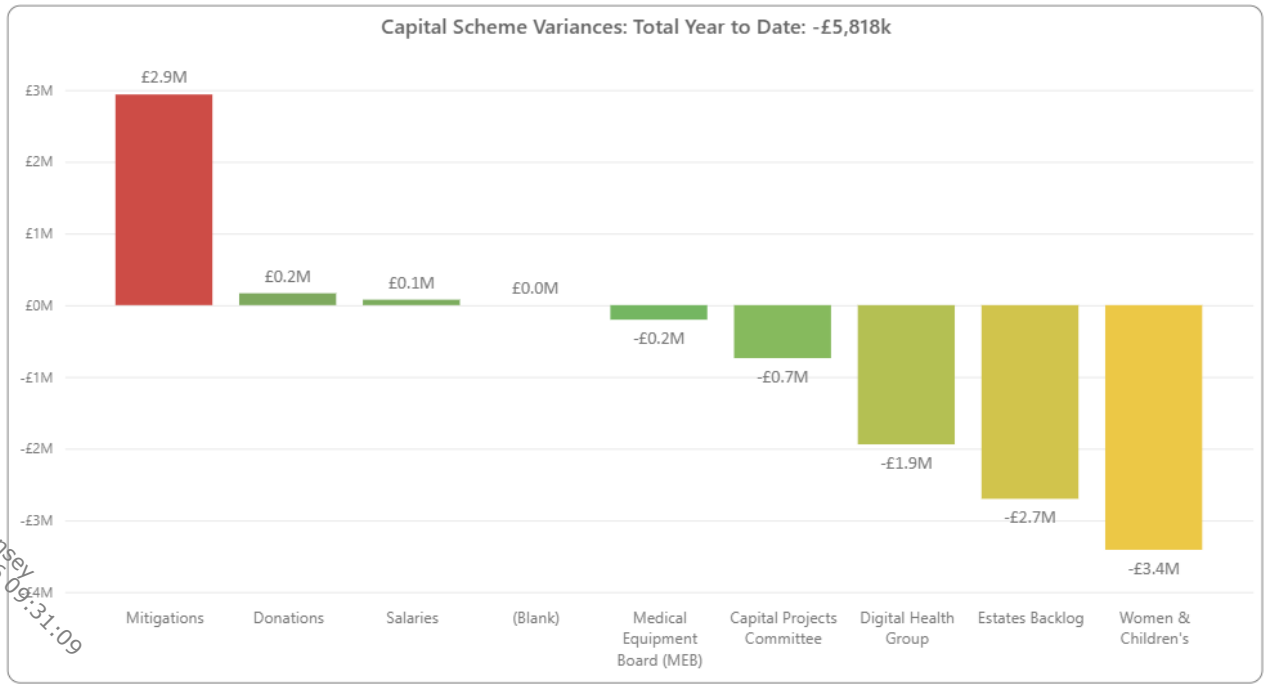
4. Year to date financial position

As at 30 September 2026, CDEL spend totals £9.302m. This is £1.926m behind plan.

As at 30 September 2026, non-CDEL spend totals £3.147m. This is £4.057m behind plan.

As at 30 September 2026, donations spend totals £0.165m. This is £0.165m ahead of plan.

Overall, expenditure is £5.818m behind plan at the end of Month 6. 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 – Critical Infrastructure is currently £1.54m behind plan due to project delays.

Estates – The Estates programme is £2.737m underspent to date. Estates Safety is £0.856m behind plan and Fire Safety is £1m behind plan. The contract for the Estates Safety work has been issued, so expenditure is expected to commence. Both the Electrical and Mechanical schemes are expected to catch up during the year.

Capital Projects Committee – the sub-group is currently £0.899m behind plan, linked to the final spend on the West Cornwall Hospital Outpatient scheme plus a delay on the Fluoroscopy Imaging Equipment replacement scheme, both of which are expected to be delivered in year.

Digital Health Board – the sub-group is currently £1.943m behind plan. £1.488m of this relates to eCare, which is behind plan due to project delays but is expected to spend to plan.

Medical Equipment Board – this programme is £0.203m behind plan and is expected to spend to plan for the full year.

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. The forecast section sets out how much of the capital brokerage and over-programming mitigations is expected to be achieved.

Mitigation	2026/27 plan (£m)	Notes
Tower Fire VAT recovery	£0.7m	Expected to be delivered
Capital brokerage	£5m	£1.5m of brokerage has been secured. NHSE is also seeking £2.5m of eCare-related funding, which, if approved, will contribute towards the £5m brokerage target.
Over programming	£1.664m	Risk. Reprioritisation of the programme will change the schemes delivered in year, making this mitigation more challenging to achieve.
Reallocation of Estates Safety funding	£1.222m	Currently on track, although delivery will depend on the reprioritisation of the capital programme.
Reimbursement from W&C programme and CFT	£1.449m	Expected to be delivered

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7. Forecast

The year-to-date CDEL position is £1.926m behind plan. The programme also requires £5m of capital brokerage and £1.664m of in-year slippage to remain within the available funding envelope.

During the past month, discussions have taken place with capital sub-groups on forecast outturns and the profiling of expenditure required to deliver the mitigation target.

These discussions identified limited opportunities for slippage or underspends. The forecast position has therefore been informed primarily by a finance-led assessment, which identified the following potential savings, these were discussed and agreed at the Capital Approvals Group on the 12 October:

Project	Sub-group	Potential saving (£m)	Comments
Linac LA4 replacement	Capital Projects Committee	£0.2m	Expect to be delivered due to a project underspend.
Fluoroscopy Imaging Equipment replacement - Tower Imaging Room 5/6	Capital Projects Committee	£0.1m	May slip due to potential delays caused by BSR approval timelines. Funding would be required in 2027/28.
NEEF - LED upgrades	Capital Projects Committee	£0.056m	Limited work remaining so underspend assumed in absence of further information from project team.
Planned Care Unit Relocation	Capital Projects Committee	£0.025m	Expect to be delivered due to a project underspend.
Robotic Surgery	Capital Projects Committee	£0.135m	£77k of this is expected to deliver, further £58k may be available if confirmed SSD no longer require equipment allocation.
Fire Dampers; Fire Hydrants	Estates Capital Group	£0.1m	Estimated combined slippage of approximately £0.1m. Funding would be required in 2027/28.
Decontamination Integral Plant equipment	Estates Capital Group	£0.042m	Can underspend if desired. If eligible revenue expenditure is transferred instead, this could create a revenue benefit rather than a capital underspend.
Lift replacements	Estates Capital Group	£0.1m	Estimated slippage, would be required in 2027/28.
Estates Fire Safety	Estates Capital Group	£0.5m	A reported underspend risk exists of c£0.3m with confirmation from

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Project	Sub-group	Potential saving (£m)	Comments
			the Capital Projects Lead that this could be £0.5m.
Total		**£1.258m**	

The Trust Board is recommended to approve the proposed reprioritisation of £1.258m of 2026/27 capital funding identified in the table above, to reduce the remaining mitigation requirement.

Further schemes could release up to £0.410m, but these do not form part of the proposed reprioritisation at this stage. The items in the table below total £0.410m.

Project	Sub-group	Potential saving (£m)	Comments
Tenvennek MRI; Trelawny Fracture Clinic X-Ray; SMH Digital X-Ray; Gamma Camera	Capital Projects Committee	£0.16m	These are all budgets for project development. Up to £0.16m could be intentionally slipped if related schemes are not approved for funding in 2027/28.
LV Distribution Boards	Estates Capital Programme	£0.09m	No natural underspend currently assumed but up to £90k could be slipped if required.
Ventilation and Heating system replacements	Estates Capital Group	£0.16m	Contingency could be released if required.

Revised mitigation target

Reconciliation	£m
Opening mitigation target: capital brokerage and over-programming	6.664
Less: brokerage secured	(1.500)
Less: potential eCare funding (not yet confirmed)	(2.500)
Less: proposed reprioritisation	(1.258)
Revised mitigation target, subject to confirmation of eCare funding	**1.406**

Capital sub-groups will continue to identify further slippage opportunities. These will be reported to the Capital Approvals Group and will inform a further round of reprioritisation in November.

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Return to Constitutional Standards Schemes

In addition to the CDEL forecast, NHSE has asked organisations to confirm how much national funding for constitutional standards will be used in 2026/27. From December reporting onwards, trusts must adhere to agreed forecasts. If an organisation then underspends by more than 10% of its 2026/27 national programme allocation for reasons it could reasonably have foreseen, 25% of the underspend will be deducted from its 2028/29 operational capital allocation. This represents a strengthened response compared with last year.

Note that this does not relate to Estates Safety or Digital schemes.

The Trust's allocated funding that is subject to this review is:

Funding allocated in 2026/27	**£m**
Truro UEC	0.150
West Cornwall UTC	1.625
Emergency Medicine Ambulatory Care	0.999
Total	**2.774**

At the date of this report the Trust has made a number of proposals in relation to the receipt of funding for 2026/27 although this has not yet resulted in a confirmed way forward.

8. Updates on capital bids for 2026/27

An update on recent capital bids is shown below:

Constitutional Standards – St Michael's Hospital

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 project has been indicated for support by NHSE, subject to approval of a business case, at £1.625m (the original value bid for). However, when the latest request for funding was made, the scheme cost was estimated at £3.23m and it is no longer deliverable at that value. The team's latest assessment is that a deliverable scheme with the required benefits would cost £8.9m.

Constitutional Standards – Truro UEC

£6.3m has been supported in principle for this scheme.

The Trust received formal confirmation during the month of £0.150m of funding in 2026/27 to develop the project.

The project team has also received confirmation of £0.999m of funding for the Extended Emergency Medicine Ambulatory Care (EEMAC) / ED Flow Improvement Scheme.

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NHSE has supported in principle the consolidation of the Truro UEC, West Cornwall UTC and EEMAC funding allocations into an enhanced Truro UEC / Same Day Emergency Care scheme with an estimated total cost of approximately £8.9m.

Further information will be reported to the Capital Approvals Group once the preferred way forward has been discussed and confirmed internally and with NHSE.

Frontline Productivity – Ambient Voice Technology

RCHT has been offered a total of £1.042m of additional Public Dividend Capital to support the system wide implementation of Ambient Voice Technology via the Frontline Productivity Programme.

This funding would enable RCHT and partners to implement AI-enabled "ambient scribing" technology which will listen to clinician-patient conversations in order to prepare draft clinical documentation ready for final review and validation by the clinician.

The funding would be split over the 2026/27 (£0.154m) and 2027/28 (£0.888m) financial years.

The funding would be dependent on RCHT and partners matching the values of the funding award; this would be achieved through the re-prioritisation of CITS staff to support the implementation project as well as the purchase of new devices which can support AVT. These costs would be funded entirely via existing budgets; there is therefore no requirement for the Trust to set-aside any additional budget to cover these costs.

The Board is asked to approve acceptance of the £1.042m of funding and should therefore note that as it will be provided in the form of Public Dividend Capital it will incur an additional PDC dividend cost of 3.5%. Based on the funding profile this would result in a £3k charge in 2026/27 and £22k in 2027/28; followed by an annual charge of £37k from 2028/29 onwards.

Purchase of the AVT licenses with this funding will be subject to approval of a full business case; this case will articulate both the cost of implementation as well as a full cost/benefit analysis & risk share of the ongoing operation of AVT across RCHT and partners. It is recommended that this business case is developed by representatives from both Cornwall IT Services and Financial Sustainability Planning.

9. Forward planning

Planning for 2027/28 has started, with the initial requests scheduled for review by the Capital Approvals Group on 12 October 2026.

After allowing for some initial adjustments, bids totalling £60m have been received for 2027/28 and £78m for 2028/29. The available funding depends on how much repayable brokerage is received in 2026/27 but could be £16.9m for 2027/28, demonstrating the scale of the challenge in setting a balanced capital programme.

Schemes to which the Trust has committed, together with the extreme-risk schemes, total approximately £30m for 2027/28. A further review is under way within each capital sub-group to test the risk assessment for each scheme and the timing of investment. The first capital planning paper will be presented to the Finance and Performance Committee in November 2026.

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The table below shows commitments for 2027/28 totalling £7.586m, based only on approved business cases. It therefore represents a subset of the approximately £30m of committed and extreme-risk schemes referred to above. These costs will be

challenged as part of the budget-setting process to confirm that they must be incurred. The funding available for 2027/28 will depend on how much brokerage is received and the terms of repayment. The working assumption is that £16.9m will be available.

Project	Capital Sub-Group Short Name	Current 2027/28 commitment (£m)
IFRS16	Other	0.300
Staff Support	Other	2.893
Immutable Minimum Viable Hospital	DHG	0.941
Fluoroscopy Imaging Equipment replacement Tower Imaging Room 5/6	CPC	2.661
eCare Programme Reset 26/27	eCare	0.791
Total		**7.586**

10. 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 current score for risk 8521 is 20 (Extreme) 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.

There is also a risk that, as the capital programme was only finalised in July, there will be challenges in delivering 12 months of spend in eight months. Given the overall need to underspend as part of the core programme, alongside the overspend risk arising from the need for brokerage, the overall risk assessment is unchanged. The Capital Approvals Group will continue to monitor the deliverability of the capital programme and reprioritise, or propose the reprioritisation of, funding accordingly.

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11. 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 £17.194m from a capital perspective.

Public Dividend Capital is not required to be repaid, although the Trust can choose to repay it. In simple terms, PDC attracts a dividend at a rate of 3.5% per year on the average balance between the start and end of the year (i.e. 1.75% in the first year of receipt). The PDC dividend cost for the first full year will be c£0.6m. This has been reflected in the financial plan for 2026/27.

During the month, the Trust received confirmation of £0.999m for the EEMAC scheme and £0.150m for the development of the Truro UEC scheme. The Trust Board is asked to approve receipt of this funding.

RCHT has been offered an additional £1.042m of Frontline Productivity PDC to support the implementation of Ambient Voice Technology (AVT). The Board is asked for its approval to accept this funding, noting that this would result in an additional £0.037m annual PDC dividend cost.

12. Accountability

The accountable director for this report is the Chief Finance Officer. Updates are provided to the Board each month.

13. Recommendations

The Trust Board is recommended to:

- **Note** the financial position for the capital programme for the period to 30 September 2026 (Month 6) including the update on planned and actual mitigations.
- **Approve** following FPC support, the proposed reprioritisation of £1.258m of 2026/27 capital funding identified in section 7, reducing the remaining mitigation requirement to £1.406m before any capitalisation of revenue spend.
- **Approve** following FPC support, the receipt of £0.999m and £0.150m of Public Dividend Capital for the EEMAC and Truro UEC schemes.
- **Approve** following FPC support, the acceptance of £1.042m of additional Public Dividend Capital (PDC) for Ambient Voice Technology via the Frontline Productivity Programme.
- **Note** that the capital planning for 2027/28 has now started with a significant gap between the request for investment and available funding. The Finance and Performance Committee will receive a capital planning report in November 2026.

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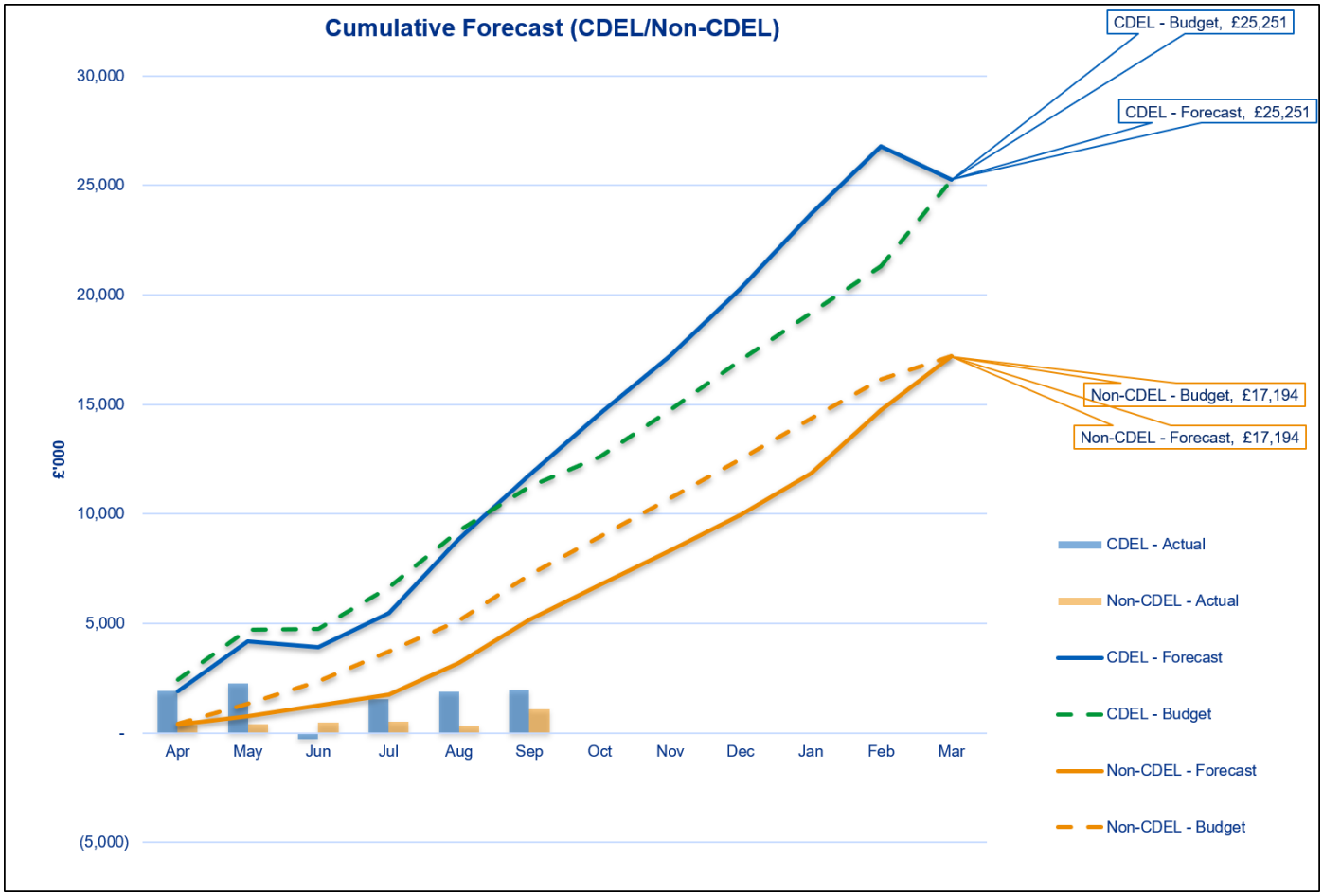
Appendix 1 – Public Dividend Capital

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 - Pathology	323	6	
Women & Children's Hospital - Critical Infrastructure Phase 2	3,038	53	
Women & Children's Hospital - Project Fees	9,214	161	
Women & Children's Hospital - Goods In Onsite	-	-	
Women & Children's Hospital - Goods In Offsite	-	-	
Capital Incentive Funding	-	-	
Constitutional Standards - UEC	150	3	
Estates Safety	3,100	54	
Total Non-CDEL spend	**17,194**		
Total PDC funding	**17,194**	**301**	
Donations			
Total Non-CDEL funding - Capital	**17,194**		
Future funding to be added			
EEMAC	999		
Ambient Voice Technology	154		
Cyber Security	650		

PDC interest for the first full year based on values above		**602**	

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30/10/2026 09:31:09

Appendix 2 – Monthly plan, actual and forecast



Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 14.3

Title of Report: RCHT Green Plan Bi-annual Report

Executive Director Lead: Ella Stracey, Chief Strategy Officer

Author and Job Title: Tanya Saker, Sustainability Manager, RCHT

Email Address: tanya.saker@nhs.net

Purpose of the Report:

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

To provide a bi-annual update to the Trust Board on the progress of RCHT towards delivery of the new RCHT Green Plan

Consultation:

The RCHT Green Plan 2025-2028 was approved by Trust Board in October 2025. This is the November update which has been received by ELT and Finance and Performance Committee, now for consideration by Trust Board. This paper has been developed through engagement with Estates and Facilities, and the Trust Risk Manager.

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?			N/A	
Quality Impact Assessment completed?			N/A	

Meg Lukey 30/10/2026 09:31:09

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
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	The Green Plan aims to tackle the environmental determinants of poor health whilst also reducing health inequalities across the region. As an anchor institution, the Trust aims to support prevention and health creation through active travel, improving local air quality, supporting the left shift to neighbourhood health, improving access to high-quality green and healthy spaces, and building community resilience to our changing climate and severe weather, particularly for those most vulnerable to climate-related health impacts.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	This work supports the delivery of high-quality services, through innovative, patient-centred and sustainable models of care, enhancing service resilience and patient experience. It aims to improve access for rural and vulnerable populations, reduce travel, addresses environmental determinants of health, and supports healthier, more resilient communities.
Sustainable and efficient use of NHS resources by RCHT	This work supports the sustainable use of resources by reducing energy consumption, enhancing waste segregation and sustainable travel; improving estate efficiency; embedding sustainable procurement; expanding digital and community-based care; and increasing resilience to climate-related risks. These actions help deliver high-quality healthcare while supporting the Trust's commitment to reach net zero by 2040.

Recommendation(s):

The Committee **is recommended to:**

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- **Note** the progress against the Trust's Green Plan with ongoing management by the new Sustainability Manager.
- **Discuss and note** the risks associated with the delivery of the Trust Green Plan have been added to the corporate risk register owing to the broad and far-reaching impacts of failure to making progress against the green agenda.

RCHT Green Plan 2025-2028, November 2026 Update

1. Situation / Executive Summary

The Green Plan was refreshed and approved by Trust Board in October 2025, setting out how RCHT aims to meet NHS net zero targets for direct emissions by 2040 and wider emissions by 2045. This report provides the first six-month progress update. Delivery is being led by the Trust's Sustainability Manager, who joined in May 2026, and highlights key achievements, priorities, risks and opportunities. Continued implementation will help embed sustainability across the Trust and support its journey to net zero.

The Sustainability Manager is responsible for the quarterly returns to NHS England documenting the Trusts progress towards Net Zero Carbon and the national Greener NHS agenda. The initial focus has been to understand the key risks associated with the Green Plan, amid other national requirements, to support future planning. While the Trust has made progress in areas of the plan such as workforce, green spaces for health and food & nutrition, there remains a significant risk to delivery owing to the need for significant investment in support of decarbonising the estate.

A new corporate risk has been reviewed and approved by the Executive Risk Group pertaining to the delivery of the Green Plan and broader NHS net zero sustainability requirements. This issue is not unique to RCHT; many trusts face challenging capital budgets with sustainability one of many pressures. The Sustainability Manager is working closely with Cornwall Foundation NHS Trust and wider local system sustainability leads across the region ensuring alignment with the ICB SW Peninsula Green Plan, recognising there may be opportunities for joint work within the system.

2. Assessment

The Green Plan has 10 key focus areas for the next three years, a brief assessment on each is provided below. The Trust is now developing a detailed delivery plan setting out specific actions required with progress intended to be monitored through the new oversight group and will inform future reporting to Board.

2.1 Workforce and Leadership – on track

There is real passion from staff across the Trust to adopt more sustainable practices and to realise environmental, social and financial benefits possible. The Green Plan Oversight Group has been re-established and will meet bi-monthly. Priorities include a review of the Trust's carbon footprint, developing a sustainability skills framework including a Board development session, a communications strategy including an annual showcase event, regular campaigns, rejuvenation of the green champions network and collaborative working with Cornwall Foundation Trust to deliver mutual financial, resource and sustainability benefits. Further work is required to embed sustainability within key policies and processes, including staff appraisals. In July 2026, the Trust became one of the first NHS trusts to air a staff viewing of the Climate Emergency Briefing. A summary of the event is presented in Appendix 1.

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2.2 Care Model Transformation – on track

The Green Plan has been embedded within the Trust's new strategy, with sustainability and carbon reduction principles also integrated into Integrated Neighbourhood Team pilot projects that support system-wide transformation with local partners. Sustainability is being embedded more consistently within the refreshed Quality Improvement approach across the Trust, with the Emergency Department continuing to lead this area with multiple sustainability quality improvement projects either completed, or underway overseen by Dr Toby Bateson. The Trust has an active group of clinicians keen to participate in a new clinical sustainability leads group, with a new clinical sustainability lead yet to be appointed.

2.3 **Digital Transformation** – at risk

The refreshed Digital Strategy includes a commitment to being secure, resilient and green, supporting the Trust's ambition to achieve net zero carbon by 2040. Currently, 30% of outpatient activity is delivered digitally, reducing patient travel, while 85% of patients engage digitally with their appointments, reducing the need for printed letters. Clinical questionnaires, outpatient referral acknowledgements and waiting list validation processes have also been digitised, reducing paper use, postage and administrative burden. The delay to the eCare rollout until April 2027 has postponed some wider sustainability benefits, including a reduction in paper consumption, waste and carbon emissions, these benefits are being explored currently.

Mitigation: Further work is needed to understand and reduce the environmental impact of the digital estate, including energy use across systems and data centres.

2.4 **Medicines and Medical Gases** – at risk

The piped nitrous oxide manifolds at St Michael's Hospital and West Cornwall Hospital have now been fully decommissioned, with services transitioning to cylinder-based provision to minimise leakage, reduce wastage and lower associated carbon emissions. A trial of cylinder provision within obstetric theatres at Royal Cornwall Hospital (Treliske) is due to commence and, if successful, will enable the remaining nitrous oxide manifolds to be decommissioned by the end of the year.

The new Women's and Children's Hospital will incorporate efficient medical gas management systems within the design of the new build, with these considerations included as part of the Outline Business Case.

Quality improvement projects also continue to support increased use of Dry Powder Inhalers (DPIs), which have a significantly lower carbon footprint than pressurised Metered Dose Inhalers (MDIs) as they do not rely on high global warming potential propellants.

Mitigation: Further audits are required across the Trust to better understand inhaler use and identify further opportunities to reduce emissions and support more sustainable prescribing practices.

2.5 **Travel and transport –** at risk

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NHS England requires all trusts to have a trust wide Sustainable Travel Strategy by March 2027, all new NHS-owned or leased vehicles to be zero-emission from 2027, and a 50% reduction in staff travel emissions by 2033. Progress is currently constrained by funding and resource limitations. In the short term, the Trust needs to better understand staff and

patient travel patterns to inform the development of an organisation Sustainable Travel Strategy and updated Travel and Transport Policy, while continuing to work with Cornwall Council on wider transport challenges and opportunities. The Trust is maximising available NHS funding opportunities when available to expand electric vehicle charging infrastructure in preparation for the transition to zero-emission vehicles, although progress is dependent on successful funding bids to NHS England and the available electrical capacity at Royal Cornwall Hospital (Treliske).

Mitigation: The Trust is currently reviewing the NHS England Sustainable Travel Strategy requirements to better understand what is deliverable before March 2027.

2.6 Estates and facilities

Heat decarbonisation – at risk

The Trust is committed to achieving net zero carbon by 2040, but delivery will require significant investment in heat decarbonisation, energy efficiency, estate electrification and supporting infrastructure. Key priorities include developing a comprehensive Heat Decarbonisation Plan, improving estate energy performance, upgrading electrical infrastructure, and exploring the connection opportunities to the proposed Langarth District Heat Network. Specialist external support and substantial capital funding will be required to develop and implement these plans, however they are expected to deliver long-term carbon and financial benefits.

The Women & Children's Hospital programme continues to embed sustainability at the core of design and delivery, with a strong focus on net zero alignment, low-carbon construction approaches, and whole-life environmental performance in line with the Trust's Green Plan and NHS Net Zero Carbon Building Standard. RIBA 2 designs are currently being revised to bring them in line with Hospital 2.0 requirements. Building Energy performance targets will be set for use in RIBA 3 design stage.

Discussions continue on connecting the Trust to the planned Langarth District Heat Network, which could provide low-carbon geothermal heat for the future, although significant investment and dedicated resource are required to progress this opportunity. The connection to the district heat network, could adopt a two-step approach; first connecting the Women's and Children's Hospital before connecting to the wider estate. Solar assessments across the estate have also been completed, and estate improvements continue in line with NHS Net Zero Building Standards, but only where capital funding and resource is available to manage this process.

Mitigation: The Trust has been working with Arup to finalise a heat decarbonisation plan for the Royal Cornwall Hospital (Treliske) as part of the Women and Children's Hospital development and will continue to explore alternative funding opportunities to deliver decarbonisation projects on the ground, and across the wider estates.

Waste management – at risk

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Waste management presents a significant risk and opportunity to reduce both financial cost and carbon emissions. National guidance, including the NHS Clinical Waste Strategy and HTM 07-01, requires better waste segregation, reducing clinical waste volumes and increasing recycling rates. Poor current segregation practices are impacting disposal costs to the Trust and the associated environmental impact, also meaning the Trust is not

compliant to national standards. Developing a Trust-wide Waste Strategy should therefore be a priority to ensure compliance, maximise recycling, reduce waste disposal costs and support national (and local) carbon reduction goals. Initial work has already begun working with waste contractors to identify improved segregation opportunities, refreshing the Waste Management Safety Group and updating the Trust's Waste Management Policy, which will also include a review of mandatory waste training for staff.

Mitigation: The refreshed Waste Management Safety Group will take forward delivery of these issues.

2.7 Supply chain and procurement - on track

Supply chain emissions are the largest source of NHS carbon emissions, making sustainable procurement a key priority for the Trust. NHS suppliers are required to demonstrate progress towards net zero from April 2027, with product-level carbon foot-printing requirements following in April 2028. In response, the Trust is strengthening its approach to sustainable procurement and social value in line with the NHS Net Zero Supplier Roadmap. Training is being developed for staff, contractors and suppliers in partnership with Cornwall Partnership NHS Foundation Trust, while a new Social Impact Strategy is also being developed to guide the Trust's future approach to social value. The greatest risk is non-compliance within the supply chain which the Trust has limited influence and direct control over.

2.8 Food and nutrition - on track

Good progress has been made in sustainable food provision through segregation of patient food waste and onward disposal through anaerobic digestion working with our waste provider BIFFA. A digital menu system and sustainable food packaging has been adopted, alongside sourcing 80% of food from local suppliers, farmers and growers. Work is now underway to develop seasonal menus and explore opportunities to include carbon footprint information within the digital menu system, helping patients make more sustainable food choices while further reducing the environmental impact of catering services.

2.9 Adaptation – at risk

This year, we have experienced the impact of multiple extreme weather events on our patients, staff, sites and services. Forecasters are now predicting the forthcoming El Nino climate phenomenon is due to be the strongest in living memory and will most certainly cause more intense storms this winter and further extreme heatwaves during 2027. Rising temperatures, flooding and severe weather pose increasing risks to estate resilience, patient safety, staff wellbeing and service continuity. Completing the Trust's Climate Change Risk Assessment is therefore a key priority to identify vulnerabilities and develop adaptation measures. This work will be undertaken over the next 6–12 months using the NHS Climate Adaptation Framework and will inform the existing corporate risk 8301, climate resilience planning, mandatory climate-related financial disclosure requirements, and an updated Climate Change Adaptation Plan.

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2.10 Green spaces for health – on track

The Trust benefits from extensive green spaces across its sites, including specialist therapeutic gardens such as the Critical Care Garden at Royal Cornwall Hospital (Treliske)

and the Marie Therese Garden at St Michael's Hospital. Recognising the importance of green spaces for health and wellbeing, a Green Spaces for Health Strategy is being developed to support staff, patients and visitors, enhance biodiversity, and strengthen social value across the estate while contributing to the Cornwall Council Local Nature Recovery Strategy. The strategy will align with the Trust's Social Impact Strategy and work with the Hospital Charity to support future improvement projects.

3. Risks

Based on the assessment above, there is a significant risk that the Trust will be unable to deliver all the objectives and commitments set out within the Green Plan, which also puts at risk the Trust's ability to meet the national 2040 net zero target. Delivery is dependent on sustained investment, organisational capacity, effective governance, and the successful implementation of several major interdependent programmes. Failure to deliver the Green Plan extends beyond the risk of not achieving the Trust's net zero ambitions, it may also impact the Trust's ability to:

- Improve energy security and self-sufficiency.
- Meet future electrical capacity requirements associated with estate expansion and electrification.
- Improve and maintain resilience to climate-related disruptions and energy market volatility.
- Reduce long-term operational and utility costs.
- Meet NHS England sustainability and regulatory requirements.
- Demonstrate leadership as an Anchor Institution within Cornwall and the wider health system.
- Deliver broader strategic objectives relating to resilience, infrastructure, financial sustainability and population health.

Mitigation: The delivery of the Green Plan (2025-2028) has been assessed by the Executive Risk Group and approved as a new corporate risk, subject to approval by the Audit and Risk Assurance Committee and will be included on the corporate risk register, with a series of key performance metrics agreed as milestones.

4. Next steps

The key actions for the period are as follows:

- Refresh the Green Plan Oversight Group (GPOG) as the key forum for engagement and oversight of Green Plan programme delivery, including a detailed breakdown of specific milestones.
- Appoint a clinical sustainability lead and formalise the clinical sustainability leads group.
- Review the current carbon footprint for the Trust, noting national publication of carbon footprints is expected from NHS England later this year for 2025-26.
- Develop a communications and engagement plan
- Support estates and facilities colleagues to develop a new waste strategy, sustainable travel strategy, and finalise the green spaces for health strategy
- Explore funding options for the development of a heat decarbonisation plan
- Commence the climate change risk assessment to inform the forthcoming Taskforce Financial Climate Disclosures (TCFD – this is a national requirement)

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- Develop a sustainability skills matrix for staff, including a development session for the Board.
- Develop a prioritised list of investment requirements, so that the Trust is ready to respond as external funding opportunities arise.

5. Accountability

The Chief Strategy Officer is the Executive lead for sustainability. The next update will be received by Finance & Performance Committee in March 2027 and Public Board in April 2027.

6. Recommendations

The Committee **is recommended to:**

- **Note** the progress against the Trust's Green Plan with ongoing management by the new Sustainability Manager.
- **Discuss and note** the risks associated with the delivery of the Trust Green Plan have been added to the corporate risk register owing to the broad and far-reaching impacts of failure to making progress against the green agenda.

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30/10/2026 09:31:09

Appendix 1 – RCHT People's Emergency Briefing on Climate Change
Knowledge Spa, 15 July 2026

1. Introduction

Following the rescheduling of the original event due to the extreme heat experienced in late June, a timely reminder of the very issues being discussed, the People's Emergency Briefing on Climate Change took place on 15 July 2026 at the Knowledge Spa. While attendance was modest, the session generated thoughtful, passionate and emotionally engaged discussion. Participants reflected on both the urgency of the climate crisis and the role that RCHT can play in responding through delivery of its Green Plan. The themes raised aligned closely with the NHS Net Zero agenda and the key action areas within the RCHT Green Plan.

2. Emotional Response

The immediate emotional response to the film was significant and should not be overlooked. Participants described feelings of:

- **Frustration** about the pace of change and perceived barriers to implementing solutions such as solar energy and electric vehicle infrastructure
- **Anger** regarding the scale of the climate emergency and the actions of organisations and governments.
- **Sadness** about environmental degradation and biodiversity loss.
- **Hope** that collective action through organisations such as the NHS can make a meaningful difference.

Importantly, these emotions translated into a desire for action rather than disengagement. Staff expressed a clear appetite to become part of the solution and wanted greater visibility of what RCHT is already achieving through its sustainability programme.

3. Participant feedback

Feedback from the event has been aligned with the RCHT Green Plan pillars for action and are set our below;

3.1 Leadership, Workforce and Sustainable Culture

A recurring theme was the need to strengthen sustainability awareness and embed climate action into organisational culture. Participants suggested:

- Including sustainability and climate awareness staff training and induction processes.
- Including sustainability and climate awareness staff training and induction processes.
- Considering whether elements should feature within mandatory training.
- Creating more opportunities for staff engagement and discussion.
- Building networks of sustainability advocates and champions.
- Sharing examples of teams already making a positive difference such as libraries and catering.
- Encouraging staff to engage with local and national decision-makers on climate issues

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3.2 Communication, Engagement and Behaviour Change

The strongest area of feedback related to communication. Participants felt that many staff are unaware of:

- Sustainability projects already underway.
- Environmental improvements already delivered.
- Financial savings generated by sustainability initiatives.
- Partnership work taking place across Cornwall's health and public sector organisations.

Suggestions included:

- Sharing success stories more regularly.
- Promoting examples of local leadership.
- Showing measurable benefits and outcomes.
- Making the climate film more widely available.
- Using events such as Green Library Week to build awareness and momentum.

3.3 Food and Nutrition

Food and catering generated considerable discussion, focusing on both environmental sustainability and health outcomes.

Topics included:

- Increasing awareness of local food sourcing
- Supporting plant-based food choices for staff and patients.
- Seasonal menu provision.
- Understanding what happens to surplus food.
- Exploring opportunities to reduce food waste.
- Reviewing whether healthy and sustainable food choices are sufficiently promoted.
- Interest in the possible return of the salad bar at The Royal.

3.4 Estates, Facilities and Circular Economy

Staff expressed interest in practical solutions which demonstrate reuse, repair and community benefit. Suggestions included:

- Developing a Social Shed or Repair Café model to reduce the amount of bulky waste disposed of (££ and carbon costs)
- Exploring support through Charitable Funds

3.5 Travel and Transport

Travel remains one of the most visible sustainability challenges for staff.
Issues highlighted included:

- Difficulties accessing the Truro site by public transport, not currently served by the Park & Ride.
- The need for improved active travel routes to and from sites.
- Better pedestrian/cycling links to the local Park and Ride facilities.
- Expansion of electric vehicle charging infrastructure.
- Opportunities to work alongside Cornwall Foundation Trust on shared transport solutions.

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4. Next steps

4.1 Immediate Actions (Next 3 Months)

- Share a summary of the event and feedback with attendees and wider staff.
- Explore options for wider viewing of the climate film.
- Develop a Green Plan communications and engagement campaign highlighting current achievements, carbon reductions and cost savings.
- Identify opportunities to strengthen sustainability content within induction, training and leadership programmes.
- Rejuvenate the Green Champions Network to maintain engagement

4.2 Medium-Term Actions (3-12 Months)

- Publish regular Green Plan progress updates linked to staff stories and measurable impact.
- Undertake a review of surplus food management and healthy sustainable food options.
- Support the development of the Social Shed initiative to reduce the quantity of unnecessary bulky waste disposal (cost and carbon)
- Continue working with partners to address public transport and active travel barriers.
- Promote collaborative sustainability initiatives with Cornwall Foundation Trust and Cornwall Council.

5. Conclusion

The event demonstrated that the values and priorities of staff are strongly aligned with the ambitions of the RCHT Green Plan. While participants expressed feelings of frustration, sadness and concern about the scale of the climate challenge, these were balanced by hope and a strong desire to contribute. The clearest opportunity for RCHT is to build on this enthusiasm by improving communication, celebrating progress already made, and creating more opportunities for staff to engage with and support Green Plan delivery.

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 15

Title of Report: People and Culture Committee Assurance Report to the Board – September 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:

- Recommended approval of the People Plan
- Recommended the Board consider the Provider Capability Self-Assessment should reflect the assurance gaps identified by the Committee. Members specifically questioned whether Amber-Green remained appropriate for the workforce elements of the capability assessment.

Issues for escalation or notification to the Trust Board`

Insufficient improvement in key people metrics. Despite significant activity and investment of effort, the Committee was not assured that sufficient progress nor improvement in outcomes had been achieved across several priority workforce measures, particularly appraisals, workforce pressures, stress-related absence and aspects of staff experience; and recommended that a more structured approach to recovery is required.

Summary of assurance and risk

Neave, Lynsey
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The Committee welcomed the **Chief People Officer report** which provided an overview of the national, regional and local workforce context. Future reporting could strengthen the link between national initiatives and the outcomes the Trust was seeking to achieve. Updates included alignment between the staff survey, staff standards, Integrated Performance Report and NHS Oversight Framework; the system-wide High Potential Scheme; Transforming People Services; and preparations for Oliver McGowan training.

The Committee welcomed the significantly improved workforce component of the **IPR** and the greater visibility of key workforce indicators and drivers. However, members were concerned that the overall direction of travel across several people metrics had deteriorated compared with July, including workforce pressures, stress-related absence and mandatory training, whilst appraisal performance remained a particular concern.

The Committee heard that appraisal performance was associated with a range of other organisational indicators. Members therefore emphasised the importance of understanding workforce performance through triangulation rather than considering individual measures in isolation.

Medicine Division was repeatedly identified as an area where workforce, quality, operational and financial pressures were intersecting. Members also highlighted the potential impact of strengthened financial controls on workforce and quality measures and the importance of triangulation across FPC, QAC and PCC.

PCC has repeatedly requested quantified trajectories, divisional recovery plans, clear milestones and evidence of impact across appraisal compliance, mandatory training, sickness absence, psychological safety and staff experience measures. The Committee did not consider that it had sufficient assurance of progress across key people metrics, nor a sufficiently clear recovery trajectory setting out what would improve, by when and with clear accountability. It was felt that a structured recovery programme needed to be developed to give confidence that the actions undertaken translate into better outcomes

The Chief Operating Officer and Dual Chief People Officer agreed to develop a workforce improvement and workforce recovery programme. This was also to incorporate relevant culture programme activity and to provide clearer assurance that interventions were producing improvements.

The Committee reviewed the Workforce Assurance Report and expressed significant concern about appraisal performance. The commitment in the staff survey action plan that all staff would have an up-to-date appraisal conversation by August 2026 had not been achieved, and the Committee could not identify evidence that the intended improvement in appraisal quality had been measured.

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30/10/2026 09:31:09

Members agreed that continuing the existing approach was unlikely to be sufficient and considered options including a shorter appraisal format, better communication, targeted interventions in Medicine Division, team-based approaches, designated appraisal periods and the possible relationship between appraisal completion and pay progression. Any pay-related approach would require careful consideration of Agenda for Change provisions, established practice, fairness and employee-relations implications.

The Committee supported a targeted approach, in hotspot areas rather than relying solely on organisation-wide interventions. It requested greater clarity about mandatory training non-attendance, accountability for improvement, and whether lessons could be learned from improved health and safety training compliance.

The Chair proposed periodically inviting divisional representatives to Committee, beginning with Medicine, to strengthen direct assurance about implementation and accountability at a divisional level.

The Committee concluded they had limited assurance particularly in relation to appraisal performance and delivery of previously agreed improvement commitments.

The Committee welcomed the revised **Professional Standards** report and improved visibility of data and trends. It noted 293 formal employee cases over the rolling year, alongside ongoing employment-related legal matters and associated potential liabilities. Despite increasing demand, benchmarking indicated comparatively strong case-management performance.

The Committee also requested improved proportional reporting of divisional hotspots, for example relative to workforce size, together with longer-term analysis of case themes. Members required further assurance sought on trends, preventative action, external investigation quality, legal costs and emerging professional-conduct themes.

Discussion emphasised upstream intervention, including managers' confidence in addressing difficult issues early and greater use of restorative approaches. The next report is expected to include longer-term analysis of themes and greater information on legal expenditure.

The Committee remained concerned about **stress and mental health-related absence.** It heard that this remained at approximately 25–30% of absence, with the IPR showing stress-related absence increasing from 30% to 32% in the latest reporting period discussed.

Neave Lynn
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A range of interventions was underway, including bespoke support with Mind, resilience initiatives and work through Occupational Health and the Health and Wellbeing team. However, the Committee could not establish clearly which interventions were driving improvement, and gaps remained in data collection and

impact evaluation. The Committee asked for stronger trend analysis, clearer evidence of intervention effectiveness and support from business intelligence where necessary to enable appropriate triangulation.

Committee members concluded they had limited assurance - interventions were evident, but improvement in outcomes had not yet been demonstrated and data limitations constrained evaluation of effectiveness.

The Committee welcomed progress within **Occupational Health** but emphasised that future assurance needed to demonstrate the service's impact, including referral volumes, waiting times, service-user and manager feedback, return-to-work outcomes and contribution to reducing sickness absence.

Members remained concerned about unresolved Occupational Health accommodation and urged Estates to prioritise the necessary work. The Committee also requested confirmation of outstanding recommendations from the previous Occupational Health review, including health surveillance requirements.

The Committee emphasised the need to view Occupational Health, EAP and preventative wellbeing interventions as one coherent system and understand their combined impact. Overall, the Committee were partially assured, but wanted further assurance regarding measurable impact, outstanding review recommendations and accommodation.

The Committee welcomed the closer alignment of staff survey actions with the **We Are RCHT Culture Programme** and noted continuing leadership network activity and planned recruitment of two additional culture practitioners. However, members identified a significant reporting and assurance gap. In integrating staff survey actions within the wider culture programme, visibility had been lost over whether some original commitments had been delivered and whether they had achieved the intended impact. Examples included completion of appraisal conversations and appraisal quality audits.

The Committee requested clearer reporting against the original staff survey action plan commitments, including measurable progress and RAG-rated delivery. There were encouraging indications around staff advocacy, but continuing concerns remained around speaking up and confidence in the organisation's ability to provide care.

The Committee concluded that they were partially assured. Considerable activity was evident, but the next Culture Assurance Report should give evidence of improvement in leading indicators and evidence local measures of success so that we can evidence that staff engagement is improving and that the Culture Transformation Approach is having an impact, and that impact against agreed staff survey priorities is also evidenced.

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30/10/2025 08:31:09

The Committee welcomed the **People Plan** and extensive co-production undertaken with staff networks, staff-side representatives and inclusion leads. The plan was considered well aligned with the Trust Strategy, People Promise, staff standards and the emerging leadership and management framework.

The Committee noted that a supporting delivery plan would translate the strategy into KPIs and measures of success for ongoing monitoring through PCC. The Committee supported the plan and proposed governance arrangements and recommended it onwards for Trust Board approval.

The Committee strongly welcomed the proposed **organisational development and leadership approach,** including closer working between RCHT and CFT and the longer-term ambition to support system and neighbourhood leadership. The approach emphasised compassionate and inclusive leadership, management capability, staff wellbeing, culture and integration.

Experience from CFT was discussed, including improved appraisal performance and increased staff survey participation following sustained investment in OD and workforce analytics. Members supported the use of measurable outcomes and dashboards to identify where targeted intervention was required.

The Committee endorsed the proposed principles and encouraged the Executive Team to progress the approach, whilst recognising that wider neighbourhood working extends beyond RCHT and CFT and will require engagement with other system partners.

The Committee received an update on progress following the **eRoster internal audit** and noted that a Financial Sustainability Plan had been developed incorporating a proposed 50% reduction in net hours balances, together with targeted reductions in agency, overtime and additional-duty-hours expenditure. Work was also underway to consider centralised, devolved and hybrid rostering models.

The Committee sought assurance that implementation would result in demonstrable improvement and asked whether elements of the audit action plan could be accelerated, particularly where they could support operational performance. Further work was underway to translate efficiency targets into financial values.

The Committee were reasonably assurance that actions were underway, with continued monitoring required to demonstrate delivery of operational and financial benefits.

The Committee received an update on the forthcoming staff **flu vaccination campaign** and noted the intention to build on the previous year's approach through clinics, roaming provision and incentives, with an ambition to increase uptake.

Neave Lynch
30/10/2025 09:31:09

A key concern was that the communications strategy requested previously had not yet been presented. Members considered this time-critical and requested that it be circulated before commencement of the campaign rather than waiting for the next Committee meeting. Greater understanding of barriers to uptake and more targeted communications were also requested.

The Committee also discussed potential benefits from a more integrated system approach to vaccination provision across RCHT, CFT and primary care. Members recommended more timely delivery of the communications and engagement approach and continued monitoring of uptake.

The Committee welcomed progress with delivery of the **Sexual Safety Charter, Sexual Misconduct Policy and Domestic Abuse and Sexual Violence Strategy.** Governance and reporting arrangements had been established, 34 allies had been trained, a further 14 were awaiting training, and the allies network had received 23 staff referrals.

The Committee were briefed on sexual misconduct referrals and heard that staff-survey evidence indicated significant under-reporting and therefore agreed that an increase in reporting could initially indicate greater confidence in speaking up rather than deterioration.

Discussion focused on barriers to reporting, learning from cases, identification of emerging hotspots, experiences of inappropriate behaviour by patients towards staff, communications and ensuring staff voices were heard. The Committee welcomed planned awareness activity in February.

The Committee noted that the **BAF** remained under review and would be updated following the Committee discussion before further consideration through the governance process. Members questioned whether existing risk scores remained reflective of the position given the absence of improvement across several workforce metrics. The Committee requested stronger alignment with the Provider Capability Assessment and clearer reflection of the assurance gaps identified during the meeting.

The Committee considered the emerging **Provider Capability Self-Assessment** ahead of submission to Trust Board. The proposed ratings were predominantly Amber-Green; however, members questioned whether this gave an appropriately candid assessment given current workforce, UEC and financial challenges.

Members considered that the workforce elements warranted an Amber-Red assessment. Members recognised the difficulty created by the absence of a middle Amber category, particularly where plans were in place and problems understood but measurable impact had not yet been demonstrated. It was confirmed that the final assessment would be for Trust Board to determine as a Board assurance statement.

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The Committee noted the Medical Education Annual Report the Clinical (Non-Medical) Education Annual Report the; Trust Strategy Bi-Annual Implementation Report and; the Strategic Workforce Group Exception Report

Neave,Lynsey
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Meeting: Trust Board in Public

Date of Meeting: 5 November 2026

Item Number: 15.1

Title of Report: RCHT People Plan 2026 - 2030

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

Author and Job Title: Alison Thorne-Henderson, Dual Chief People Officer

Email Address: alison.thorne-henderson1@nhs.net

Purpose of the Report:

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

The purpose of this report is to present the updated RCHT People Plan 2026–2030 following consultation with Staff Side representatives, Staff Network Chairs and inclusion leads, and to seek approval for the Plan to progress through the next stage of governance. The report summarises the principal consultation themes, the amendments made in response and the proposed arrangements for delivery and assurance.

Consultation:

The People Plan has previously been considered by the Executive Leadership Team and has subsequently been shared with Staff Side representatives, Staff Network Chairs and inclusion leads. Feedback was supportive of the overall direction, structure and priorities of the Plan and did not identify a need for significant restructuring.

The principal themes raised related to the quality and consistency of line management, inclusive leadership, neurodiversity, psychological safety, staff voice, meaningful development conversations, preventative wellbeing, reasonable adjustments, support for disabled colleagues, colleagues with long-term conditions and carers, and belonging for internationally educated colleagues.

The Plan has been amended in response to this feedback. Key changes include clearer commitments on neuro-inclusion, Staff Network co-production, regular development and career conversations, organisational causes of poor wellbeing, reasonable adjustments and support for internationally educated colleagues. The detailed delivery plan will

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continue to be developed in partnership with Staff Side, Staff Networks and relevant colleagues with lived experience.

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?	☒			No adverse impacts have been identified at this stage. Consultation feedback has strengthened the Plan's consideration of neurodiversity, disability, long-term health conditions, carers, reasonable adjustments, anti-racism, internationally educated colleagues, Staff Networks and equitable access to employment, development and progression. Equality impacts will continue to be reviewed through the annual delivery plan and as individual actions or programmes are developed.
Quality Impact Assessment completed?			☒	Not applicable as this is a strategic workforce plan rather than a service change or clinical pathway proposal. Quality benefits are expected through improved staff experience, leadership, wellbeing, safety and workforce sustainability.
Data Protection Impact Assessment completed?			☒	Not applicable at this stage. Any future work involving new systems, data collection or staff-level data will be reviewed through the appropriate information governance route.

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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	The Plan supports improved population health by strengthening the workforce needed to deliver safe, effective and sustainable care for communities across Cornwall. It includes priorities on staff wellbeing, inclusion, local employment pathways, neighbourhood working and prevention.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The Plan is expected to improve quality by supporting safer staffing, stronger leadership, improved teamworking, better staff experience, reduced harm and increased time for care, improvement and research.
Sustainable and efficient use of NHS resources by RCHT	The Plan supports sustainable use of resources through improved retention, reduced sickness absence, local workforce pipelines, reduced reliance on temporary staffing, improved job design, digital enablement and workforce planning aligned to future service models.

Recommendation(s):

The Trust Board in Public is recommended to:

- **Note** that feedback was received from Executive Leadership Team, Staff Side representatives, Staff Network Chairs and inclusion leads and included within the paper presented today (a summary of consolidated feedback is in appendix 2);
- **Note** that the feedback was supportive of the overall direction and priorities of the People Plan and did not require significant restructuring;
- **Approve** the RCHT People Plan 2026–2030;
- **Support** continued co-production of the annual delivery plan with Staff Side, Staff Networks and relevant colleagues with lived experience to execute the plan; and

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- **Endorse** the proposed governance and assurance arrangements, including annual delivery planning and a quarterly People Plan assurance dashboard to be reported through the People and Culture Committee.

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RCHT People Plan 2026-2030

1. Situation / Executive Summary

This paper presents version 8 of the RCHT People Plan 2026-2030 for Executive Leadership Team approval to progress to the People and Culture Committee. The Plan sets out the Trust's strategic approach to supporting, developing and valuing colleagues so that they can deliver Outstanding Care for One and All. It aligns with the Trust Strategy 2026-2035, NHS People Promise, NHS Staff Standards, NHS Leadership and Management Framework and Medium-Term Integrated Workforce Plan.

2. Background

The People Plan has previously been presented to ELT and has been updated to version 8. It has been reviewed by Staff Side and Staff Networks. The Plan responds to local workforce intelligence, the 2025 NHS Staff Survey, national workforce pressures and the requirements of system transformation. It has six priorities: staff health, wellbeing and safety; compassionate and inclusive leadership; sustainable workforce models; local pipelines and partnerships; inclusion and belonging; and releasing time to care, improvement and research.

3. Assessment

The Plan provides a clear framework for delivery, assurance and improvement over 2026-2030. It strengthens alignment between workforce priorities, the Culture Programme, NHS Staff Standards, University Hospital Status, Cornwall Medical School, digital transformation, neighbourhood working and local education and employment pipelines. Delivery will be overseen through the People and Culture Committee, supported by annual delivery planning and a quarterly People Plan assurance dashboard.

Changes following consultation

Consultation feedback broadly endorsed the proposed direction and six priorities of the People Plan. No significant restructuring was proposed. Amendments have therefore focused on strengthening existing commitments rather than changing the overall framework.

Changes include:

- explicit commitments relating to neurodiversity and neuroinclusive employment practice;
- stronger expectations for compassionate, inclusive and accountable line management;
- greater emphasis on regular development, career and wellbeing conversations throughout the year;
- recognition of Staff Networks as partners in co-production and organisational improvement;
- clearer "You Said, We Did" arrangements;

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- a stronger preventative approach to wellbeing, including workload, fatigue, rest, flexibility and workplace conditions;
- greater visibility of disabled colleagues, colleagues with long-term conditions and carers; and
- strengthened commitments to belonging, community connection and retention for internationally educated colleagues.

These amendments strengthen the Plan without changing its six-priority structure.

4. Risk

Key risks relate to delivery capacity, workforce pressures, consistency of leadership and management practice, staff engagement, financial constraints and the ability to demonstrate measurable improvement over time. These risks will be mitigated through clear governance, partnership working with Staff Side and staff networks, annual delivery planning, quarterly assurance reporting, and escalation through the People and Culture Committee where progress is off track.

If the Plan is not approved and implemented, there is a risk that workforce, culture, wellbeing, inclusion and leadership improvement activity becomes fragmented, weakening assurance and reducing the Trust's ability to respond to national standards and local workforce priorities.

There is also a risk that the Plan's inclusion and staff-experience commitments are perceived as insufficiently responsive to consultation if the amendments are not visible, measurable and reflected in delivery arrangements. This will be mitigated through publication of the principal consultation themes, clear alignment between feedback and amendments, continued co-production with Staff Side and Staff Networks, and inclusion of relevant measures within the quarterly assurance dashboard.

5. Accountability

The Dual Chief People Officer is accountable for delivery, supported by the Executive Team, Divisional leadership, POD, OD, EDI, staff networks, recognised trade unions, Staff Side representatives and relevant assurance groups.

The People and Culture Committee will receive regular assurance, with further reporting to Trust Board as required. A strategic delivery plan will be developed to monitor annual progress, milestones, owners, key performance indicators, risks and assurance routes.

6. Recommendations

The Trust Board in Public is recommended to:

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- **Note** that feedback was received from Executive Leadership Team, Staff Side representatives, Staff Network Chairs and inclusion leads and included within the paper presented today;

- **Note** that the feedback was supportive of the overall direction and priorities of the People Plan and did not require significant restructuring;
- **Approve** the RCHT People Plan 2026–2030;
- **Support** continued co-production of the annual delivery plan with Staff Side, Staff Networks and relevant colleagues with lived experience to execute the plan; and
- **Endorse** the proposed governance and assurance arrangements, including annual delivery planning and a quarterly People Plan assurance dashboard to be reported through the People and Culture Committee.

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RCHT People Plan 2026–2030

Delivering Outstanding Care for ‘One and All’ through Supported and Valued People

Royal Cornwall Hospitals NHS Trust

2026–2030

NB PHOTOS TO BE ADDED BY COMMUNICATION TEAM BY TRUST BOARD SUBMISSION

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Foreword and Sign-off

Our people are at the heart of everything Royal Cornwall Hospitals NHS Trust does. The experience of colleagues directly shapes the quality, safety and compassion of care we provide for patients, families and communities across Cornwall. This People Plan sets out our shared commitment to creating the conditions where every colleague feels supported, valued, included and able to do their best work.

The next four years will bring significant opportunity and challenge. We will need to respond to changing population needs, national workforce pressures, new models of care, digital transformation and the opportunities created through University Hospital Status and Cornwall Medical School. To succeed, we must continue to invest in compassionate leadership, strong team working, staff wellbeing, inclusion, learning and development, and the redesign of work so colleagues have more time for care, improvement and research.

This Plan is also a statement of accountability. It aligns our local ambitions with the Trust Strategy, the NHS People Promise, the NHS Staff Standards and the NHS Leadership and Management Framework. It describes how we will use evidence, staff voice and partnership working with trade unions and staff side colleagues to understand what is working well, where improvement is needed, and how we will track progress over time.

We recognise that improvement will only be meaningful if it is felt by colleagues in their day-to-day experience of work. Delivery of this Plan will therefore require sustained leadership focus, honest reflection, constructive challenge and practical action across Divisions, corporate teams and system partners. Through this shared commitment, we will build a stronger, more inclusive and sustainable workforce, enabling outstanding care for one and all.

Signed by:

Alison Thorne-Henderson and Richard Kramer

Dual Chief People Officer and Chair of People and Culture Committee

Photos to be added by the Communications Team before Trust Board submission.

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Executive Summary

The RCHT People Plan 2026-2030 sets out how Royal Cornwall Hospitals NHS Trust will support, develop and value its workforce as a core enabler of Outstanding Care for One and All. It aligns to the Trust Strategy 2026-2035, the NHS People Promise, the NHS Staff Standards, the NHS Leadership and Management Framework and the Medium-Term Integrated Workforce Plan. It also recognises the strategic workforce opportunities created by University Hospital Status and Cornwall Medical School, particularly in strengthening recruitment, retention, education, research, academic careers and local training pipelines. Its ambition is to make RCHT a top-performing Trust for staff experience, leadership, wellbeing and inclusion, with colleagues proud to work here and confident to recommend RCHT as an employer of choice.

The Plan responds to local workforce intelligence, the 2025 NHS Staff Survey, national workforce pressures and the requirements of system transformation. It also reinforces RCHT's role as one of the county's largest employers and an anchor institution, with a responsibility to widen employment prospects, apprenticeships and career pathways for local communities. It focuses on six priorities: health, wellbeing and safety; compassionate and inclusive leadership; sustainable workforce models; local pipelines; inclusion and belonging; and releasing time to care, improvement and research.

The Plan also responds directly to the three shifts described within the NHS 10 Year Plan for Health: from hospital to neighbourhood care, from treatment to prevention and from analogue to digital. Workforce redesign, educational partnerships, research and innovation, digital transformation and new multidisciplinary models of care will support the development of a workforce that is adaptable, productive and equipped to meet the changing needs of the population of Cornwall. University Hospital Status and Cornwall Medical School will provide important opportunities to strengthen workforce supply, research capability, educational partnerships and long-term workforce sustainability.

The Plan integrates with the RCHT Culture Programme, the NHS Staff Standards and the NHS Leadership and Management Framework, strengthening delivery expectations for line management, health and wellbeing, violence prevention and reduction, tackling racism, sexual safety, flexible working and consistent leadership and management capability. It provides a clear framework for annual delivery planning, assurance and improvement.

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The Plan is founded on genuine partnership working with recognised trade unions and staff side colleagues. RCHT will involve trade union representatives early, openly and meaningfully in the design, implementation and evaluation of

workforce, culture and service change; respect collective bargaining and consultation arrangements; share relevant information in good time; and seek jointly developed solutions wherever practicable. This partnership will support fair employment practice, safe and healthy workplaces, effective change, equality, staff voice and sustainable improvements for colleagues and patients.

Delivery will be overseen through the People and Culture Committee, supported by a quarterly assurance dashboard and annual delivery plan. Key outcomes will include improved staff experience, reduced sickness absence and turnover, stronger leadership capability, improved inclusion and better conditions for safe, high-quality care.

The People Plan is the enabling strategy for delivery of the Trust's Medium-Term Integrated Workforce Plan. Whilst the Medium-Term Integrated Workforce Plan identifies the workforce numbers, skills, roles and workforce supply required to deliver future services, the People Plan describes how RCHT will attract, develop, support, retain and engage the workforce needed to achieve those ambitions. Together, the two plans provide a coherent approach to workforce sustainability, capability, productivity and staff experience.

Our People Vision

Our People Vision is to build a supported, skilled and inclusive workforce who feel valued, listened to and proud to work at RCHT. We want every colleague to understand how their role contributes to Outstanding Care for One and All, and to feel enabled to give their best every day. We recognise that culture and leadership shape the lived experience of work. This Plan therefore places strong emphasis on compassionate and inclusive leadership, fairness, belonging and psychological safety. By investing in our people, we strengthen our ability to improve care, innovate and adapt to future challenges.

Using AI and digital tools to release time and build digital confidence. Digital literacy at RCHT will include confidence in using emerging AI-enabled tools appropriately, safely and ethically. We will support colleagues at all levels to understand what AI is, where it can help, and where human judgement remains essential. We will develop skills and competencies in AI to ensure risks are mitigated and that we do not neglect those vulnerable to the impact of AI across all generations.

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Strategic Context and Alignment

This People Plan is a key enabling strategy for the delivery of the RCHT Trust Strategy 2026-2035. It strengthens the workforce contribution of University Hospital Status and Cornwall Medical School, using education, research, academic development and local training opportunities to support recruitment, retention and future workforce supply. It supports the strategic objectives of Supported and Valued People, Safe High-Quality Care and Improving Together, through the work of our culture programme, which is illustrated below.

It aligns with national direction set out in the NHS 10 Year Plan for Health, which requires fundamental changes to how care is delivered – including a shift from hospital to community, from treatment to prevention, and from analogue to digital. These changes demand new skills, new workforce models and a renewed focus on staff wellbeing and engagement.

The Plan also reflects commitments within the NHS People Promise, NHS Staff Standards and NHS Leadership and Management Framework, and is informed by our Medium-Term Integrated Workforce Plan, ensuring that workforce growth, skills, management capability, affordability, University Hospital Status and Cornwall Medical School opportunities are aligned to clinical strategy and place-based workforce need.

The People Plan should be read alongside the Medium-Term Integrated Workforce Plan. The Medium-Term Integrated Workforce Plan provides the strategic assessment of future workforce demand, supply, productivity, skill mix and workforce redesign requirements. The People Plan complements this by setting out the organisational culture, leadership, inclusion, health and wellbeing, talent, education and workforce experience actions required to recruit, retain, develop and support the workforce identified within that plan. Delivery of both plans will be monitored through aligned governance and assurance arrangements.

Our ambition

The People Plan builds the foundations for empowered Divisions and Corporate Teams to feel proud that RCHT delivers Outstanding Care for One and All through Supported and Valued People.

We will achieve this by investing in leadership, workforce capability, skill mix redesign, educational partnerships, neighbourhood workforce models, digital transformation and research opportunities. Together, these actions will ensure colleagues are developed, supported and enabled to deliver outstanding care while building sustainable careers within Cornwall and the NHS.

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Engagement and co-production

The People Plan has been informed by engagement with Staff Side representatives, Staff Network Chairs and inclusion leads. Feedback was supportive of the overall direction and priorities of the Plan and has been used to strengthen commitments relating to inclusive leadership, neurodiversity, staff voice, belonging, meaningful development conversations, preventative wellbeing, reasonable adjustments and support for internationally educated colleagues.

Staff Side and Staff Networks will continue to be involved as partners in developing, implementing and evaluating the annual delivery plan. We will provide visible feedback on how colleague and representative input has influenced action through clear “You Said, We Did” arrangements.

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Evidence Base for 2026–2030

The Plan is grounded in evidence from the NHS Staff Survey, workforce intelligence, national policy and local engagement. This evidence indicates that the Trust should focus on the following core drivers of staff experience, workforce sustainability and care quality:

1. **High-Quality Line Management and Supportive Leadership**
   Strong, supportive and visible line management is repeatedly shown to be one of the strongest drivers of staff satisfaction and engagement. Supportive line management and well-structured team environments lead to less discrimination and a more supportive culture
2. **Well Structured, Meaningful Appraisals**
   High-quality annual appraisals, those with clear objectives, development focus, and a sense of feeling valued, are consistently among the strongest predictors of improved staff experience.
   The NHS Leadership and Management Framework now provides a national code, standards and competencies for clinical and non-clinical managers and leaders at every level. RCHT will align appraisal quality, management development, leadership programmes and talent conversations to this framework so that managers are supported to lead with confidence, consistency, compassion and accountability.
3. **Teamwork and Psychological Safety / Freedom to Speak up**
   Teams that work interdependently, meet regularly, and have shared objectives contribute significantly to staff morale and organisational outcomes. Teamwork is strongly associated with patient satisfaction and lower adverse events (through reduced burnout and improved communication). This creates an environment where there is trust in the organisation to act on concerns that are raised and improved ease of speaking up.
4. **Workload, Stress Reduction & Staff Wellbeing**
   Burnout, stress, and fatigue directly reduce staff satisfaction and increase errors. Staff burnout and stress are directly linked to adverse events and reduced patient satisfaction; improving wellbeing interventions mitigates this.
5. **Employee Voice & Involvement in Decision-Making**
   Feeling heard and involved strongly predicts satisfaction and engagement. The NHS People Promise highlights staff voice as a critical lever for staff engagement improvement. RCHT will strengthen this through formal and informal listening, with recognised staff networks and trade unions and staff side colleagues as a vital source of collective workforce insight. Representatives will be involved at the formative stage of plans, provided with timely and accessible information, given appropriate facilities and time

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to contribute, and supported to test proposals, identify workforce impacts and co-develop practical solutions.

6. **Equality, Diversity & Inclusive Culture**
   Reducing discrimination and improving fairness in career opportunities and daily treatment boosts satisfaction and trust performance. Equity of opportunities has a positive effect on staff outcomes, while aggression and discrimination have the strongest negative effects.
7. **Good Job Design: Autonomy, Clarity and Meaning**
   Staff are more satisfied when they have meaningful work, clarity about their role, and autonomy in how they perform it. Meaningful, well-designed roles with autonomy are strongly associated with higher engagement and lower burnout.
8. **Communication & Organisational Culture**
   Clear compassionate communication from leadership and within teams is a critical organisational driver. Communication quality is directly linked to better patient satisfaction and fewer adverse events. Engagement campaigns succeed when employer branding and communication is clear, human focused, compassionate, narrative-driven, and led from the top.

Aims of the People Plan

The aim of this People Plan is to translate the Trust Strategy, national people priorities and local workforce evidence into a clear programme of action for 2026–2030. It sets out how RCHT will support, develop and value colleagues so they can deliver safe, high-quality, compassionate care and feel proud to work here.

The Plan will provide a consistent framework for annual delivery planning, assurance and improvement. It will help the Trust focus on the areas that matter most to colleagues and patients: wellbeing and safety, compassionate and inclusive leadership, sustainable workforce models, local education and employment pipelines, inclusion and belonging, and releasing time for care, improvement and research.

By 2030, the Plan aims to improve staff experience and advocacy, strengthen leadership and management capability, reduce avoidable workforce harm, improve inclusion, support retention and workforce sustainability, and create clearer evidence of progress through Board and committee assurance.

People Plan Priorities

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The People Plan is structured around six strategic priorities which reflect both national evidence and local feedback from our workforce. These priorities provide a clear framework for action over the next four years.

1. Leading the way in supporting staff health, wellbeing and safety, ensuring support is visible, accessible and proactively promoted.
2. Ensure leaders and managers have the capability, confidence and accountability to lead compassionately, inclusively and effectively, applying people policies fairly and consistently and creating a positive day-to-day experience for colleagues.
3. Developing sustainable workforce models aligned to neighbourhood health, integrated care and new ways of working.
4. Building strong local pipelines into clinical and non-clinical careers through education, apprenticeships, Cornwall Medical School, University Hospital Status, talent development and anchor institution partnerships.
5. Celebrating diversity of all staff and the contribution of globally educated colleagues, fostering inclusion and belonging.
6. Releasing time to care, quality improvement and research by improving job design, processes and digital enablement.

Alignment with the NHS Staff Standards:

The NHS Staff Standards, published on 6 July 2026, set national minimum employment requirements for secondary care organisations across six areas: line management, health and wellbeing, violence prevention and reduction, tackling racism, championing sexual safety and promoting flexible working. This People Plan has been reviewed against those standards and now explicitly incorporates the required linkages, improvement opportunities, assurance arrangements and delivery measures.

People Plan priority	**NHS Staff Standards linkage**	**Improvement implications for delivery**
Supporting staff health, wellbeing and safety	Health and wellbeing; violence prevention and reduction; championing sexual safety	Strengthen proactive wellbeing risk assessment, rest and recovery spaces, violence reduction actions, safe reporting routes, post-incident support and Board-level oversight of psychological and physical safety.
Developing compassionate, inclusive and capable managers and leaders	Line management; tackling racism; championing sexual safety; promoting flexible working	Embed consistent manager expectations, appraisal quality, inclusive leadership development, fair employee relations practice and manager capability to support flexible working, dignity at work and anti-racism. Deliver on Lord Mann's

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		recommendations through RCHT action plan.
Delivering sustainable workforce models aligned to neighbourhood health	Flexible working; line management; health and wellbeing	Ensure new workforce models include flexible deployment, retention impact assessment, safe staffing, role clarity, workforce redesign governance and partnership engagement with staff side.
Building strong local and educational pipelines	Line management; tackling racism; promoting flexible working	Strengthen inclusive career pathways, widening participation, apprenticeship routes, talent conversations and development opportunities for under-represented groups.
Celebrating diversity and fostering inclusion and belonging	Tackling racism; championing sexual safety; line management	Improve inclusion ambition to measurable anti-racism, sexual safety and belonging actions, supported by WRES, WDES, staff survey, employee relations and speaking-up intelligence.
Releasing time to care through job design and digital enablement	Line management; health and wellbeing; promoting flexible working	Use digital and administrative redesign to reduce burden, improve job design, support autonomy, improve rostering and increase time available for patient care, improvement, research and team leadership.

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NHS Staff Standards Gap Analysis: 2026 Board and Committee Evidence

This gap analysis triangulates the NHS Staff Standards requirements with RCHT Board and committee evidence considered during 2026. It draws particularly on the 2025 Staff Survey action plan, workforce and culture assurance, the Lord Mann response, and the national Staff Standards information pack. The assessment is an initial strategic view rather than a substitute for the formal evidence-based self-assessment and will be updated annually.

NHS Staff Standard	2026 RCHT evidence and current strengths	Principal gap or risk	Initial assessment and priority action
Line management	Board reporting identifies appraisals as the largest comparative Staff Survey gap. The People Plan, Culture Programme and leadership framework provide a clear route to standardise manager expectations, supervision, wellbeing conversations and appraisal quality.	Variation in management capability, meaningful appraisal, team routines and confidence to manage change may continue to weaken staff experience, accountability and advocacy.	**High priority.** Implement a minimum management offer, manager self-assessment, appraisal quality audit, regular one-to-ones and divisional exception reporting.
Health and wellbeing	Wellbeing is embedded in the People Plan, with sickness absence, stress, fatigue, workload and hotspot interventions reflected in workforce assurance and the Culture Programme.	Operational pressure, organisational change and workload remain material risks. Evidence needs to demonstrate consistent preventative risk assessment, access to support, rest and recovery, and measurable impact across all Divisions.	**High priority.** Complete divisional wellbeing risk assessments, agree hotspot plans, improve access and uptake data, and triangulate staff experience with absence, retention and

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			safety intelligence.
Violence prevention and reduction	Violence prevention, reporting, post-incident support and hotspot analysis are identified within the People Plan and Health and Safety assurance routes.	A single Board-level evidence set is needed to demonstrate prevention controls, trends by staff group and location, quality of post-incident support, learning, repeat hotspots and action on abuse by patients and the public.	**High priority.** Establish data collection, named hotspot action owners, post-incident support standards and evidence that learning changes practice.
Tackling racism	The 2026 Lord Mann response confirms Board ownership, EDI objectives, network sponsorship, bystander development, use of WRES data and configuration of incident reporting for hate crime.	Further work is required to increase awareness and trust in reporting routes, link appropriately with police reporting, evidence timely and fair case handling, strengthen anti-racism learning and demonstrate equitable recruitment, progression and employee relations outcomes.	Deliver the RCHT Lord Mann anti discrimination action plan, publish measurable Board objectives, monitor WRES and Staff Survey indicators, audit case handling and improve reporting confidence.
Championing sexual safety	The People Plan recognises sexual safety, dignity at work, safe reporting, bystander confidence and support for affected staff, with proposed triangulation through culture and speaking-up routes.	Formal assurance is needed on full charter implementation, mandatory learning, specialist investigator capability, victim-centred support, policy alignment, non-victimisation safeguards and Board accountability.	Complete the sexual safety charter assurance framework, monitor training and investigation quality, and report anonymised themes and learning.

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Promoting flexible working	Flexible working is linked to retention, workforce redesign, roster quality, wellbeing and neighbourhood models in the People Plan.	Current evidence does not yet show consistent decisions, accessibility of routes, outcomes by staff group, appeal themes, roster fairness or whether flexible working improves retention without compromising safety and service delivery.	Introduce central monitoring of requests and outcomes, equality analysis, appeal learning, manager training and divisional roster-quality assurance.

Mapping of NHS Staff Standards to the NHS Staff Survey

The mapping below translates the six standards into a practical measurement framework. It uses relevant NHS Staff Survey themes and items as indicators of staff experience, supplemented by operational, safety, equality, employee relations and workforce evidence. No single survey item should be treated as proof of compliance; assurance should triangulate survey trends with policy implementation, process quality, workforce outcomes and lived experience.

NHS Staff Standard	**2025 NHS Staff Survey question numbers and indicators**	**RCHT interpretation and 2026 priority**	**Supporting evidence and assurance**
Line management	**Q7a and Q7h; Q9d, Q9f and Q9i; Q23a, Q23c and Q23d; Q24d and Q24e.** These cover support from the immediate manager, recognition and feedback, involvement and development, appraisal quality and whether appraisal helps staff improve how they do their job.	Use appraisal as a lead indicator because the 2025 action plan identifies it as the largest comparative gap. Track quality and impact, not completion alone, alongside manager support and advocacy.	Appraisal audit, one-to-one frequency, manager development uptake, employee relations themes, turnover, absence, pulse feedback and divisional variation.

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Health and wellbeing	**Q11a and Q11c; Q12b.** These cover work pressure, burnout and the extent to which the organisation takes positive action on health and wellbeing. Wider supporting items should include stress, presenteeism, rest, fatigue and work-life balance where reported in the detailed benchmark output.	Board reporting identifies health and safety climate as a priority. Focus on operational pressure, fatigue, stress and hotspot teams, with visible action and recovery support.	Sickness absence, stress-related absence, occupational health access and outcomes, wellbeing risk assessments, roster and fatigue indicators, retention and safety incidents.
Violence prevention and reduction	**Q13a, Q13b and Q13c; Q13d.** These measure experience of physical violence from patients, relatives or the public, managers and colleagues, together with whether the most recent incident was reported.	Measure both prevalence and confidence that reporting leads to timely support and prevention. Disaggregate by Division, role, shift pattern and protected characteristic where appropriate.	Incident rates and severity, repeat hotspots, police/security involvement, post-incident support, staff absence, risk assessments and action closure.
Tackling racism	**Q14a, Q14b and Q14c; Q15a and Q15b; Q16a and Q16b; Q17.** These cover bullying, harassment or abuse; discrimination from patients/public, managers or colleagues; reporting; and organisational fairness in career progression and development. Results should be analysed by	Use Staff Survey findings with WRES to test whether the Lord Mann actions improve lived experience, reporting confidence, fairness and belonging.	WRES metrics, recruitment and promotion outcomes, disciplinary and grievance disproportionality, hate-crime reporting, case timeliness, staff network feedback and Board EDI objectives.

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	ethnicity and triangulated with WRES.		
Championing sexual safety	**Q16c** (unwanted sexual behaviour); supported by **Q14a–Q14c, Q15a–Q15b and Q17** where relevant to harassment, discrimination, reporting and organisational response. The dedicated sexual safety item should be the primary survey measure, with dignity, reporting confidence and psychological safety used as contextual indicators.	Staff Survey evidence should be supplemented by a dedicated sexual safety pulse because prevalence may be under-reported and national survey items may not provide sufficient diagnostic detail.	Sexual safety charter assurance, learning completion, case themes, investigation timeliness and quality, victim-centred support, FTSU intelligence and staff network feedback.
Promoting flexible working	**Q6a, Q6b and Q6c.** These cover achieving a good balance between work and home life, satisfaction with opportunities for flexible working patterns, and confidence to approach the immediate manager to discuss flexible working.	Assess whether staff experience fair and consistent access, and whether flexibility supports retention, inclusion and wellbeing while maintaining safe services.	Requests, approvals and refusals; reasons and appeals; equality analysis; roster quality; turnover; vacancy and absence trends; exit and stay interview themes.

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Formal NHS Staff Standards Improvement Plan

The improvement plan below provides the initial delivery framework for strengthening alignment between the RCHT People Plan, the NHS Staff Standards and the wider RCHT improvement approach. It will be used to track delivery, identify areas requiring additional support or escalation, and provide quarterly assurance to the People and Culture Committee, with onward reporting to Trust Board where required.

Action	Owner	KPI	Assurance route
Complete a baseline self-assessment against the six NHS Staff Standards, identifying current evidence, gaps, accountable leads and required actions.	Dual Chief People Officer, supported by POD and Culture Improvement Group	Baseline completed; action plan agreed; quarterly reporting established.	People and Culture Committee; Trust Board through quarterly assurance report.
Develop an integrated line management and leadership improvement programme aligned to the NHS Leadership and Management Framework, covering manager expectations, appraisal quality, supervision, employee relations practice, wellbeing conversations, flexible working decisions, operational delivery, improvement and change leadership.	POD, supported by Culture Improvement Group	Manager self-assessment completion; leadership and management development uptake; appraisal completion and quality audit; reduction in avoidable ER escalation.	People and Culture Committee; divisional performance reviews; Executive People Group.
Strengthen health, wellbeing and violence prevention actions, including proactive wellbeing risk assessment,	Associate Director People Experience, supported by Inclusive Wellbeing Group	Sickness absence trajectory; violence incident reporting and repeat hotspot reduction; wellbeing plan completion.	Health and Safety Committee; People and Culture Committee;

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hotspot analysis, prevention controls, post-incident support and learning.	and Health and Safety Committee		Quality Assurance Committee by exception.
Create a sexual safety and dignity at work improvement triangulation covering safe reporting, investigation quality, leadership visibility, bystander confidence and support for affected staff.	OD, Learning and Development, Sexual Safety Lead and ER leads	Sexual safety data reviewed; training uptake; speaking-up themes reviewed; staff survey dignity and safety indicators monitored.	Speaking Up and Culture routes; People and Culture Committee; Audit and Risk Committee by exception.
Develop measurable anti-racism, inclusion and belonging actions, triangulating WRES, WDES, staff survey, employee relations, recruitment, promotion and retention data.	EDI and OD teams; Intersectionality Group; Inclusive Wellbeing Group	WRES/WDES improvement indicators; staff survey inclusion scores; ER disproportionality; recruitment and promotion equity measures.	People and Culture Committee; Trust Board annual equality reports.
Implement a flexible working improvement plan covering policy consistency, roster design, manager confidence, appeal themes, staff experience and retention impact.	Roster Lead, OD, Associate POD Directors and ER teams	Flexible working requests and outcomes; appeal themes; retention and staff survey work-life balance indicators.	Divisional performance reviews; People and Culture Committee; Workforce Planning Group.
Agree and implement a trade union partnership framework covering early engagement, collective consultation, facilities and time for representatives, joint workforce intelligence, escalation and dispute resolution, and joint evaluation of material workforce change.	Dual Chief People Officer and Staff Side Chair, supported by POD and divisional leaders	Framework agreed; annual joint work programme delivered; proportion of material changes engaged on before options are finalised; consultation quality and representative feedback; disputes resolved at the earliest appropriate level.	Joint Negotiating and Consultative Committee; Strategic Workforce Group; People and Culture Committee.

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Introduce a quarterly People Plan assurance dashboard covering NHS Staff Standards, staff survey indicators, workforce metrics and delivery milestones.	Associate Director of Workforce Compliance and Operations	Dashboard live; quarterly reporting delivered; exception reports agreed for off-track actions.	Strategic Workforce Group; People and Culture Committee; Trust Board integrated performance report.

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Priority 1: Supporting Staff Health, Wellbeing and Safety

Staff health, wellbeing and safety are fundamental to patient safety, quality, productivity and organisational resilience. RCHT will take a proactive approach to wellbeing, reducing avoidable work-related harm, supporting recovery and ensuring wellbeing is considered in workforce, operational and leadership decisions.

Our approach will extend beyond the provision of wellbeing services. We will identify and address organisational causes of poor wellbeing, including excessive workload, fatigue, insufficient rest and recovery, inflexible working arrangements, poor workplace conditions and the cumulative impact of organisational change.

Objective: ***Embed staff health, wellbeing and safety as core organisational priorities, ensuring support is proactive, visible and easily accessible for all colleagues.***

What success looks like:

- Wellbeing, safety and fatigue considerations are embedded in operational, workforce and leadership decisions.
- Sickness absence, work-related stress and preventable harm reduce over time.
- Staff voice is actively sought, acted on and visible through clear “you said, we did” feedback loops.
- Support is accessible, well-communicated and embedded in everyday practice.
- Divisions and Corporate Teams identify and take action on organisational causes of stress, fatigue and poor wellbeing.
- Colleagues have appropriate access to rest, recovery, flexibility and safe, supportive workplace conditions.
- Wellbeing impact is considered in workforce redesign, organisational change and operational decision-making.
- Hotspot interventions demonstrate what action has been taken and whether colleague experience has improved.

Priority 2: Developing Compassionate, Inclusive and Capable Managers and Leaders

High-quality line management and supportive leadership

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Compassionate, inclusive and capable leadership is one of the strongest drivers of staff experience, retention, safety and performance. RCHT will align its leadership and management development approach to the NHS Leadership and

Management Framework, ensuring managers and leaders have the skills, confidence and accountability to lead teams through change, support wellbeing, manage performance fairly and create psychologically safe environments.

Objective: Ensure leaders and managers have the capability, confidence and accountability to lead compassionately, inclusively and effectively, applying people policies fairly and consistently and creating a positive day-to-day experience for colleagues.

What success looks like:

- Managers understand people management as a core accountability and are supported to evidence capability against the NHS Leadership and Management Framework.
- Leaders' role-model Trust values, inclusive behaviours and clear communication.
- Managers are confident in compassionate conversations, performance management, wellbeing, financial and operational accountability, improvement and change leadership.
- Leadership capability drives improved staff experience, engagement and retention.
- Managers apply people policies, processes and employment practices fairly, consistently and inclusively.
- Colleagues receive regular one-to-one, wellbeing, development and career conversations throughout the year, rather than relying solely on the annual appraisal.
- The quality of line management is assessed through staff experience, employee relations themes, appraisal quality, retention and other available workforce intelligence.
- Managers understand their responsibility to create psychologically safe, inclusive working environments and are held to account where expected standards are not met.

Meaningful appraisals, development and performance conversations

Objective: Ensure every colleague receives a high-quality, meaningful appraisal, supported by regular development, career and wellbeing conversations throughout the year, which enables them to feel valued, develop their potential and contribute to Trust priorities.

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What success looks like:

- Appraisals focus on role clarity, objectives, development and wellbeing, not compliance.
- All colleagues have a Personal Development Plan aligned to service and Trust priorities.
- Appraisal quality and impact are monitored, not just completion.
- Colleagues report that appraisal, one-to-one and career conversations are meaningful, inclusive and relevant to their development, wellbeing and aspirations.

Teamwork, Psychological Safety & Freedom to Speak Up

Objective: Create a culture where teamwork thrives and all colleagues feel safe to speak up, challenge appropriately and contribute to improvement.

What success looks like:

- Teams feel confident to raise concerns, share learning and challenge without fear.
- Freedom to Speak Up is visible, trusted and results in timely, meaningful action.
- Leaders and managers role-model openness, learning and just culture behaviours.
- Staff are kept informed about actions taken in response to concerns raised, so the loop is closed and trust is strengthened.

Priority 3: Developing Sustainable Workforce Models

New ways of working

Delivering neighbourhood health and integrated care requires flexible, multidisciplinary workforce models. RCHT will develop roles, skills and career pathways that support neighbourhood and care closer to home, encouraging collaboration across organisational boundaries and the whole system to create sustainable deployment of staff. Working with Cornwall Partnership NHS Foundation Trust, primary care, Cornwall Council, VCSE organisations, the police and wider system partners, RCHT will contribute to place-based workforce planning that supports prevention, population health and integrated neighbourhood teams. We will actively redesign our workforce to ensure colleagues are enabled to work at the top of their professional capability, supported through enhanced skill mix, advanced practice, apprenticeships, nursing

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associates, assistant practitioners, digital roles and other innovative workforce models. University Hospital Status and Cornwall Medical School will be key enablers of workforce innovation, educational excellence and sustainable workforce transformation.

All material workforce redesign and organisational change will be undertaken in partnership with recognised trade unions and staff side colleagues. Engagement will begin before preferred solutions are finalised and will include transparent sharing of the clinical, workforce, equality, financial and safety case for change; proportionate equality and workforce impact assessment; genuine consideration of alternatives; and clear feedback on how consultation has influenced decisions. RCHT will comply with employment law, national NHS agreements and local collective consultation arrangements, seek to achieve change without compulsory redundancy wherever practicable, and ensure affected colleagues receive fair treatment, representation and appropriate support.

Objective: Build flexible, sustainable workforce models that support neighbourhood health, integrated care delivery and future service transformation.

What success looks like:

- Workforce models enable neighbourhood working with all partners, care closer to home and improved system flow.
- Roles support multidisciplinary working and collaboration across organisational boundaries.
- Workforce planning anticipates future skills needs , utilises research and academic knowledge and reduces reliance on temporary staffing.
- As an anchor institution, RCHT will work with partners to ensure workforce redesign supports employment, skills and apprenticeship opportunities for local communities, alongside sustainable service transformation.
- Digital skills are actively grown and available to all teams to enhance and develop new ways of working
- Workforce redesign programmes demonstrate improved skill mix utilisation and reduced vacancy risks.
- Growth in advanced practice roles, nursing associates, apprenticeships and alternative career pathways.
- Increased numbers of rotational, integrated and neighbourhood workforce roles operating across organisational boundaries.

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- Workforce planning is aligned to future service models, population health need, educational partnerships and research opportunities.
- Digital capability is strengthened across all staff groups to support future models of care.
- University Hospital Status and Cornwall Medical School contribute to workforce innovation and service transformation.

Priority 4: Building Strong Local Pipelines and Partnerships

Building strong local pipelines

As one of the largest employers in Cornwall, and as a proud anchor institution, RCHT will strengthen local education, apprenticeship, research and employment pathways. University Hospital Status and Cornwall Medical School will be key enablers, supporting recruitment and retention by creating clearer routes into NHS careers, strengthening academic and research opportunities, supporting local training supply and giving colleagues more reasons to build long-term careers with RCHT and within Cornwall.

As a University Hospital, RCHT has an opportunity to become a leading learning organisation within the South West. We will strengthen partnerships with Cornwall Medical School, the University of Exeter, local schools, colleges and training providers to create integrated educational pathways into healthcare careers. These pathways will support entry into NHS employment, professional registration, advanced clinical practice, leadership, research and lifelong learning opportunities. Through these partnerships we will increase workforce supply whilst also developing the skills and capabilities required for future healthcare delivery.

Objective: Grow a resilient, future workforce by strengthening local education, training, research, digital capability and development pathways into clinical and non-clinical roles, using University Hospital Status, Cornwall Medical School and anchor institution partnerships to support recruitment, retention, workforce transformation and local opportunity.

What success looks like:

- Increased access to employment through apprenticeships, work experience, entry routes from communities and staff networks, and targeted anchor institution activity that opens up NHS careers to local people.
- Clear progression pathways support long-term careers in Health and social care working with all partners including VCSE

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- Education, university and Cornwall Medical School partnerships are aligned to workforce need, joint roles, clinical education, research opportunities and retention priorities.
- Increased student placements, apprenticeships, work experience opportunities and return-to-practice programmes.
- Growth in joint academic appointments, research opportunities and educational partnerships.
- Enhanced career pathways supporting progression from entry-level roles to advanced practice, specialist and leadership positions.
- Improved recruitment and retention resulting from local education and training pipelines.
- Increased participation in research, innovation, quality improvement and digital health programmes.
- Greater collaboration with VCSE partners, local authorities and educational institutions to strengthen workforce supply and community benefit.

Priority 5: Celebrating Diversity, Inclusion and Belonging

Celebrating diversity

RCHT will build an inclusive culture where diversity is valued, inequality is actively addressed and every colleague feels respected, safe and able to thrive. This includes strengthening Staff Networks, improving the experience and timeliness of reasonable adjustments, creating neuroinclusive working environments, supporting disabled and neurodivergent colleagues, colleagues with long-term health conditions and carers, supporting globally educated colleagues, and taking measurable action on discrimination, bullying, racism, sexual safety and belonging.

Objective: Build an inclusive culture where diversity is celebrated, inequality is actively addressed, and every colleague feels respected and treated fairly.

What success looks like:

- Inequalities in experience, progression and outcomes are identified and reduced.
- Bullying, harassment, discrimination and racism are actively prevented and addressed.
- Managers understand reasonable adjustments and know where to access advice and support.

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- Staff networks are influential, supported and connected to improvement priorities.
- Delivery of Lord Mann RCHT Action Plan.
- Recruitment, onboarding, learning and development, workplace systems and working environments are reviewed and improved using neuroinclusive principles.
- Managers have the awareness and confidence to support neurodivergent colleagues and respond appropriately to requests for workplace adjustments.
- Disabled and neurodivergent colleagues, colleagues with long-term health conditions and carers experience timely, effective and equitable support.
- Staff Networks and colleagues with lived experience contribute to the design, delivery and evaluation of inclusion priorities.
- The experience of reasonable adjustments is monitored for timeliness, quality, consistency and impact.
- Internationally educated colleagues and their families are supported to develop belonging, cultural connection and access to community networks.
- Internationally educated and globally recruited colleagues report improved belonging, access to support, career development and intention to remain at RCHT and within Cornwall.

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Priority 6: Releasing Time to Care, Improvement and Research

Releasing time to care quality improvement and research by improving job design, processes and digital enablement.
Ensure roles are clearly designed, meaningful and empowering, enabling colleagues to use their skills effectively and sustainably.

RCHT will reduce unnecessary administrative burden, improve job design and maximise the benefits of digital investment, including eCare, ambient technologies such as Heidi, automation, artificial intelligence and data-enabled workforce planning. We will support all colleagues to develop the knowledge, confidence and digital skills required to work safely and effectively within an increasingly digital NHS. Through digital transformation we will release time for patient care, quality improvement, education, research and leadership whilst ensuring strong information governance, clinical safety and ethical use of technology.

Objective:
Reduce unnecessary administrative burden and improve job design so colleagues can focus on patient care, improvement and research.
What success looks like:

- Colleagues understand their role, priorities and contribution to patient care.
- Unnecessary task burden is reduced, enabling autonomy and professional judgement.
- Job design supports wellbeing, development and service sustainability.
- More staff time is spent on direct patient care and value-adding activity.
- Processes are streamlined and digitally enabled to reduce duplication and waste.
- Protected time supports quality improvement, education and clinical research.
- A digital literacy and AI capability framework is implemented across all staff groups.
- Increased use of ambient and AI-enabled technologies reduces administrative burden.
- Workforce planning utilises digital analytics and predictive workforce intelligence.
- Staff confidence in digital and AI-enabled technologies improves year on year.
- Digital transformation demonstrably increases time available for patient care, education, research and quality improvement.
- Digital innovation supports service productivity, workforce wellbeing and operational efficiency.

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Governance, Delivery and Accountability

Working in Partnership with Trade Unions

RCHT recognises trade unions as independent representatives of colleagues and as essential partners in delivering this Plan. The Trust will maintain effective joint negotiating and consultative arrangements, support representatives to fulfil their roles, and create regular opportunities for strategic dialogue with executive and divisional leaders. Partnership discussions will cover workforce planning, organisational and service change, health and safety, wellbeing, equality and inclusion, employment policy, learning, digital transformation and the workforce implications of productivity programmes. The shared expectation is early engagement, mutual respect, constructive challenge, evidence-based discussion and a commitment to resolve differences at the earliest appropriate level.

- A jointly agreed annual partnership work programme aligned to the People Plan and Culture Programme.
- Early trade union involvement in the governance of material workforce and organisational change, including options appraisal and impact assessment.
- Routine sharing of relevant workforce, safety, equality and staff-experience intelligence, subject to information governance requirements.
- Joint review of consultation quality, implementation impacts, unresolved issues and lessons learned.
- Quarterly partnership assurance to the People and Culture Committee, including areas of agreement, challenge, risk and required action.

Delivery of this People Plan will be overseen through the People and Culture Committee, with regular reporting to Trust Board. Progress will be measured through a quarterly People Plan assurance dashboard covering NHS Staff Standards compliance, staff survey indicators, workforce metrics, culture programme delivery milestones, qualitative feedback and trade union partnership measures. The Dual Chief People Officer is accountable for delivery, supported by the Executive Team, Divisional leadership, POD, OD, EDI, staff networks, recognised trade unions, staff side representatives and relevant assurance groups. Formal review points will align with annual staff survey results, workforce performance reporting, joint partnership reviews and quarterly exception reporting where actions are off track.

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Appendix A: Alignment to Trust Strategy

Trust Strategy objective	People Plan contribution	Board assurance focus
Supported and Valued People	Core enabling strategy for staff experience, wellbeing, leadership, inclusion, retention and workforce sustainability.	Staff survey, NHS Staff Standards, sickness absence, turnover, appraisal quality and leadership capability. Culture Improvement Programme.
Safe High-Quality Care	Improves care quality through safer staffing, wellbeing, psychological safety, team effectiveness and reduced avoidable harm.	Workforce stability, safety culture, violence prevention, speaking up and quality-linked workforce metrics.
Improving Together	Builds capability for improvement, staff voice, learning culture, digital enablement and releasing time to care.	Improvement participation, staff voice feedback loops, digital adoption and delivery milestones.
Partnering with Purpose	Strengthens local workforce pipelines, educational partnerships, neighbourhood workforce models, integrated care working, research collaboration, University Hospital Status, Cornwall Medical School opportunities, digital transformation and anchor institution commitments that support the wider Cornwall workforce, economy and population health improvement agenda.	Apprenticeships, local recruitment routes, joint roles, Cornwall Medical School and university partnerships, anchor institution impact, neighbourhood workforce delivery, education partnerships, research impact and digital capability measures.

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Appendix B: Success Measures

Domain	Core measures	Assurance route
NHS Staff Standards	Baseline assessment, quarterly progress, evidence of improvement across all six standards.	Strategic Workforce Group, People and Culture Committee; Trust Board.
Staff experience and culture	Staff survey indicators for engagement, advocacy, wellbeing, line management, teamwork, safety, inclusion, discrimination, bullying and flexible working.	Culture Improvement Group, Inclusive Wellbeing Group, People Plan dashboard; Culture Programme reporting.
Workforce sustainability	Sickness absence, turnover, retention, temporary staffing reliance and workforce stability.	Integrated performance reporting PPPPP meetings; Quarterly divisional reviews.
Safety, dignity and voice	Freedom to Speak Up, violence and aggression, sexual safety, dignity at work, employee relations and reporting themes.	Speaking Up and Culture routes; Health and Safety Committee; People and Culture Committee.
Leadership and development	NHS Leadership and Management Framework self-assessment, leadership and management development uptake, appraisal completion and quality, personal development plans, manager capability and leadership programme uptake.	Strategic Workforce Group; PPPPP meetings, Quarterly divisional performance reviews.
Inclusion and belonging	WRES, WDES, gender pay gap, reasonable adjustment experience, recruitment, promotion, retention and staff network influence.	Inclusive Wellbeing Group, Intersectionality Group, Equality reports; People and Culture Committee.
Trade union partnership and employee voice	Timeliness of engagement; delivery of the joint work programme; consultation quality; representative participation; jointly agreed outcomes; unresolved issues and disputes; evidence of changes made following staff side input.	Joint Negotiating and Consultative Committee; Strategic Workforce Group; People and Culture Committee.

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Flexible working and job design	Flexible working outcomes, appeal themes, roster quality, work-life balance indicators and releasing time to care milestones.	Inclusive Wellbeing Group, Workforce Planning Group; People Plan dashboard.
Anchor institution, University Hospital Status and Cornwall Medical School	Apprenticeship routes, local recruitment pathways, school, college, university and Cornwall Medical School partnerships, research and academic career opportunities, and retention impact.	Strategic Workforce Group; People and Culture Committee; Trust Board through People Plan assurance.
Workforce Transformation, Skill Mix and Digital Capability	Advanced practice growth, apprenticeship development, neighbourhood workforce roles, digital literacy, AI capability, research participation, educational partnership outcomes, workforce redesign benefits and productivity improvements.	Strategic Workforce Group, Digital Programme Board, People and Culture Committee and Trust Board.

A strategic Delivery Plan will be developed to monitor annual progress against the People Plan, including clear milestones, owners, KPIs, RAG ratings, risks and assurance routes. This will enable the People and Culture Committee to track delivery, identify variation across Divisions and Corporate Teams, and escalate areas requiring additional support or decision-making.

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Appendix C: People Plan on a Page

Purpose

Purpose	Enable Outstanding Care for One and All by building a supported, skilled and inclusive workforce who feel valued, listened to and proud to work at RCHT.	
Strategic drivers	Trust Strategy 2026–2035; NHS 10 Year Plan for Health; NHS People Promise; NHS Staff Standards; NHS Leadership and Management Framework; Medium-Term Integrated Workforce Plan; 2025 NHS Staff Survey. The Lord Mann Review.	
Outcomes by 2030	Improved staff wellbeing, engagement and retention; psychologically safe teams; stronger leadership; sustainable workforce models; inclusive culture; more time for care, improvement and research.	
Priority	**Focus**	**Headline outcome**
1. Health, wellbeing and safety	Proactive wellbeing, safe working, violence prevention and recovery.	Staff are safer, healthier and better supported.
2. Compassionate and inclusive leadership	NHS Leadership and Management Framework, line management, appraisal quality, psychological safety, operational delivery, improvement and communication.	Managers lead consistently, compassionately and effectively.
3. Sustainable workforce models	Neighbourhood health, integrated roles, flexible deployment, skill mix redesign, advanced practice, digital capability and workforce planning.	Workforce models are sustainable, productive and aligned to future care, neighbourhood working and service transformation.
4. Local pipelines	Education, apprenticeships, work experience,	More local people can build long-term careers with RCHT, supported by apprenticeships, education partnerships, research

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and partnerships	progression, University Hospital Status, Cornwall Medical School, research partnerships, academic careers and anchor institution activity.	opportunities, Cornwall Medical School, University Hospital Status and anchor institution activity.
5. Inclusion and belonging	Anti-racism, reasonable adjustments, staff networks, sexual safety and dignity.	Colleagues feel respected, included and able to thrive.
6. Releasing time to care	Job design, process improvement, eCare, digital skills, AI capability, ambient technologies and administrative reduction.	More time is available for care, improvement, education and research through digitally enabled and well-designed work.

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Appendix D: Culture Programme Alignment

Culture programme theme	Why it matters	Key actions	Measures
Line management excellence	Supportive line management drives engagement, advocacy, sickness absence and team effectiveness.	Manager essentials programme; minimum management offer; 1:1s, stay conversations, team learning reviews and wellbeing checks.	Staff survey line manager items; sickness absence; turnover; pulse feedback.
High-quality appraisals and development	Meaningful appraisals support role clarity, development, wellbeing and performance.	Leadership and management framework alignment; simplified appraisal framework; quality checklist; monthly quality sampling; self-assessment; personal development plans.	Framework self-assessment completion; appraisal completion and quality; PDP completion; staff survey development indicators.
Teamworking and psychological safety	Strong teamwork and communication support safer care, better learning and confidence to speak up.	Team charters; huddles and debriefs; civility and inclusion commitments; bystander development.	Teamwork indicators; speaking-up confidence; psychological safety pulse measures.
Workload, rostering and wellbeing	Work pressure and fatigue affect safety, engagement, sickness absence and retention.	Burnout deep dives; hotspot interventions; roster optimisation; rest and recovery support; wellbeing offer.	Work pressure and stress indicators; sickness absence; agency spend; fatigue-related incidents.
Staff voice and visible leadership	Listening, involvement and visible leadership improve engagement and trust.	Quarterly listening cycle; divisional listening groups; leadership rounding; “you said, we did” feedback.	Staff voice indicators; pulse response rates; time to publish actions; qualitative advocacy themes.

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Equality, diversity and inclusion	Fairness, anti-discrimination and belonging are core to staff experience, safety and patient care.	Staff network support; WRES and WDES priorities; anti-racism; reasonable adjustments; civility and reporting routes.	WRES, WDES, staff survey discrimination and bullying indicators, reasonable adjustment experience and ER themes.

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RCHT People Plan 2026–2030 - Consolidated Feedback Log

Purpose: To provide a consolidated summary of feedback received from Staff Side representatives, Staff Networks and inclusion leads on Version 8 of the RCHT People Plan, together with recommended amendments for consideration prior to People and Culture Committee review.

Overview

Overall feedback was supportive of the direction, structure and content of the People Plan. No respondents proposed significant restructuring of the document. Feedback focused on strengthening existing themes and ensuring greater visibility of inclusion, belonging, leadership and staff experience priorities.

1. Leadership and Line Management

Feedback highlighted that staff experience is strongly influenced by the quality and consistency of line management. Respondents requested greater emphasis on compassionate, inclusive and accountable leadership, alongside stronger support for managers to apply policies fairly and consistently. Recommended enhancement: strengthen language around manager accountability, inclusive leadership capability and regular development conversations.

2. Inclusion, Belonging and Staff Voice

Respondents strongly supported the inclusion and belonging priority. Feedback emphasised the importance of psychological safety, staff voice and ensuring staff networks are recognised as partners in organisational improvement. Recommended enhancement: strengthen references to co-production with Staff Networks and visible “You Said, We Did” feedback mechanisms.

3. Neurodiversity

The most significant gap identified by respondents was the lack of explicit reference to neurodiversity. Recommendations included neurodiversity-informed recruitment, manager awareness and training, workplace adjustments, inclusive environments and stronger staff voice mechanisms for neurodivergent colleagues. Recommended enhancement: include specific neurodiversity commitments within Priority 5 and associated delivery measures.

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4. Appraisals, Development and Career Conversations

Feedback suggested that annual appraisals can be perceived as transactional and that greater emphasis should be placed on continuous development, wellbeing and career conversations. Recommended enhancement: reinforce

expectations for regular development discussions throughout the year and monitor quality as well as completion.

5. Wellbeing and Workplace Experience

Respondents emphasised that wellbeing should extend beyond wellbeing services and address workload, rest, recovery, flexibility and workplace conditions. Recommended enhancement: strengthen references to preventative wellbeing approaches and reducing organisational causes of stress.

6. Disability, Long-Term Conditions and Carers

Feedback requested greater visibility of disabled staff, colleagues with long-term conditions and carers. Recommended enhancement: explicitly reference carers and long-term conditions within inclusion and wellbeing priorities and strengthen commitments regarding reasonable adjustments and equitable support.

7. Ethnic Minority Staff, Global Workforce and Community Belonging

Feedback from the Ethnic Minority Network highlighted the importance of belonging, cultural connection, retention and community integration for internationally educated colleagues and their families. Recommended enhancement: further strengthen Priority 5 by emphasising belonging, community integration and the contribution of staff networks to cultural inclusion and retention.

Summary

The consultation feedback broadly endorses the direction of the People Plan. The strongest recommendation is to make neurodiversity more explicit and to strengthen references to belonging, staff voice, inclusive leadership and support for disabled staff, carers and internationally educated colleagues. These amendments can be incorporated without significant restructuring of the document.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 16

Title of Report: Audit and Risk Assurance Committee Assurance Report to the Board – October 2026

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

- Endorsed the refreshed, more strategic presentation of the Board Assurance Framework (BAF), subject to final validation by Executive Leads and Lead Committees.
- Agreed the proposed change to the Internal Audit Plan.
- Supported continued assurance reporting on the enhanced financial controls at each Committee meeting.
- Noted the Corporate Risk Register and findings from the associated assurance review.
- Supported progression of the Emergency Preparedness Resilience and Response (EPRR) annual assurance report to Trust Board, with the further information on the two partially compliant standards to be strengthened and recommended greater articulation of lessons learned through this annual report.

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Issues for escalation or notification to the Trust Board

Workforce risk and assurance - the Committee highlighted the limited assurance position for workforce, leadership and culture within the BAF and sought alignment with the Corporate Risk Register. The Committee requested a review of the workforce risks in light of that limited assurance position.

Financial recovery and effectiveness of enhanced financial controls - the Committee welcomed the strengthened financial control framework but emphasised that assurance must demonstrate that controls are embedded, consistently applied and effective, rather than simply confirming that controls exist. Implementation remained at differing levels of maturity across divisions.

Infrastructure and fire risk relating to EPRR – The Committee highlighted the continuing significance of infrastructure risk and, following the recent fire incident, sought prompt assurance on the effectiveness of emergency response arrangements, relevant controls and lessons learned

Internal Audit programme delivery - concern was raised about a number of audits being deferred. Management agreed to review the programme and determine whether audits could remain closer to their original timescales, particularly given the concentration of activity towards year-end and the planned eCare go-live period. It was agreed to hold a meeting of Audit and Risk Assurance Committee in February 2027 which will approve the internal audit plan for 2028.

Limited assurance on e-rostering - the Committee considered the limited assurance Internal Audit findings on e-rostering and stressed that the associated actions should be progressed with greater urgency. Financial and workforce control activity is to be better aligned, with an update to the Committee ahead of its December meeting.

Organisational capacity and cumulative delivery risk - the Committee highlighted the breadth of recovery plans, transformation programmes, improvement requirements and associated controls being managed simultaneously. Members considered the importance of ensuring that this cumulative delivery risk is appropriately captured within the BAF and that assurance activity focuses on what demonstrably makes a difference.

Summary of assurance and risk

The Committee welcomed the **enhanced financial controls framework** and supported regular assurance reporting to the Committee. The Committee considered the need to demonstrate not simply that controls were in place, but that they were consistently applied, proportionate and effective, with clear links to financial recovery and, where possible, evidence of impact. The interaction between financial controls, workforce measures, quality and equality impact assessment was also emphasised.

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The Committee noted that implementation was at differing levels of maturity across divisions and that full compliance was not yet expected. Internal Audit confirmed that its high-level financial controls work would examine grip and control at divisional level, providing an additional source of assurance.

The Committee strongly welcomed the refreshed **Board Assurance Framework** and endorsed its more strategic, high-level presentation and alignment with the Trust Strategy and risk appetite. Members considered that the BAF should increasingly drive committee agendas and scrutiny towards the most significant gaps in assurance. Particular discussion focused on the limited assurance position relating to workforce, leadership and culture, the need for consistent and measurable progress reporting against actions and milestones, and maintaining an audit trail where delivery dates change. The Committee also sought further consideration of the cumulative risk arising from the scale of organisational transformation and delivery requirements, together with the effects of climate change and wider infrastructure resilience.

The Committee noted the significant current organisational risk profile, including infrastructure risks which may remain elevated for a prolonged period because of capital constraints. Members sought greater visibility of workforce risks in the **Corporate Risk Register**, consistent with the limited assurance position reflected in the BAF, and requested consideration of whether the wider financial recovery risk was sufficiently captured. These matters will be considered further through the Executive Risk Group and future Committee reporting.

The Committee agreed the proposed change to the **Internal Audit Plan**, replacing the planned patient pathway identification audit with a safety culture review, with the interdependencies with patient safety to be reflected in its scope. Members requested stronger information on implementation of Internal Audit recommendations, including trend information. Concern was also raised about proposed movement of a number of audit reports later in the programme, and management confirmed that the proposed timings would be reviewed to determine whether work could be brought forward where possible and it was agreed the Committee would meet in February 2027 which would include the approval of the internal audit plan 2028.

The Committee also considered the limited assurance work relating to **e-rostering**. It emphasised the urgency of strengthening the relevant controls and the need to align the associated workforce and financial control actions. An update was requested before the next Committee meeting.

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The Committee received reasonable assurance on delivery of the **clinical audit programme,** with all Priority 1 mandatory audits reported as on track. It welcomed the progress made since the previous Internal Audit review, while noting that further work was required to strengthen divisional engagement, central visibility of local audit activity and alignment with organisational priorities.

The Committee received positive assurance regarding **counter-fraud** arrangements. It noted that no significant concerns had been identified through the Economic Crime and Corporate Transparency Act compliance review, with minor actions remaining, and welcomed the planned mid-year review of counter-fraud standards.

The Committee welcomed the significant improvement in **Emergency Preparedness, Resilience and Response (EPRR) compliance**, noting that 60 of 62 standards were compliant, with two standards partially compliant and action plans in place. Prior to submission to Trust Board, the Committee requested that the report provide greater clarity on the expected timescales for achieving full compliance and the arrangements for subsequent Committee oversight – this linked to discussion on a recent fire incident, the Committee considered that assurance should be obtained promptly on the effectiveness of emergency response arrangements and lessons arising through the annual reporting on EPRR.

The Committee received the **External Audit** update and considered progress against External Audit recommendations. Members noted the distinction between completion of specific management actions and the wider organisational position, particularly in relation to financial sustainability.

The Committee noted the **losses and special payments** position and welcomed continued action to reduce staff payroll debt and wastage. The Committee also noted opportunities to reduce ward and theatre wastage through effective inventory management and closer alignment with divisional financial recovery activity.

The Committee welcomed the enhanced analysis of **single tender actions**, including cumulative trends, urgent and emergency classifications and departmental analysis. The improved reporting should support more targeted scrutiny of recurring themes and repeated use by particular services, suppliers or categories.

Members received the **Trust Seal Bi-Annual Report**.

The Board is recommended to:

- The Trust Board is asked to receive the Audit and Risk Assurance Committee Assurance Report, note the assurance received and the matters highlighted for Board attention, and note the actions being progressed in response to the areas where further assurance is required.

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Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 16.1

Title of Report: Board Assurance Framework

Executive Director 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** ☐

To present the outcome of the comprehensive review and refresh of all six Board Assurance Framework (BAF) principal risks, aligning them to the Trust Strategy, the Board-approved risk appetite statements and recognised good practice for a strategic, high-level assurance framework. The report also provides assurance that relevant gaps in assurance, actions and progress updates from the previous versions have been traced into the refreshed BAF so that substantive matters have not been lost.

Consultation:

The refresh has drawn on the previous versions of each BAF element, the Trust Strategy and strategic objectives, the Trust risk appetite statements, existing committee and Board assurance, the Corporate Risk Register and current improvement and transformation programmes.

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	No separate impact assessment is required for the refresh itself.

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Assessment completed?				Equality and health inequality implications remain reflected within the relevant principal risks and controls.
Quality Impact Assessment completed?			x	The BAF is an assurance and oversight document. Quality impacts are addressed within BAF 1 and through quality impact arrangements referenced across transformation and recovery programmes.
Data Protection Impact Assessment completed?			x	No new processing of personal data is proposed. Information governance and confidential information risks remain captured within BAF 1 and BAF 5.

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 refreshed BAF strengthens Board oversight of risks to timely, safe and person-centred care, integrated and neighbourhood models, workforce sustainability and the wider determinants affected by service access and infrastructure.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The refresh retains explicit assurance on patient safety, access, delayed care, transformation, workforce capability, digital resilience and estates compliance, including the consequences for quality and unequal outcomes.
Sustainable and efficient use of NHS resources by RCHT	The refreshed risks connect financial sustainability, productivity, digital benefits, integration, workforce planning and risk-based capital prioritisation, supporting a clearer view of dependencies and sustainable resource use.

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Recommendation(s):

The Committee **is recommended to:**

- **receive and discuss** the refreshed element of the Board Assurance Framework;
- **confirm** that the revised principal risks appropriately reflect the Trust Strategy and the agreed risk appetite statements;
- **endorse** the more strategic and high-level presentation of the BAF
- **approve** the risk scores, tolerable ranges, target dates, action ownership and status

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Board Assurance Framework

1. Situation / Executive Summary

All six BAF elements have been comprehensively reviewed and reframed as strategic principal risks. The refresh aligns each element to the Trust Strategy, applies the Board's risk appetite to the tolerable risk range and target trajectory, and strengthens the distinction between the BAF and the Corporate Risk Register. The result is a more focused framework that describes the strategic threat, its causes and consequences, the principal controls, the three lines of assurance, the remaining gaps and the actions required to close them.

Previous gaps in assurance, actions and progress updates were not simply removed when the risks were streamlined. They were consolidated where they described the same underlying assurance need, carried forward into the most relevant refreshed gap or action, or retained through the supporting controls, assurance sources and links to the Corporate Risk Register. The refreshed documents therefore reduce duplication while preserving substantive assurance content and the audit trail of ongoing improvement work.

Summary of the six refreshed BAF elements

BAF	Principal risk focus	Strategy alignment	Risk appetite / tolerable range	Overall assurance
1	Safe, timely, high-quality and person-centred care	Safe, High-Quality Care	High/Open; 8–12	Medium
2	A sustainable, skilled, healthy, inclusive and thriving workforce	People and Culture	Open (Moderate/High); 8–12	Limited
3	Effective partnerships and integrated health services	Partnering with Purpose	Open; 8–12	Medium
4	Recurrent financial sustainability and capacity to invest	Improving Together	Open/Seek with cautious application; 8–12	Medium
5	Digital	Improving	Minimal/Cautious	Medium

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	transformation, infrastructure, cyber resilience and capability	Together – digital enablement of transformation and eCare	for cyber; Open for transformation; 9–12	
6	Safe, resilient, compliant and sustainable estate and infrastructure	Improving Together	Cautious; 6–8	Medium

2. Background

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.

The BAF is intended to support the Board in maintaining oversight of the principal risks to delivery of the Trust’s strategic objectives. The review identified the need for each element to operate at a consistently strategic level, avoiding duplication of individual operational or project risks while retaining clear links to the Corporate Risk Register and the programmes through which mitigation is delivered.

- Each principal risk is now explicitly anchored to the relevant Trust strategic objective and, where available, the year-one strategic priorities.
- Risk descriptions have been rewritten using a consistent cause-risk-impact structure, supported by concise risk causes and consequences.
- Risk appetite is shown alongside a tolerable risk range and target date, enabling the Board to distinguish deliberate risk-taking from exposure outside tolerance.
- Controls and mitigations have been consolidated around the principal mechanisms that manage the strategic risk.
- Assurance has been structured across the three lines of defence to clarify the origin and independence of evidence.
- Gaps in assurance focus on areas where evidence is incomplete, outcomes are not yet demonstrated or delivery remains uncertain.
- Actions are directly connected to the gaps and contain executive ownership, due dates,

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progress and delivery status where available.

- Relevant Corporate Risk Register entries remain linked to each BAF element so that detailed risks can be escalated and triangulated without overloading the BAF.

3. Assessment

3.1 Alignment to the Trust Strategy

The refresh uses the Trust Strategy as the organising framework for the six principal risks. BAF 1 is aligned to safe, high-quality care; BAF 2 to the culture and workforce objective; BAF 3 to partnering with purpose; BAF 4, BAF 5 and BAF 6 to Improving Together and organisational sustainability, with BAF 5 specifically reflecting the digital transformation required to deliver eCare, modernise services and support sustainable improvement. This provides a clearer line of sight from strategy, through principal risk, to control, assurance and action.

3.2 Application of risk appetite

The risk appetite statements have been incorporated into each BAF element rather than treated as a separate reference. The tolerable range reflects the level of exposure the Board is prepared to accept while strategic change is delivered. The refresh also recognises that appetite may differ within a single risk. BAF 5, for example, distinguishes a minimal or cautious appetite for cyber and information security exposure from an open appetite for managed digital transformation. The scoring fields provide for current and prospective assessment against the tolerable range and target date.

3.3 High-level focus and good practice

The principal risks have been made more strategic by consolidating overlapping issues and moving detailed operational matters to the supporting risk and assurance architecture. The refreshed framework keeps the Board’s attention on whether the Trust can deliver its strategic objectives, whether the principal controls are effective, what evidence supports that conclusion and where assurance remains insufficient. The linked Corporate Risk Register retains the detailed risk populations, while the BAF draws out themes and dependencies requiring Board oversight.

3.4 Continuity and traceability from the previous BAF

A preservation approach was applied to the previous versions. Content was assessed by substance rather than wording. Where several previous gaps or actions addressed the same assurance question, they were consolidated into a broader strategic gap with a corresponding outcome-focused action. Progress updates have been retained where they demonstrate completed governance, controls introduced, delivery achieved, current performance or continuing exposure. Detail that is no longer appropriate for the BAF remains available through the linked programme governance, committee reporting or Corporate Risk Register rather than being treated as lost.

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BAF 1 – Safe, high-quality care

- Carries forward urgent and emergency care performance, patient flow, corridor care and escalation capacity through the Clinical Vision of Flow, the 11-point recovery plan and GIRFT actions.
- Retains elective, diagnostics and cancer recovery, long waits and harm review requirements, together with targeted quality improvement for stroke and fractured neck of femur.
- Preserves assurance on the safe delivery of eCare and organisational change and on information governance action following reviews and investigations.

BAF 2 – Workforce

- Carries forward workforce supply, hard-to-fill roles, workforce planning, vacancies, sickness absence, appraisal, mandatory training and temporary staffing.
- Retains leadership and management capability, culture transformation, staff survey improvement, wellbeing and Occupational Health, inclusion, safety and speaking-up arrangements.
- Includes readiness for eCare, neighbourhood health and wider organisational change.
- Previous separate improvement activities are consolidated into a medium-term workforce plan, a Trust-wide workforce recovery plan and integrated culture and staff-survey delivery arrangements.

BAF 3 – Integrated health services

- Consolidates governance, accountability and decision-making for integrated care, neighbourhood health and closer provider collaboration.
- Retains the need for measurable partnership benefits, University Hospital and academic collaboration outcomes, and a clear link to patient and population benefit.
- Carries forward capacity, capability, resource, financial and interdependency risks across eCare, integration and neighbourhood transformation.
- Preserves workforce, culture, communications, engagement, co-production, options appraisal, due diligence and independent assurance requirements.

BAF 4 – Finance

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- Carries forward delivery of the Financial Recovery Plan, recurrent savings and reduction of the underlying deficit.
- Retains divisional ownership, standardised financial controls and alignment of finance, workforce, activity, quality and operational performance.

- Preserves the requirement for a credible Medium-Term Financial Plan, productivity and benefits realisation, and risk-based capital prioritisation.
- Continues explicit oversight of affordability and benefits risks for eCare and the Women and Children's Hospital Programme.

BAF 5 – Digital infrastructure and capability

- Carries forward eCare implementation, clinical engagement, organisational sustainment and benefits realisation.
- Retains Digital Strategy delivery, cyber strategy implementation, cyber posture, multi-factor authentication and resilience testing.
- Preserves information governance, record-access monitoring, digital skills, legacy infrastructure, network resilience, immutable backup and supply-chain dependencies.
- Includes digital maturity and adoption, including AI governance, and the digital requirements associated with Hospital 2.0 and the Women and Children's Programme.

BAF 6 – Physical infrastructure and supply chain

- Carries forward the Estates Strategy and Masterplan, the Six-Facet Survey and a risk-prioritised multi-year backlog maintenance programme.
- Retains capital affordability and prioritisation, statutory compliance, asbestos, contractor governance, maintenance, training and records integrity.
- Preserves critical infrastructure resilience, fire remediation and learning from severe-weather and business-continuity events.
- Continues oversight of the Green Plan, sustainability leadership, heat decarbonisation and the funding and delivery trajectory.

3.5 Cross-cutting themes and dependencies

- eCare features across quality, workforce, integration, finance and digital risks, supporting a single view of programme readiness, productivity, safety, capacity and benefit realisation.
- Workforce capacity, culture and leadership are treated as enabling conditions across all six risks rather than solely within BAF 2.
- Financial affordability and capital prioritisation connect BAF 4 with digital and estates infrastructure and major strategic programmes.
- Quality and equality impact assessment, patient safety guardrails and engagement are retained as protections for recovery, transformation and integration.

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- The three-lines model makes clearer where assurance is operational, corporate or independent, and where further independent evidence is required.

3.6 Feedback from Committees (October 2026)

Feedback from the October committee cycle will be incorporated into the refreshed BAF. Committees supported the more strategic approach and alignment with the Trust Strategy and risk appetite, while emphasising the need for clearer measurable milestones, ownership and audit trails for changes in delivery dates, and for scrutiny to focus on whether controls and actions are demonstrably reducing risk. Particular attention was drawn to the limited workforce assurance position; financial recovery and the effectiveness of strengthened controls; quality safeguards associated with financial recovery; infrastructure and climate resilience; and the cumulative organisational risk associated with delivery of multiple recovery and transformation programmes. ARAC also emphasised that the BAF should increasingly drive committee agendas towards the most significant gaps in assurance which was recognised by each Committee.

4. 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.

The principal risk arising from the refresh is that consolidation could inadvertently obscure an important operational issue or create a gap between the BAF and the underlying Corporate Risk Register. This has been mitigated through the continuity review, explicit links to the Corporate Risk Register, retention of material progress evidence and assignment of each gap to a corresponding action. A further risk is inconsistency in scoring, ownership, dates or status where final executive validation is outstanding. These fields should be completed before formal approval and then reviewed through the relevant lead committee.

5. Accountability

Each BAF element remains accountable to its named Executive lead and lead committee. The Company Secretary is responsible for maintaining the overall BAF framework and coordinating reporting to the Trust Board. Lead committees should review the relevant principal risk, test the sufficiency of assurance, scrutinise progress against actions and escalate any material change in exposure or control effectiveness. The Audit and Risk Assurance Committee should continue to oversee the effectiveness of the overall risk-management and assurance framework.

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6. Recommendations

- **receive and discuss** the refreshed element of the Board Assurance Framework;

- **confirm** that the revised principal risks appropriately reflect the Trust Strategy and the agreed risk appetite statements;
- **endorse** the more strategic and high-level presentation of the BAF
- **approve** the risk scores, tolerable ranges, target dates, action ownership and status

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BAF 1. Failure to provide safe high-quality care to patients

Strategic Objective	**We will provide safe, high quality care, refining our model of care to be person centred and as close to home as possible.**
Risk Description	There is a risk that the Trust is unable to consistently deliver timely, safe, high-quality and person-centred care due to sustained demand and capacity pressures, delays across urgent, emergency and planned care pathways, and insufficient progress in improving patient flow and delivering more care closer to home. This may result in patients waiting longer than clinically appropriate for assessment, treatment and discharge, leading to avoidable harm, poorer clinical outcomes, deterioration in patient experience, widening health inequalities and failure to meet required quality, performance and regulatory standards including 4 and 12 hour ED constitutional standards and RTT 81%.
Strategic Objectives	**Safe, High-Quality Care** • 52 week waits eliminated - Reducing the number of people waiting longer than a year for appointments is a national planning ambition for 2026/27, leading to an improved patient experience. • Introduction of robotic assisted surgery - To reduce a local acute health inequality by enabling local access to modern, surgical procedures associated with improved patient outcomes. • Urgent and Emergency Care Together with our partners, we will optimise our urgent and emergency care pathways across Cornwall and Isles of Scilly, enabling us to deliver our clinical vision of flow.
Risk cause(s)	• Sustained UEC demand and flow pressures – below annual operating plan for 4 hour and 12 hour performance and delivering unacceptable levels of corridor care • Delayed discharge and insufficient community capacity and no criteria to reside • Workforce and recruitment challenges with the Trust above workforce WTE plan • Increasing elective demand and long waits. • Financial and infrastructure constraints.
Risk impact	• Patients wait longer than clinically appropriate for care. • Increased risk of avoidable harm and safety incidents. • Poorer clinical outcomes. • Deterioration in patient and carer experience. • Widening health inequalities. • Failure to meet constitutional and regulatory standards. • Reputational damage and loss of public confidence.

Lead Director	Chief Nursing Officer and Chief Medical Officer with Chief Operating Officer	**Lead Committee**	Quality Assurance Committee	**Date of last review by Committee**	

BAF risk scoring

Risk Score	16	**Risk appetite**	High - Open	**Tolerable risk score**	8-12	**Target date to tolerable score**	April 2028

Risk controls or mitigations	A. Board oversight of quality, safety and operational performance through Trust Board, QAC and FPC and weekly UEC briefing to the Board. B. Integrated Performance Report and Board Assurance Framework providing triangulated oversight of quality, operational, workforce and financial performance. C. Clinical Vision of Flow Programme and 11-point UEC Recovery Plan delivering improvements in patient flow, discharge and urgent care performance. D. RTT, diagnostics and cancer recovery programmes with executive ownership, daily performance oversight and external improvement support. E. Quality and Equality Impact Assessment process and clinical safety guardrails for all transformation and recovery initiatives. F. Delivery of neighbourhood care, Hospital at Home, virtual wards and integrated pathways to provide more care closer to home. G. Workforce, culture and organisational development programmes supporting safe staffing and sustainable service delivery. H. eCare implementation programme to improve quality, safety and clinical effectiveness.

Actual and prospective scores	**Actual**			**Projected**
	Q4	**Q1**	**Q2**	**Q3**
Consequence	4	4	4	4
Likelihood	4	4	4	5
Current risk score (LxC)	16	16	16	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	• Divisional governance and performance reviews. • Daily operational management arrangements, including UEC command and control arrangements. • Clinical Vision of Flow Programme. • 11-point UEC Recovery Plan ("Simply Getting UEC Right"). • RTT, Cancer and Diagnostics Recovery Programmes. • Patient safety incident management and learning processes. • Harm review processes for long waits and delayed care. • Safer staffing reviews and workforce establishment management. • Clinical quality governance processes, including mortality, morbidity and patient safety reviews. • Delivery of neighbourhood care, virtual wards, Hospital at Home and discharge improvement initiatives. • Daily and weekly performance monitoring and escalation processes	• Executive Leadership Team oversight. • Quality Assurance Committee scrutiny. • Finance and Performance Committee scrutiny. • People and Culture Committee scrutiny of workforce risks. • Trust Board oversight of quality, UEC, planned care and performance. • Integrated Performance Report and quality dashboard. • Board Assurance Framework and Corporate Risk Register monitoring. • Quality and Equality Impact Assessment process. • Clinical Effectiveness Group. • Performance Assurance Framework. • eCare programme governance and assurance. • Winter resilience governance arrangements. • Board walkrounds and ward-to-board assurance processes.	• NHS England Regional oversight and performance review arrangements. • GIRFT reviews and assurance against Clinical Operational Standards. • Care Quality Commission inspections and regulatory oversight. • Internal Audit reviews. • Independent Well-Led Reviews. • Royal College reviews, peer reviews and accreditation programmes. • Integrated Care Board quality, performance and recovery oversight. • Local Maternity and Neonatal System assurance. • Operational Delivery Networks. • External benchmarking against NHS Oversight Framework standards. • Independent reviews of eCare, patient safety, maternity and other high-risk programmes as commissioned
Gaps in assurance	1. Ability to consistently deliver urgent and emergency care standards (4 and 12 hour ED) and sustain improvements in patient flow (not achieving 30% of discharged before midday and 80% before 5pm daily). 2. Ability to eradicate corridor care and eliminate reliance on escalation spaces on a sustained basis by 31 October 2026. 3. Delivery of elective (RTT 81%), diagnostic (DM01) and cancer recovery programmes, including elimination of long waits, reduction in waiting times and reduction of harm associated with delayed care 4. Delivery of GIRFT standards: Model ED, Model Discharge and Model 72 hours of assessment; 5. Ability to comply with Annual Operating Plan requirements for No Criteria to Reside (42). 6. Effectiveness and consistency of harm review processes in identifying, escalating and mitigating patient harm arising from delays in care. 7. Safe implementation of major transformation programmes, including eCare and organisational change, without adverse impact on quality, safety or performance. 8. Delivery of key clinical quality and patient safety improvement priorities, including stroke performance, NOF mortality outlier and compliance with nationally recognised standards of care and access to theatre. 9. Effectiveness of information governance arrangements, including prevention of unauthorised access to confidential information, management of information incidents and maintenance of regulatory compliance.		
Overall level of assurance	Medium		

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Actions to address gaps in assurance					
No.	**Action required**	**Executive Lead**	**Due date**	**Progress Report**	**On or off track**
1.	Deliver and embed the Clinical Vision of Flow and 11-point UEC Recovery Plan, with demonstrable improvement against agreed UEC	COO / CMO / CNO	December 2026	• ED Crowding (9048) Risk score: 25. Mitigating actions in place and Executive Risk Group oversight/monitoring against marker (Aggregated Patient Delay)	Off track

	trajectories and constitutional standards.			• 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 - strengthened Executive controls provide a credible recovery framework, with early evidence of improvement in ambulance handovers and 12-hour stays. • UEC Recovery plan in place (11-point Plan) – monitored through QAC and Board which clear milestones and trajectories • UEC is considered near the start of every public and private Board meeting, supported by weekly CEO reports • Focus on revised OPEL action cards and 21 GIRFT Clinical Operational Standards. • 24/7 COO/CNO oversight of key decisions to protect hospital capacity and flow - From 29 September, corridor care admissions require COO or CNO approval, alongside the instruction to move patients from ED at 11.5 hours • Opened a community Same Day Emergency Care (SDEC) at West Cornwall Hospital • Implemented a 'medical take controller' (Middle Grade / Registrar controlling requests to admit from the community and ED) • Ceased the use of the Medical Day Unit (MDU) so that the space can be returned to dermatology and the medical resource deployed to the front of the pathway • Early improvement is evident. Mean ambulance handover time reduced from 92 minutes in August to 51 minutes at 22 September. Month-to-date 12-hour performance improved from 16.45% to 14.26% and was forecast to outperform the revised regional trajectory. However, Type 1 four-hour performance remained substantially unchanged at 46.48% and behind the revised trajectory. Corridor care continued and system constraints remained material, with 93 patients having no criteria to reside on 23 September against the Annual Operating Plan assumption of no more than 42.	
2.	Deliver the corridor care eradication plan, implement GIRFT recommendations and demonstrate sustained removal of corridor care and reduction in escalation capacity.	Chief Operating Officer	31 October 2026	• The plan is to stop using all escalation areas and end corridor care by the end of October 2026 aligned to the deliverables in the 11-point UEC GIRFT action plan. A structured approach to eliminating corridor care and reducing escalation capacity is being implemented. This includes real-time identification of patients in corridor spaces, a maximum intended stay of 45 minutes, immediate escalation where this is at risk of being exceeded and root cause analysis for corridor stays over 45 minutes. A phased de-escalation plan has also restricted or ended overnight use of a number of escalation areas, including SDMA side rooms, the Discharge Lounge and the Eden day-case area, with work progressing to reduce Medical Day Unit use	On track
3.	Deliver RTT, diagnostics and cancer recovery trajectories as set out in the RTT Recovery plan, including reduction in waiting lists, elimination of long waits and restoration of compliance with national standards.	Chief Operating Officer	30 November 2026	• **RTT:** Enhanced controls include daily activity reviews, external support from BearingPoint, additional outpatient clinics, GIRFT theatre and outpatient reviews, pathway validation and specialty-level action. However, RTT performance is 73.1% against the 81% ambition, the waiting list has increased to 44,996, and the current recovery forecast only reduces it to 42,400 against a plan of 37,750. Long waits also remain material, with 446 patients waiting over 52 weeks. RTT recovery plan established and will be monitored by ELT, FPC and QAC • **Diagnostics:** Recovery actions include maximising Community Diagnostic Centre capacity, additional echocardiography slots, targeted endoscopy and neurophysiology recovery, and weekly operational oversight. However, DM01 performance remains 81.4% against a 97.3% plan and 99% standard, so compliance aims to be recovered by November 2026 • **Cancer:** pathway constraints but targeted recovery through the Cancer Action Delivery Board, daily monitoring, outsourcing and additional workforce and clinic capacity. Noting that cancer backlog over 62 days exceeds 200 patients, histology timeliness remains below 50%, and breast and MaxFax backlogs remain significant. The weekly monitoring of the 62-day PTL are key to closing the current performance gap	Off Track

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4.	Deliver and embed GIRFT Model ED, Model Discharge and 72-Hour Assessment standards	Chief Operating Officer/ Chief Nursing Officer and Chief Medical Officer	March 2027	• The Trust has completed an initial Trust-wide baseline self-assessment against the 15 standards within the 72-hour Model Acute Pathway. No standard is fully compliant across the Trust, 14 are partially compliant and continuity of care is non-compliant. Assurance remains partial, particularly in relation to continuity of care, timely assessment and specialty review, seven-day support services, transfers to the appropriate specialty bed and data quality. • Separate assessments have also been undertaken for Model ED and Model Discharge. The September UEC material reported 42 Model ED indicators complete and three partially complete, while the Model Discharge review identified next steps but confirmed that the Trust was not fully compliant. • A single prioritised improvement plan is being developed across the three models, with named executive and operational owners, measurable milestones, delivery dates and defined evidence requirements. The External Review Team will monitor completion using the methodology applied to CQC actions, with progress reported through UEC, clinical flow and quality governance arrangements and formally updated to the Quality Assurance Committee within six months.	Off Track
5.	Embed a consistent organisation-wide harm review process and strengthen oversight of learning, escalation and assurance relating to delayed care	Chief Medical Officer	March 2027	• 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. • 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 PPPPs (Patients) governance process. • Patient safety incidents are overseen through the Patient Safety Incident Review and Oversight Group, and the Patient Safety Incident Response Framework provides the Trust-wide route for incident investigation, learning and assurance.	On track
6.	Maintain assurance and oversight of eCare implementation and organisational change programmes, including monitoring of quality, safety and operational impacts.	Chief Operating Officer / Chief Strategy Officer (SRO)	April 2027	• The eCare programme improved from Red to Amber in September and was reported as remaining on track for the planned go-live date of 4 April 2027. Monthly assurance is informed by the Programme Board, Delivery Board, delivery groups, programme management arrangements and the senior programme leadership team. • Progress includes an agreed reporting recovery plan, weekly reporting monitoring, commencement of People Readiness engagement, migration of approximately 1.75 million records through the current mini-load, weekly operational readiness meetings, an Operations Readiness Checklist, progress across outpatient validation and redesign, improved diagnostics workstreams, completion of the workflow and documentation review and approval of the updated training plan. NHS England Gateway 4 assurance was also planned for September and October. • Significant risks remain. Assurance has not yet been achieved that eCare will avoid adverse productivity impacts, and this risk is linked directly to delivery of the RTT recovery plan.	On track
7.	Deliver targeted improvement programmes for identified quality outliers i.e. #NOF and provide evidence of sustained improvement against agreed quality metrics and national standards.	Chief Medical Officer	March 2027	**Fracture Neck of Femur:** • A structured fractured neck of femur improvement programme is now in place following the Trauma Summit. The programme includes a standardised hip-fracture pathway and care plan, a dedicated multidisciplinary review process, day-one mobilisation, prompt analgesia, orthogeriatric liaison, weekend cover, a Trauma Surge Standard Operating Procedure, appointment of a lead consultant, recruitment to trauma-coordinator roles and two locum consultants commencing in September. • Performance improved from 38% of patients receiving surgery within 36 hours in July to 48% in August. However, this remained materially below the required standard. Theatre capacity and competing demand continued to constrain delivery. The National Hip Fracture Database also notified the Trust of possible mortality-outlier status, with the fractured neck of femur 95% lower confidence level elevated at 124.91. A Divisional	Off Track

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				improvement group was established to review the position and develop the formal response. • The programme is therefore established and the direction of travel for time to surgery is improving, but sustained improvement in timeliness and mortality has not yet been demonstrated and QAC continue to have oversight **Stroke Performance** • Material improvement in access to the stroke unit; CT and 90%-of-stay measures meeting standard, but SSNAP E and important pathway/mortality risks remain.	
8.	Implement recommendations arising from information governance reviews and investigations, strengthen access controls and monitoring arrangements, and restore compliance with statutory information governance requirements.	Senior Information Risk Owner	March 2027	• 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 • Trust engaged with independent experts to investigate the data breach identified in late 2025 and action plan in response • A Trust-wide action plan has been established in response to the NHS England requirements concerning unlawful access to patient records, with completion planned by 31 March 2027. The programme includes policy and disciplinary procedure updates, communications and training, strengthened incident investigation, targeted and random access audits, a documented audit programme, enhanced governance reporting and a final compliance assessment. • Initial actions have progressed. The Code of Confidentiality and records policy include relevant provisions; the Chief Medical Officer has issued a Trust-wide communication and the message has been added to the system login banner; induction training was planned for update; targeted and random audits have commenced; and audit access has been extended to additional senior Information Governance staff.	Off Track

Links to Corporate Risk Register (CRR) – Safe and high-quality care					
CRR reference	**Title**	**Executive Lead**	**Current risk score**		**Review date**
9839	Paediatric ED crowding risk (NBPR)	Emma Wise	15	12	Apr-27
9754	BC014 Security Services - Compliance with NHSE Violence Prevention and Reduction Standard	Miss Natasha Quick	12	6	Mar-27
9719	BC002 Security Services - Training (Security Officers)	Miss Natasha Quick	15	6	Sep-26
9664	Safeguarding Maternity Provision	Suzie Williams	15	9	Mar-27
9524	Maternity Triage	Mrs Sarah Harvey-Hurst	16	4	Sep-26
9397	SDSA corridor waiting area accommodating acutely unwell patients	Zoe Ainsworth	15	9	Apr-26
9106	Delivery of the Children in Care service and related statutory duties	Alison Birch	16	2	Oct-26
9048	ED Overcrowding	Mr Dan Bawden	25	8	Apr-26
8922	SECSR_001 Lack of Security at the RCH to Support the Trust	Miss Natasha Quick	16	12	Oct-26
8585	NOF mortality increases	Charlotte Chapman	12	9	Feb-26

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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

Strategic Objective	**We will nurture a culture where everyone feels respected, heard and supported to thrive. We celebrate inclusion, foster belonging and purpose for all - empowering teams to make a meaningful difference every day.**
Risk Description	There is a risk that the Trust is unable to attract, recruit, develop and retain a skilled, engaged, healthy and inclusive workforce with the leadership capability, capacity required to support a culture that fosters belonging and inclusivity, psychological safety, continuous improvement and organisational transformation. This may result in workforce instability, reduced productivity, poor staff experience and wellbeing and confidence to speak up, inability to deliver transformation, deterioration in patient experience and outcomes, and failure to achieve the Trust's strategic objectives.
Risk cause(s)	• Workforce shortages in key professions. • Recruitment and retention challenges including our geographical area • Financial constraints. • Organisational change fatigue. • Leadership and management capability gaps. • Wellbeing and sickness absence pressures. • Cultural and behavioural challenges. • System workforce dependencies.
Impacts if risk realised	• Reduced staff engagement and wellbeing. • Increased turnover and sickness absence. • Reduced organisational resilience. • Inability to deliver strategic transformation programmes. • Reduced productivity. • Poor patient experience and outcomes. • Increased agency and temporary staffing costs. • Failure to deliver financial and operational plans.
Strategic Objectives (Year 1)	• Implementation of our new organisational structures - Increase our patient focus to ensure clinical effectiveness and excellence in both patient outcome and patient experience with increased operational focus to improve quality, capacity, throughout and to reduce waste. • Launch of a new Culture Improvement Plan - Building a culture where everyone feels cared for, listened to and makes a difference – ultimately improving staff experience at work

Lead Director	Dual Chief People Officer	**Lead Committee**	People and Culture Committee	**Date of last review by Committee**	)

BAF risk scoring

Initial risk score	16	**Risk appetite**	Open (Moderate/ High)	**Tolerable risk score**	8-12	**Target date to tolerable score**	March 2028

Risk controls or mitigations	A. Workforce Sustainability -Term Workforce Plan aligned to Trust Strategy and MTFP. B. Divisional workforce planning arrangements. C. Recruitment and retention programme. D. Temporary staffing reduction programme. E. Strategic accommodation plan. F. Apprenticeship and workforce pipeline programmes. G. Culture Transformation Programme. H. People Plan. I. Leadership and Management Development Framework. J. Civility and Respect programme. K. People Promise and Just Culture implementation.

Actual and prospective risk scores (as at end of quarter)	**Actual**			**Projected**
	Q3	**Q4**	**Q1**	**Q2**
Consequence	4	4	4	4
Likelihood	4	4	4	4
Current risk score (LxC)	16	16	16	16

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	L. Freedom to Speak Up arrangements. M. Occupational Health provision. N. Attendance Management Framework. O. Staff Survey improvement programme. P. Pulse survey and engagement mechanisms. Q. WRES, WDES and Gender Pay Gap action plans. R. Staff Networks. S. Inclusive recruitment arrangements. T. Organisational change governance framework. U. Workforce transformation programme. V. System workforce planning arrangements. W. eCare workforce readiness programme.	

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	• Divisional workforce reviews. • Establishment control and staffing management. • Recruitment and retention oversight. • Appraisal and performance management processes. • Statutory and mandatory training compliance. • Attendance management processes. • Staff wellbeing and occupational health interventions. • Local culture and engagement action plans. • Workforce transformation implementation plans.	• People and Culture Committee. • Strategic Workforce Group. • Culture Transformation Group. • Workforce Performance Reviews. • Integrated Performance Report. • Staff Survey action plan monitoring. • Equality, Diversity and Inclusion reporting. • Freedom to Speak Up reporting. • Guardian of Safe Working Hours reporting. • Board Assurance Framework and Corporate Risk Register.	• NHS Staff Survey benchmarking. • CQC Well-Led assessments. • Internal Audit reviews. • National Workforce Indicators benchmarking. • NHS Staff Standards compliance reviews. • External workforce and organisational development reviews. • WRES and WDES statutory submissions. • NHS England workforce assurance requirements.
Gaps in assurance	1. Delivery of a sustainable workforce plan that addresses workforce supply, succession planning and hard-to-fill roles. 2. Assurance that the Trust's workforce improvement and recovery arrangements will deliver measurable improvement in key workforce metrics, including vacancies, sickness absence, appraisals, mandatory training and temporary staffing utilisation. 3. Assurance that leaders and managers have the capability, capacity and accountability to deliver workforce performance, organisational change and cultural improvement. 4. Assurance that the Culture Transformation Programme and People Plan will deliver sustained improvements in staff experience, engagement, wellbeing, speaking up and organisational culture. 5. Assurance that Occupational Health, wellbeing and mental health support services are effective, sufficiently resourced and delivering measurable reductions in stress-related sickness absence and improvements in workforce wellbeing. 6. Assurance that appraisal, mandatory training, supervision and performance management arrangements are consistently implemented and delivering the intended workforce, patient safety and organisational benefits. 7. Assurance that all staff work within a safe, inclusive and respectful environment where concerns are raised and addressed appropriately. 8. Assurance that the workforce has the capacity, capability and readiness to support service transformation, neighbourhood health models and major change programmes.		
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.	Continuously refresh the Medium-Term Workforce Plan aligned to the Trust Strategy, Neighbourhood Health model, financial plan and service transformation requirements, including targeted recovery	Dual Chief People Officer	April 2027	• Medium Term Workforce Plan developed and under review; • Trust approved Financial, Operational and Workforce Plan for 2026/27; • Workforce planning at Division level to ensure effective management of resources and keep focus on long term	

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	plans for hard-to-fill roles and critical workforce shortages at Divisional level			workforce planning not short term resourcing solutions. • the People Plan 2026-2030 has been developed and will be supported by an annual delivery plan and quarterly assurance dashboard • Workforce controls include centralised vacancy and establishment management, strengthened controls over temporary staffing, rostering and deployment, and divisional recovery plans with clear accountability and trajectories. Delivery is monitored through executive review of workforce expenditure, productivity, sickness, recruitment, retention and key workforce metrics, with quality and equality impact assessment and escalation to the relevant Board committees where controls or recovery trajectories are not achieved.	
2.	Develop and implement a Trust-wide Workforce Recovery Plan, bringing together vacancies, sickness absence, appraisals, mandatory training, turnover, bank and agency usage, staff survey outcomes and workforce productivity measures into a single improvement programme with trajectories, hotspots and divisional accountability.	Dual Chief People Officer	April 2027	• Performance evidence reinforces the need for the action: appraisal performance reduced from 59.6% to 57.9%, mandatory training remained at 77.39%, and registered nurse vacancies increased from 7.05% to 8.03%, despite improvement in total vacancies, turnover and medical vacancies • Agreed action at Trust Board October 2026 - Development of a workforce recovery plan • The People and Culture Committee receives workforce performance information through the Integrated Performance Report and workforce assurance reporting, covering vacancies, appraisals, sickness absence, mandatory training, bank and agency usage, staff survey outcomes and workforce indicator – Committee highlighted a lack of assurance and requested further assurances	
3.	Implement a Leadership and Management Development Framework aligned to the NHS Leadership Competency Framework and NHS Staff Standards, including targeted support for managers in hotspot areas and training in appraisal, attendance management, difficult conversations and culture leadership.	Dual Chief People Officer / Chief Strategy Officer	April 2027	• People Plan 2026-2030 to be presented to Trust Board in November 2026 which would be supported by through the development of implementation plan • The Culture Transformation Programme is already focused on leadership behaviours and how values are reflected in leadership styles, launch of the Fundamentals of Management programme, appraisal training and the integration of culture, inclusion, wellbeing and psychological safety into manager development • The People and Culture Committee has also highlighted the need to link management development to improved appraisal rates, sickness absence and staff experience, and to target support according to divisional need.	
4.	Deliver the integrated Culture Transformation and Staff Survey Delivery Plan with clearly defined priorities, RAG-rated milestones, measurable outcomes and reporting through the IPR and Culture Programme.	Dual Chief People Officer / Chief Strategy Officer	September 2027	• The Staff Survey Action Plan and We Are RCHT Culture Transformation Programme have been integrated into a single roadmap; • Six staff survey priorities are aligned to six culture transformation workstreams; • Culture roadmap includes defined activities, delivery dates, accountable leads and intended measures across leadership, psychological safety, wellbeing, engagement, inclusion and recognition;	•

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				• measurable outcomes are identified through staff survey and People Promise indicators, pulse surveys, appraisal compliance, Freedom to Speak Up measures, sickness absence, workforce equality standards, survey participation and other workforce metrics; • a dedicated Benefits Management workstream is intended to monitor culture transformation KPIs; and • Culture measures will be incorporated into the Performance Accountability Framework and Integrated Performance Report, with oversight through the Culture Programme.	
5.	Deliver service capability and seek improvements in Occupational Health and Wellbeing model and monitor of intervention effectiveness. As well as address accommodation	Dual Chief People Officer	April 2027	• Review of location identified potential opportunity which is being explored with Estates; • Occupational Health review completed and future service model under development. • Data collection and trend reporting being strengthened.	
6.	Deliver targeted recovery plans for appraisal, statutory and mandatory training compliance, including hotspot intervention plans, enhanced divisional accountability and revised appraisal approaches at Divisional level	Dual Chief People Officer	April 2027	• Recovery actions have been introduced, but appraisal and mandatory training performance remain below the required level. • Appraisal and statutory and mandatory training performance remain below the required level, with appraisal completion at 57.9% and statutory and mandatory training at 77.39% in the latest reported position. Targeted management action has improved health and safety statutory training to 91.34%, and the learning from this approach will be applied across other training areas. Divisional recovery plans will include monthly trajectories, hotspot analysis, identified barriers, protected time, named accountability and escalation for missed milestones. Reporting will also assess appraisal quality and the relationship between compliance, staff engagement, workforce performance and patient safety.	
7.	Deliver a Workforce Inclusion and Safety Improvement Plan aligned to the NHS Staff Standards, Sexual Safety Charter, Violence Prevention and Reduction Standard, Freedom to Speak Up framework and EDI improvement priorities.	Dual Chief People Officer / Chief Operating Officer	April 2027	• Sexual Safety and Domestic Violence arrangements and policy established. • Trust responded to Lord Mann review outcomes and recommended statement of compliance. • Annual reporting on WRES, DES, Gender Pay Gap is well established but there remains a gap with regard to improvement actions. People and Culture Committee to receive outcomes	
8.	Implement an OD framework for delivery of organisational change, eCare, neighbourhood health and future service transformation, including workforce impact assessments, readiness reviews and change support arrangements.	Dual Chief People Officer / Chief Strategy Officer	April 2027	• Workforce planning is being linked to the emerging neighbourhood model, with Integrated Neighbourhood Teams under development, neighbourhood leads identified and a draft integrated workforce plan developed with partners; • The workforce implications of neighbourhood health and future models of care are not yet fully quantified	

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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

Strategic Objective	**We will build strong and lasting partnerships which enable us to deliver outstanding care for One & All.**
Risk Description	There is a risk that the Trust is unable to develop and sustain the effective partnerships, shared governance, aligned priorities and collective delivery arrangements required to integrate care across organisational boundaries and deliver the Trust's strategic ambitions for neighbourhood health, integrated pathways and stronger regional and academic collaboration. This may result in fragmented pathways, poorer patient experience and outcomes, continued pressure on acute services, widening health inequalities, ineffective use of system resources, failure to realise the benefits of integration, delayed strategic transformation and reduced confidence among patients, staff, partners and regulators.
Risk cause(s)	• Lack of an agreed system operating model, strategic end state and clear governance, accountability and decision-making arrangements. • Differing organisational priorities, cultures, incentives, financial pressures and risk appetites, with insufficient trust and shared leadership. • Insufficient involvement and engagement of clinicians, staff, patients, communities, primary care, local authorities and VCSE partners. • Limited programme capacity, capability and resources, compounded by competing operational and transformation priorities. • Unresolved commissioning, contracting, funding, financial modelling, risk-sharing and resource-shift arrangements. • Fragmented data, digital, information-sharing and workforce arrangements across partners. • Weak translation of strategic agreements into operational change, measurable benefits and effective assurance, influenced by changing national, regulatory and system arrangements.
Impacts if risk realised	• Fragmented and poorly coordinated care, leading to avoidable harm, delays, duplication, poorer experience and outcomes, and widening health inequalities. • Continued pressure on urgent, emergency and acute services, with failure to shift care closer to home, strengthen prevention or improve population health. • Failure to deliver neighbourhood health, integrated pathways, service transformation, regional collaboration and University Hospital ambitions. • Ineffective use of system resources and inability to realise or manage shared financial, productivity, workforce, clinical and operational benefits and risks. • Deterioration in staff experience, engagement and retention, undermining delivery of operational, financial and strategic plans. • Reduced confidence among patients, communities, staff, partners and regulators, leading to reputational damage, increased oversight or regulatory intervention.
Strategic Objectives Year 1	• Neighbourhood Care Blueprint agreed with system partners - The local Cornwall and Isles of Scilly System is able to define shared ambitions for realising neighbourhood based models of care, in support of the national 10 Year Plan ambition of shifting care from hospital into the community. • CRDC-funded research hub opens - Build a delivery model capable of opening, recruiting to and delivering commercial studies efficiently and at scale, expanding access to commercial research through secondary care, primary care and community settings. • A refreshed Memorandum of Understanding (MoU) with University of Plymouth agreed - To continue to develop our relationship with the University, in support of our broader University Hospital Status ambitions. • Neighbourhood Care - We will co-design, partner and integrate with impact, ensuring that the neighbourhood health model of Cornwall and the Isles of Scilly enables both excellence in acute and specialist secondary care services as well as transforming the health and delivery of care in our local communities. • Research and Development - We will grow our clinical academia, increasing participation in research and become a University Hospital by 2030.

Lead Director	Chief Strategy Officer	**Lead Committee**	Finance and Performance Committee	**Date of last review by Committee**	

BAF risk scoring

Initial risk score	12	**Risk appetite**	Open	**Tolerable risk score**	8-12	**Target date to tolerable score**	March 2028

Risk controls or mitigations
A. Trust Strategy 2026–2035 and Partnering with Purpose strategic objective. B. Executive and Board oversight of integration, partnership and neighbourhood health. C. Integrated Health and Wellbeing Partnership and system leadership arrangements. D. Neighbourhood health governance, including RCHT participation in the Neighbourhood Innovation Delivery Team. E. Clinical leadership and involvement in integrated pathway and service redesign. F. Partnership working with the ICB, CFT, primary care, Cornwall Council, VCSE and regional partners. G. Formal options appraisal, due diligence and impact assessment for material integration proposals.

Actual and prospective scores	**Actual**			**Projected**
	Q4	**Q1**	**Q2**	**Q3**
Consequence	4	4	4	4
Likelihood	3	3	3	3
Current risk score (LxC)	12	12	12	12

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	H. Trust governance and risk-management arrangements for oversight and escalation of partnership and integration risks. I. Strategy implementation and benefits monitoring through the Executive, Finance and Performance Committee and Trust Board. J. Established provider collaborative, clinical network, university and regional partnership arrangements.

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 • Executive SROs and programme leads for integration, neighbourhood health and provider collaboration. • Integrated Health and Wellbeing Partnership CEO group. • Neighbourhood Innovation Delivery Team and pan-organisational Neighbourhood Delivery Team. • RCHT divisional neighbourhood leads and neighbourhood champions. • Clinical pathway and service leads delivering integrated models across urgent care, frailty, paediatrics, planned care and discharge. • RCHT/CFT programme and operational working groups. • Provider collaborative, clinical network, academic and cross-border partnership groups. • Programme-level risk registers, delivery plans, milestones, benefits measures and escalation arrangements. • Routine engagement with primary care, local authorities, VCSE partners, patients and communities.	• Bi-annual reports on delivery against Trust Strategy, • 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) • Executive Leadership Team oversight of the integration and partnership portfolio. • Finance and Performance Committee scrutiny of BAF 3, strategy implementation, programme delivery and system performance. • Quality Assurance Committee scrutiny of the quality, safety, patient experience and health inequality consequences of service change. • People and Culture Committee oversight of workforce, culture, leadership and staff engagement implications. • Audit and Risk Assurance Committee oversight of governance, risk management, partnership controls and assurance gaps. • Trust Board review of strategic intent, collaboration agreements, options appraisal, due diligence and any material decisions. • Executive Risk Group review of escalated programme and corporate risks. • Integrated action tracker covering actions, dependencies, benefits, risks, resources and decisions. • System-level governance and reporting through ICB and partnership arrangements. • Periodic reporting against the Trust Strategy and neighbourhood health milestones.	• External well-led governance reviews (RCHT and/or system-wide) (A – G) • Care Quality Commission inspections (A – G) • Internal audit review of partnership governance, programme management and benefits realisation. • External audit consideration of partnership working, governance and value for money. • NHS England and ICB review of strategic proposals, system plans and regulatory requirements. • CQC assessment of leadership, partnership working, service quality and integration. • Independent legal, financial, workforce and clinical due diligence for any organisational integration proposal. • Independent options appraisal and validation of costs, benefits, risks and alternative models. • Independent quality and equality impact assessment where service models or organisational arrangements materially change. • External benchmarking of neighbourhood outcomes, service use, health inequalities and integrated-care performance. • Academic or independent evaluation of neighbourhood tests of change and population health outcomes. • External well-led or system governance review where commissioned.
Gaps in assurance	1. The future system operating model, governance, accountabilities and decision-making arrangements for integrated care, neighbourhood health and closer provider collaboration are not yet fully agreed or embedded. 2. Assurance that the Trust's strategic partnerships are delivering measurable benefits and outcomes, including through integration, neighbourhood health, regional and academic collaboration and progress towards University Hospital status		

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	3. There is insufficient assurance that the capacity, capability, resources and financial arrangements required to deliver the scale and pace of the Trust's major transformation programmes, including eCare, integration and neighbourhood transformation, are fully identified, aligned and secured, with interdependencies effectively managed. 4. There is not yet comprehensive assurance that workforce, organisational culture, communications and engagement arrangements will enable successful integration, including effective co-production with staff, patients, communities and system partners.. 5. Options appraisal, due diligence and independent assurance have not yet been completed to demonstrate that emerging partnership and integration arrangements are safe, sustainable, legally and financially robust and capable of delivering the intended benefits.
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.	Agree and implement a clear system partnership and integration governance framework, defining the operating model, respective organisational responsibilities, decision-making authority, escalation routes, reporting arrangements and accountability to the Trust Board.	Chief Strategy Officer (SRO)	March 2028	The Trust has continued proactive engagement with the ICB and system partners as system arrangements have developed. The twin-track approach distinguishes the delivery of integrated care and neighbourhood services from the exploration of closer organisational integration between RCHT and CFT. The Trust has supported the establishment of the Integrated Health and Wellbeing Partnership CEO group to provide system leadership and accountability for these connected workstreams. A draft RCHT/CFT Collaboration Agreement has been developed, setting out shared objectives, guiding principles, obligations, escalation arrangements and potential joint governance mechanisms. Existing Executive, Committee and Board oversight remains in place while this framework is developed. Further work is required with partners to finalise the system operating model, terms of reference, delegated authority, reporting responsibilities and the relationship between partnership, neighbourhood and organisational governance	In progress
2.	Develop and implement a partnership benefits and outcomes framework which demonstrates the impact of the Trust's key strategic partnerships and progress against integration, neighbourhood health and University Hospital ambitions.	Chief Strategy Officer (SRO)	March 2028	The Trust has aligned the integration programme with the strategic ambitions for neighbourhood health, integrated urgent and emergency care, care closer to home and reduced health inequalities. Outcome areas have been identified across population health, patient experience, quality, workforce, inequalities and sustainability. The Trust is actively participating in the Neighbourhood Innovation Delivery Team and wider neighbourhood delivery arrangements. Divisional neighbourhood leads and champions have been identified, and practical work is progressing across peri-operative medicine, frailty, musculoskeletal and paediatric pathways. Existing flow, system recovery and integrated pathway programmes continue to provide operational evidence of partnership activity. The Trust is now working with partners to convert these activities into a consolidated benefits framework, including agreed baselines, measurable patient benefits, delivery trajectories and named benefit owners. This is required to enable the Board to assess whether partnership activity is producing demonstrable improvement rather than relying principally on evidence of activity and developing arrangements. Alongside system integration and neighbourhood transformation, the Trust continues to progress its University Hospital ambition. A University Hospital Steering Group is being established to coordinate university partnerships across the Trust and support the ambition to become a University Hospital by 2030.	In progress

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				Development of a Clinical Academia Strategy is also underway, bringing together the Trust's ambitions for research and development, university partnerships, clinical education and University Hospital statu	
3.	Ensure effective oversight of the Trust's major transformation portfolio, including eCare and integration, with clear programme governance, resources, financial arrangements, dependencies, risks and delivery milestones.	Chief Strategy Officer (SRO)	March 2028	Executive leadership and SRO responsibilities are established across the Trust's principal transformation programmes, with governance and reporting through the Executive Leadership Team, relevant committees and Trust Board. Divisional neighbourhood leadership arrangements have also been established and the Trust continues to participate in system transformation and planning forums. eCare remains a key Trust transformation programme, with monthly programme assurance provided to ELT, Finance and Performance Committee and Trust Board. Following the decision to defer go-live, a revised April 2027 implementation date has been agreed and significant planning is underway to support delivery. The October Board also received assurance that the programme status had improved from Red to Amber. The Trust has refreshed its Strategy and developed operational, financial and workforce plans to strengthen organisational focus and prioritisation. Board assurance arrangements support oversight of deliverability, while programme and corporate risks are managed through established risk-management arrangements. The integration programme has recognised that existing teams should not be expected to absorb the full additional workload associated with integration and neighbourhood transformation. Further work is required to develop a consolidated view of the capacity, capability, resources and interdependencies across eCare, integration, neighbourhood transformation and other major strategic programmes, alongside a costed resource plan covering programme capacity, clinical leadership, analytical support, workforce expertise, legal advice and communications capability. The associated financial model will also need to address implementation costs, affordability, resource shifts, risk sharing, stranded costs and benefits realisation.	In progress
4.	Develop and implement a joint workforce, culture, communications and co-production plan covering staff, staff-side representatives, patients, communities, primary care, Cornwall Council, the VCSE sector and regional partners.	Chief Strategy Officer (SRO)	March 2028	The Trust has recognised that culture, trust, workforce capacity and staff engagement are central to successful integration. Existing organisational culture arrangements provide a foundation for supporting staff through change, and the Trust continues to develop leadership and management approaches that support transformation. Engagement has extended to CFT, primary care leadership, Kernow Health, Cornwall Council, VCSE leaders, the ICB and regional partners, including University Hospitals Plymouth. RCHT and CFT have maintained regular Chair and Chief Executive engagement, and wider partner perspectives have informed the emerging partnership and integration approach. Patient benefit, community involvement and the role of wider partners have been established as principles for the programme. A comprehensive joint communications, workforce and co-production plan has not yet been finalised. The next phase will formalise how staff, patients, communities, unions and partners influence model design, governance, implementation and evaluation. It will also set out the workforce and cultural	In progress

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				implications of new ways of working, including arrangements for communication, engagement, leadership development and organisational readiness	
5.	Complete proportionate options appraisal, due diligence, impact assessment and independent assurance before any material decisions are taken on future partnership, service or organisational integration arrangements.	Chief Strategy Officer (SRO)	March 2028	The Trust is working with partners to develop future partnership and integration arrangements. Any material proposal will be subject to proportionate options appraisal, due diligence, impact assessment, engagement and regulatory requirements, considering clinical quality, patient benefit, workforce, finance, governance, legal compliance and delivery capability. Initial risks and assurance requirements have been identified, with detailed assessments to be completed as proposals develop. Existing Board, committee and risk-management arrangements continue to provide oversight. Independent legal, financial, clinical and governance assurance will be commissioned where required, with evidence reported to the relevant committees and Trust Board before approval of any material change.	

Links to Corporate Risk Register (CRR) – Integrated Health Services					
CRR reference	**Title**	**Executive lead**	**Current risk score**	**Target risk score**	**Review date**
10369	DGR614 NHSE agreement to Go Live (ECPR)	John Howarth	15	1	Dec-27
10368	DGR616 CFT Readiness (ECPR)	John Howarth	16	1	Dec-27
10365	Productivity at and after Go-Live DGR615 (ECPR)	John Howarth	20	1	Dec-27
9752	(ECPR) (DGR058, DGR059, DGR060, DGR062, DGR063) - eCare impact on ability to apply accurate and timely Clinical Coding	Linzi Lancaster	16	12	Jun-26
9743	(ECPR) (DGR053, DGR054, DGR071) - eCare impact on Trust wide Business Intelligence (RADAR) capability	Linzi Lancaster	12	8	Dec-26
9742	(ECPR) (DGR002, DGR049) RCHT Capacity to Fully Engage with eCare while Delivering Operational Activity Targets	Jo Floyd	16	8	Mar-26
9081	Clinical Coding Resource	Linzi Lancaster	15	6	Aug-26
8462	Use of ICE for blood tests in Rheumatology	Mr Andrew Pothecary	12	4	Apr-26

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BAF 4. Failure to achieve financial sustainability

Strategic Objective	Improving Together - Together we learn and make improvements to become a sustainable organisation, for our staff, for our finances and our environment.
Risk Description	There is a risk the Trust will be unable to deliver sustained recurrent financial improvement, improve productivity and maintain effective control of revenue, capital and cash, there is a risk that it will not achieve a financially sustainable operating model or create sufficient capacity to invest in its workforce, digital capability, estate and service transformation. This may result in failure to meet statutory financial duties, increased regulatory intervention, deterioration in infrastructure and services, reduced organisational resilience, and adverse impacts on patient care, staff experience, and reputation plus delivery of the Trust's strategic objectives.
Risk cause(s)	• Inconsistent application and effectiveness of financial controls • Insufficient identification and delivery of recurrent, cash-releasing savings. • Operational pressures, including urgent and emergency care, escalation capacity, temporary staffing and workforce inefficiency. • Limited delivery capacity and uneven divisional ownership of financial recovery and productivity improvement. • Weak alignment of activity, workforce, quality and finance assumptions. • Delays or reduced benefits from major transformation programmes, including eCare. • Unfunded or insufficiently funded recurrent commitments and workforce costs. • Revenue and capital affordability pressures arising from major infrastructure programmes. • Capital constraints, dependency on brokerage or external funding, and competing safety priorities. • System-level financial pressures, commissioning uncertainty and changes to national funding. • Inadequate understanding or management of the financial consequences of service redesign and organisational change.
Impacts if risk realised	• Failure to achieve the annual financial plan or medium-term financial recovery trajectory. • Increased NHS England oversight, mandated controls or other regulatory intervention. • Deterioration in cash and liquidity, with reduced ability to meet operational commitments. • Insufficient investment in safe staffing, equipment, digital systems and the physical estate. • Delayed transformation and inability to improve productivity or redesign services sustainably. • Resources being diverted from priority services or short-term controls adversely affecting quality, access or staff experience. • Continued reliance on non-recurrent measures, increasing the savings requirement in future years. • Reduced organisational resilience and inability to respond to emerging operational or strategic pressures. • Reputational damage and loss of confidence among staff, partners, regulators and the public.
Strategic Objectives	**Improving Together** • Launch of the new Financial Sustainability Programme - To develop a new approach to achieving longer term financial sustainability for the Trust with supporting infrastructure to facilitate delivery of identified savings schemes in year.

Lead Director	Chief Financial Officer	**Lead Committee**	Finance and Performance Committee	**Date of last review by Committee**	

BAF risk scoring

Initial risk score	16	**Risk appetite**	Open/Seek Cautious	**Tolerable risk range**	8-12	**Target date to tolerable score**	March 2027

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 Division G. Performance Assurance Framework

Current and prospective scores	**Actual**			**Projected**
	Q4	**Q1**	**Q2**	**Q3**
Consequence	4	4	4	4
Likelihood	4	4	4	4
Current risk score (LxC)	16	16	16	16

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	H. Cost Improvement Programme (CIP) initiatives across Divisions 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. Division financial governance letters; committing Divisions 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)

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	• Divisional Boards and corporate directorate management. • Budget holders and accountable operational managers. • Divisional finance, workforce, activity and quality reviews. • Finance Business Partners supporting Divisions and corporate functions. • Delivery of Divisional recovery plans and FSP workstreams. • Scheme-level gateway evidence, benefits tracking and risk management. • Workforce establishment, vacancy, rostering, bank and agency controls. • Procurement and non-pay expenditure controls. • Quality and Equality Impact Assessments for individual schemes. • Capital project and programme management. • Monthly forecasting, expenditure monitoring and corrective action. • Local risk registers and escalation through the Performance Assurance Framework.	• Executive Leadership Team. • Financial Sustainability Programme Board. • Divisional Delivery Board and executive performance reviews. • Finance and Performance Committee. • Quality Assurance Committee scrutiny of quality and patient-safety impacts. • People and Culture Committee scrutiny of workforce and staff impacts. • Audit and Risk Assurance Committee oversight of financial governance, internal control and the BAF. • Trust Board oversight of financial performance, recovery and strategic risk. • Capital Approvals Group and Investment Group. • Executive Risk Group and Corporate Risk Register. • Central finance, procurement, workforce, quality-governance and programme-assurance functions. • Monthly revenue, capital, cash, productivity and FSP reporting. • Medium-Term Financial Plan and annual-plan reviews. • Risk-appetite, delegated-authority and escalation arrangements.	• Internal audit of core financial controls, workforce controls, procurement, contract management, capital governance and financial sustainability. • External audit of the financial statements and value-for-money arrangements. • NHS England oversight, financial intervention and provider capability assessment. • ICB and regional assurance of system plans, contracts and recovery. • Counter Fraud independent investigation and reporting arrangements. • External gateway or specialist review of major capital and transformation programmes. • Independent post-investment and benefits-realisation reviews. • Benchmarking against national productivity, cost and performance data. • Independent well-led and governance reviews.

Gaps in assurance	1. Assurance that the full Financial Recovery Plan will deliver the required in-year improvement within the necessary timescale 2. Assurance that savings delivery is sufficiently recurrent to reduce the underlying deficit and prevent financial pressures being carried into subsequent years. 3. Assurance that all Divisions have fully developed, quantified and deliverable recovery plans, with consistent executive and divisional ownership and clear alignment between finance, workforce, activity, quality and operational performance and have consistent financial controls 4. Assurance that the Medium-Term Financial Plan contains a credible and deliverable pathway to sustainable recurrent balance, supported by the future clinical, workforce, digital, estate and operating models 5. Assurance that productivity opportunities are being identified, prioritised and converted into cash-releasing recurrent benefits at the pace and scale required, including benefits from eCare and other transformation programmes 6. Assurance that the capital programme can be delivered within available resources without unacceptable reliance on mitigations, brokerage or the deferral of safety-critical investment. 7. Assurance on the confidence of revenue consequences, affordability and benefits realisation of major programmes, particularly eCare and the Women and Children's Hospital Programme.

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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	Deliver and monitor the Trust-wide Financial Recovery Plan through enhanced governance and monthly benefits tracking.	Chief Finance Officer	March 2027	The Financial Recovery Plan was reviewed by the Finance and Performance Committee in September 2026 and approved by the Trust Board in October 2026. Delivery is overseen through the Financial Sustainability Programme Board, Executive Leadership Team, Finance and Performance Committee and Trust Board, supported by divisional and corporate financial controls and monthly benefits tracking. The NHS mid-year review included a specific focus on financial recovery. The programme builds on the route to breakeven and recovery arrangements established during 2025/26, including executive escalation with operational areas, workstream senior responsible officer oversight and regular tracking of delivery. Further assurance is required that the full plan will deliver the required in-year improvement within the remaining timescale	In progress / off track
2	Increase recurrent savings through sustainable productivity, efficiency and service redesign programmes.	Chief Finance Officer	March 2027	schemes against the full requirement. Delivery actions are assigned to workstream senior responsible officers and monitored through the programme's governance arrangements. Previous work reduced the proportion of schemes assessed as high risk; however, further assurance is required that savings are recurrent, cash releasing and sufficient to reduce the underlying deficit rather than transfer financial pressures into future years. Productivity, efficiency and service redesign opportunities should continue to be developed alongside the Trust's activity, workforce, quality and operational assumptions.	In progress / off track
3	Strengthen divisional accountability through integrated recovery plans and standardised financial controls.	Chief Finance Officer / Chief Operating Officer	March 2027	Divisional and corporate financial controls are in place, supported by Finance Business Partners, divisional governance arrangements and executive oversight. Recovery actions are assigned to workstream senior responsible officers and monitored through regular programme meetings and performance reviews. Further work is taking place to ensure that every Division has a fully quantified and deliverable recovery plan, with clear ownership and consistent alignment between finance, workforce, activity, quality and operational performance.	In progress
4	Maintain an integrated Medium-Term Financial Plan aligned to future clinical, workforce, digital and estate models.	Chief Finance Officer	March 2027	The Medium-Term Financial Plan has been developed through the national planning process, with previous submissions considered by the Trust Board and feedback received from NHS England. Executive engagement has taken place with NHS England and the ICB to support alignment and identify options to reduce the forecast deficit. The plan continues to require refinement to demonstrate a credible and deliverable pathway to recurrent financial balance, aligned to future clinical, workforce, digital, estate and operating models. Updates will continue to be reported through the Finance and Performance Committee and Trust Board.	On going
5	Implement a Trust-wide productivity and benefits realisation framework.	Chief Finance Officer	April 2027	The Financial Sustainability Programme provides the developing structure through which productivity opportunities and financial benefits are identified and monitored. Scheme-level gateway evidence, benefits tracking and risk-management arrangements form part of the refreshed assurance framework. Further work is required to establish a consistent Trust-wide productivity and benefits-realisation framework that converts improvement opportunities into recurrent, cash-releasing benefits at the pace and scale required. This should include clear baselines, accountable owners, delivery milestones and arrangements for validating financial and non-financial benefits. For eCare, further review has previously been sought of benefits realisation for 2026/27 and subsequent years against the approved business-case assumptions.	In progress

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6	Deliver a risk-based capital prioritisation and affordability framework.	Chief Finance Officer	April 2027	The Trust's capital programme has been agreed, reviewed and reprioritised through the Capital Approvals Group with reporting to FPC and Trust Board and follows engagement across relevant operational and corporate areas. This has included consideration of the capital consequences of the revised eCare timetable.	
7	Strengthen major programme affordability, financial oversight and benefits realisation arrangements.	Chief Finance Officer / Chief Strategy Officer	April 2027	Financial oversight of eCare continues through the programme's governance arrangements. Following the decision to revise the go-live date to April 2027, the programme review considered the associated financial consequences, which remain a significant risk. The draft sustainment plan previously identified revenue requirements above the Full Business Case assumptions, and further review of benefits realisation against the approved business case has been sought. Revenue affordability for the Women and Children's Hospital Programme continues to be considered through programme governance and the development of the Outline Business Case refresh. The Trust continues to work with the New Hospital Programme on affordability, design and business-case requirements.	Off track

Links to Extreme Risks on Corporate Risk Register (CRR) – Financial recovery					
CRR reference	**Title**	**Executive Lead**	**Current risk score**	**Target risk score**	**Review date**
10374	0006_PGM-RIS_PR04 Delay or Uncertainty in National Capital Funding Approval and Release NBPR	Sue Harris	12	6	Dec-27
10373	0006_PGM-RIS_PR02 Capital Affordability Gap Impacts Business Case Approval NBPR	Sue Harris	16	1	Dec-27
10367	Funding DGR619 (ECPR)	John Howarth	20	1	Dec-27
10261	NBPR - 002 - Affordability (Revenue / Operating Model)	Sue Harris	16	3	Mar-27
9751	(ECPR) (DGR109, DGR190) eCare Cash Releasing Benefits	Mrs Emily Cudmore	16	9	Jan-27
8589	Financial Sustainability Programme (FSP) Delivery (ECPR)	Mr Doug Riley	16	12	Mar-27
8521	Capital Programme - funding and delivery	Adam Wheeldon	20	15	Oct-26

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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

Strategic Objective	Analogue to Digital: embracing technology to transform care and services, empowering patients and enabling clinicians to deliver better care, while improving organisational efficiency.
Risk Description	There is a risk that the Trust is unable to deliver the digital transformation required to support sustainable improvement due to limitations in digital capability, technology infrastructure, workforce capacity, data quality, cyber resilience and successful implementation of new digital solutions. This may result in reduced productivity, inefficient processes, poorer staff and patient experience, financial inefficiency, inability to realise planned benefits, compromised information security and failure to deliver strategic objectives.
Strategic Objective Year 1	Our electronic patient record, eCare goes live - This directly supports the national ambition to move from analogue to digital, enabling significant improvements to patient care through introducing a new, electronic patient record.
Risk cause(s)	• Legacy digital infrastructure and systems. • Delays in delivery of eCare and associated programmes. • Workforce digital capability and capacity constraints. • Information governance and cyber security risks. • Data quality and reporting limitations. • Financial and programme delivery pressures. • Reliance on partners and suppliers.
Risk impact	• Failure to deliver anticipated productivity improvements. • Delayed transformation and service redesign. • Reduced staff experience and digital adoption. • Poorer quality of operational and strategic decision-making. • Information governance breaches and cyber incidents. • Financial inefficiencies and unrealised benefits. • Reduced ability to meet NHS digital and regulatory requirements.

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**	

BAF risk scoring

Initial risk score	20	**Risk appetite**	Minimal/Cautious (cyber) Open (digital transformation)	**Tolerable risk range**	9-12	**Target date to tolerable score**	June 2030

Risk controls or mitigations	A. Digital Strategy implementation programme. B. eCare programme governance and readiness framework. C. Digital Programme Board and executive oversight arrangements. D. Cyber Security Strategy/Programme. E. Information Governance Framework. F. Data Quality Improvement Programme. G. Business Continuity and Disaster Recovery arrangements. H. Digital workforce and training programme.

Actual and prospective scores	**Actual**			**Projected**
	Q4	**Q1**	**Q2**	**Q3**
Consequence	5	5	5	5
Likelihood	4	4	4	4
Current risk score (LxC)	20	20	20	20

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	I. Benefits realisation framework for digital investments. J. NHS DSPT compliance programme. K. Technology lifecycle and infrastructure replacement programme. L. Internal and external assurance of major digital programmes.

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	• eCare Programme Board. • Digital Services operational management. • Information Governance Group. • Cyber Security Group. • Data Quality Groups. • Digital project and programme management arrangements. • Business continuity testing and incident management. • DSPT self-assessment processes. • Benefits realisation monitoring. • System owner and divisional accountability for digital systems.	• Executive Leadership Team. • Digital Health Group. • Digital Transformation Board (System). • Finance and Performance Committee. • Quality Assurance Committee. • Audit and Risk Assurance Committee. • Board Assurance Framework. • Corporate Risk Register. • Information Governance Steering Group. • SIRO oversight. • Performance and programme management reporting. • Internal assurance reviews	• Internal Audit reviews. • NHS England digital and cyber oversight. • DSPT external validation. • Independent programme assurance reviews. • External cyber security assessments. • ICO oversight. • CQC assessments relating to digital maturity and governance. • Supplier and implementation partner assurance. • External benchmarking and peer review.
Gaps in assurance	1. Successful implementation and benefits realisation of eCare. 2. Compliance with the digital component of Hospital 2.0 (NHP) as part of Women's and Children's Programme 3. Digital maturity and adoption across clinical and corporate services including Artificial Intelligence (AI) 4. Cyber resilience and protection against rapidly developing cyber threats. 5. Information governance and protection of confidential information platforms. 6. Digital workforce capability and capacity to support transformation. 7. Replacement of legacy infrastructure and system and supply chain resilience. 8. Demonstration of productivity, financial and operational benefits arising from digital investment.		
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.	Complete eCare implementation and embed benefits realisation programme	Chief Strategy Officer and Chief Information Officer	April 2027	Following the Board's decision in April 2026 to defer implementation, the revised eCare go-live date is April 2027. The additional period is being used to review clinical workflows, strengthen staff training and readiness, and confirm that appropriate safeguards are in place, particularly in high-pressure clinical areas. Monthly assurance reports are being provided to the Trust Board and the programme is operating a structured go-live readiness review. A sustainment plan is also being developed, setting out the post-implementation governance model and resource requirements for Care Groups and digital services. Benefits realisation should be incorporated explicitly within the revised programme plan and sustainment arrangements	
2.	Ensure design artifacts are effective	Chief Information Officer	April 2027	assurance is required that the programme's design artefacts comply with the digital requirements of Hospital 2.0 and are aligned with the Trust's future digital architecture, infrastructure, interoperability and eCare	

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				requirements and this is being considered as part of the Women's and Children's Programme	
3.	Deliver Digital Strategy roadmap and adoption programme - Improved digital maturity assessment, increased use of digital workflows and reduction in paper-based processes	Chief Information Officer	2026 – 2031	The Trust Digital Strategy was approved by the Trust Board in March 2026, with an annual progress update to be provided to the Board. Delivery of the digital portfolio is overseen through the Digital Health Group, with quarterly assurance reporting to the Finance and Performance Committee. The next phase should establish a measurable implementation roadmap covering digital maturity, adoption of digital workflows and reduction in paper-based processes	
4.	Deliver Cyber Security Improvement Programme and resilience testing	Chief Information Officer / Senior Information Risk Owner	2026/28	The Trust is in year two of its multi-year Cyber Security Strategy, with delivery monitored through the Cornwall Cyber Review Group and reported through information governance arrangements. External funding was secured to support the 2025/26 programme, and the Trust has continued to maintain mitigating controls while the wider strategy is reviewed. Annual Board cyber security training was completed in December 2025. Further work is required to demonstrate delivery against the revised strategy, resilience testing, supplier assurance and the NHS England expectations for Board and executive oversight. Refreshed Cyber Strategy working its way through internal governance in November 2026	
5.	Deliver Information Governance Improvement Plan and strengthen monitoring of record access	Chief Information Officer / Senior Information Risk Owner	April 2027	Consideration and development of new platforms, noting that eCare would support data being in one platform Existing information governance arrangements are being supplemented through staff communications, policy development and guidance on the appropriate use of AI platforms. The implementation of eCare is expected to support more consistent information management through consolidation of data within a principal platform. Further evidence is required on delivery of the Information Governance Improvement Plan, monitoring of inappropriate or unusual record access, audit outcomes and actions taken in response to identified concerns through Quality Assurance Committee (link with BAF element 1)	
6.	Develop digital skills and workforce development programme – Increase digital training compliance and improved digital capability assessment results	Chief Information Officer	April 2027	Training and communications are being delivered to support eCare readiness, including work to ensure that staff understand clinical workflows and are confident using the system safely. Staff communications and guidance have also been issued on the use of AI platforms, supported by policy development and a Board development session. These activities should now be brought together through a Trust-wide digital skills programme, supported by a baseline capability assessment, defined training requirements and measures of completion and effectiveness	
7.	Deliver network infrastructure refresh and resilience programme	Chief Information Officer	April 2028	The cyber security and infrastructure programme continues while funding and investment requirements are reviewed. Monitoring controls are in place and work has focused on cyber posture, supplier assurance and the resilience of systems supporting eCare Review of configuration of data centre network the immutable backup and Minimal Viable IT Infrastructure solution has been approved, supporting investment of £3.01m to strengthen cyber resilience and address the limitations of the existing secondary backup infrastructure. The approved solution will provide immutable backup targets, cyber-threat detection and scanning capabilities, and an isolated recovery environment from which critical services can be restored following a major cyber incident.	

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8.	Deliver and monitor digital benefits realisation framework particularly operational benefits	Chief Information Officer	April 2027	The developing eCare sustainment model will provide the governance framework for ensuring that the solution remains aligned with operational and user requirements following implementation.(i.e. ensuring, during the build of the solution, is addressing business need and is fit for purpose whilst addressing benefits realisation). Benefits realisation should be embedded throughout the revised eCare plan, with clear ownership, baseline measures and reporting of clinical, operational, workforce, productivity and financial benefits through programme and committee governance	

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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**
10366	Reporting Delivery DGR617 (ECPR)	John Howarth	20	5	Dec-27
9972	Lack of Immutable Backups (EPRR)	Robert Phillips	20	5	Aug-26
9969	VoIP licence renewal	Robert Phillips	12	5	Mar-26
9551	(ECPR) E Care functionality (ACCT)	Rebecca Whittaker	12	5	Apr-27
9384	(ECPR) End of IT System support and maintenance - eCare	Miss Liz Evans	16	5	Dec-26
8303	Cyber-Attack EPRR	Mr Martin Price	20	5	Sep-26

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BAF 6. Failure to transform and maintain a safe and fit-for-purpose estate infrastructure for patients, staff and visitors

Strategic Objective	Together we learn and make improvements to become a sustainable organisation, for our staff, for our finances and our environment.
Risk Description	There is a risk that the Trust is unable to maintain and transform its estate and critical infrastructure at the pace required to provide safe, resilient, compliant and sustainable healthcare environments, due to the age and condition of the estate, significant backlog maintenance, constrained capital and workforce capacity, infrastructure limitations and dependencies on external funding and major capital programmes. This could result in harm to patients, staff or visitors; disruption to clinical services and business continuity; statutory or regulatory non-compliance; increased financial pressures; and failure to deliver the Trust's strategic ambitions for sustainable and transformed care
Risk cause(s)	• Ageing estate and critical infrastructure. • Significant backlog maintenance requirements. • Constrained capital funding and competing investment priorities. • Capacity and capability constraints within operational Estates. • Reliance on external funding, national approvals and major capital programmes. • Critical infrastructure operating at or approaching capacity or end of life. • Gaps in the consistent effectiveness of statutory compliance and estates controls. • Supply-chain and inflationary pressures. • Increasing infrastructure resilience requirements, including severe weather. • Increasing environmental sustainability and decarbonisation requirements.
Risk Impact	• Harm to patients, staff or visitors. • Disruption to clinical services and business continuity. • Failure to meet statutory, regulatory or healthcare technical requirements. • Regulatory intervention or enforcement. • Reduced resilience of critical infrastructure and services. • Increased reactive maintenance, remediation and capital costs. • Failure to reduce significant estates and infrastructure risks within planned timescales. • Delays to major strategic developments and clinical transformation. • Inability to provide safe, effective and modern healthcare environments. • Failure to achieve environmental sustainability and decarbonisation ambitions. • Adverse impact on staff working environments. • Reputational damage and reduced stakeholder confidence.
Strategic Objectives – year 1	• Business case for new Women and Children's Hospital submitted - Outline Business Case approved to enable progress to Full Business Case stage. • Cardiac services re-location - Re-location of cardiac services is a key enabler of the Women & Children's Programme • Appoint a specialist Sustainability Lead - To lead delivery of the Trust's Green Plan, enabling the Trust to meet Net Zero Carbon reduction. •

Lead Director	Director of Estates and Facilities	**Lead Committee**	Finance and Performance Committee	**Date of last review by Committee**	

BAF risk scoring

Initial risk score	12	**Risk appetite**	Cautious	**Tolerable risk range**	6 – 8	**Target date to tolerable score**	March 2029

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

Actual and prospective scores	**Actual**			**Projected**
	Q4	**Q1**	**Q2**	**Q3**
Consequence	4	4	4	4
Likelihood	3	3	3	3

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	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) L. Clinical Strategy relevance to support risk controls and mitigations	**Current risk score (LxC)**	12	12	12	12

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	• Specialist estates safety/compliance arrangements for fire, water, ventilation, asbestos and other infrastructure disciplines. • Authorised Persons and operational safe systems of work. • Planned and reactive maintenance arrangements. • Estates Performance, Improvement, Governance and Compliance function. • Capital/project management arrangements and Capital Approvals Group. • Contractor and supplier management. • Dynamic infrastructure risk assessment and escalation through the CRR. • Business continuity arrangements.	• Executive oversight and Executive Risk Group consideration of material estates risks. • Finance and Performance Committee oversight of capital, estates performance, major capital programmes, sustainability and BAF 6. • Quality Assurance Committee oversight of health and safety, fire, asbestos and other estates-related safety assurances. • Audit and Risk Assurance Committee oversight of risk-management effectiveness and relevant audit findings. • Trust Board oversight through the BAF, CRR escalation and approval of significant strategic capital decisions. • Corporate Health and Safety oversight and scrutiny of statutory compliance/action plans. • Finance/procurement oversight of capital affordability, prioritisation and procurement compliance.	• Internal audit reviews relevant to estates, health and safety, procurement and financial controls. • External audit, including value-for-money assessment. • Independent Authorising Engineers and other competent-person assurance where applicable. • Six-Facet Survey undertaken by an external specialist. • Health and Safety Executive/regulatory oversight. • Cornwall Fire and Rescue Service engagement/assurance. • Building Control and other statutory/regulatory bodies. • NHS England/New Hospital Programme gateway and external assurance processes for major capital schemes.
Gaps in assurance	1. Assurance that the Estates Strategy/Masterplan and risk-based multi-year backlog maintenance programme provide a deliverable, funded route to improve the condition and resilience of the estate in line with the Trust Strategy. 2. Assurance that available capital is sufficient, and prioritised effectively, to address the highest estates and infrastructure risks while supporting strategic transformation. 3. Further assurance is required that estates health and safety and statutory compliance controls are consistently embedded and effective, particularly for asbestos, fire, maintenance systems, contractor management, training, information/records and completion of remedial actions 4. Insufficient assurance that risks associated with critical infrastructure capacity, ageing assets, adverse weather and infrastructure failure can be reduced within acceptable timescales without disruption to clinical services. 5. Further assurance is required that the Trust's programme of fire-risk remediation will reduce identified fire risks across the estate within agreed timescales and that improvements are sustainably embedded. 6. Assurance that the Trust has the capacity, resources and funded delivery trajectory necessary to achieve the Green Plan and longer-term decarbonisation commitment		
Overall level of assurance	Medium		
Actions to address gaps in assurance			

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No.	Action required	Executive Lead	Due date	Progress Report	On or off track or proposed complete
1.	Refresh the Estates Strategy/Masterplan aligned to the Trust and Clinical Strategies and translate the Six-Facet Survey into a risk-prioritised multi-year backlog maintenance programme.	Director of Estates and Facilities	March 2028	The Trust has completed the 2024 Six-Facet Survey, providing an updated assessment of estate condition, and is using this to inform risk-based prioritisation of backlog maintenance. The backlog maintenance programme has been aligned with capital planning and is subject to regular oversight through the Capital Approvals Group. A specification for the refreshed Estates Strategy has been developed, with delivery being progressed through the Women and Children's programme arrangements to support a more streamlined approach. The Strategy will reflect the refreshed Trust and Clinical Strategies and national NHS changes. Completion of the Strategy and associated long-term delivery trajectory remains outstanding	Off track / ongoing
2.	Estates capital trajectory showing required investment against available capital, prioritisation of highest-rated infrastructure risks, dependencies and residual/unfunded risk.	Director of Estates and Facilities	March 2027	The Trust has undertaken prioritisation of its capital programme, focusing available investment on the highest-risk statutory compliance, resilience and operational continuity requirements. Prioritisation exercises have been undertaken across the Electrical and Mechanical programmes, schemes are being developed to support informed investment decisions, and alternative funding routes are being explored. The capital programme continues to be actively reprioritised as funding and delivery risks change. Further assurance is required on the medium-term affordability of the programme and the trajectory for reducing residual estates risks.	Off track / ongoing
3.	Complete and monitor the consolidated estates/H&S improvement plan covering asbestos, contractor governance, statutory maintenance, training, data/record integrity and remedial actions, with explicit evidence of control effectiveness.	Director of Estates and Facilities / Chief Operating Officer	March 2027	Following identified weaknesses in health and safety and statutory compliance controls, the Trust has developed an action plan covering areas including asbestos management, contractor oversight, training compliance, record integrity and accountability, with monitoring through Quality Assurance Committee arrangements. Following the West Cornwall Hospital asbestos incident, works were stopped and made safe, an investigation was undertaken and corrective actions identified. The Health and Safety assurance process has subsequently identified areas of limited or moderate assurance for incorporation into a time-specific improvement plan. Further evidence of sustained implementation and control effectiveness is required before the assurance gap can be closed	Ongoing
4.	Complete prioritised resilience plans for critical infrastructure, incorporating electrical capacity, water, ventilation and other high-rated infrastructure risks and learning from severe weather/business continuity events.	Director of Estates and Facilities	March 2027	The Trust has strengthened risk-based prioritisation of critical infrastructure through its capital programme and Corporate Risk Register. Detailed scopes and programme governance have been developed across the Critical Infrastructure Programme, with Electrical and Mechanical programmes being prioritised against available funding. The Trust is progressing the critical electrical infrastructure solution through the Women and Children's Programme, while alternative funding opportunities for other infrastructure requirements continue to be explored. Significant infrastructure risks remain and delivery of the planned	Ongoing

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				mitigations is required to demonstrate sustained risk reduction.	
5.	Deliver the prioritised fire remediation programme and maintain enhanced oversight until the Trust can evidence sustainable implementation of actions and corresponding reduction in fire risk.	Director of Estates and Facilities	March 2027	The Trust has continued its phased programme of fire improvement works and has pursued external NHS England Estate Safety Fund investment to accelerate remediation. Fire risks have been reviewed more broadly across the estate rather than being confined to the tower programme, and work has been undertaken to ensure relevant fire risks are appropriately reflected within the Corporate Risk Register. Existing governance arrangements provide oversight of the remediation programme and wider organisational fire-safety responsibilities. Delivery of the remaining works and evidence of sustained reduction in fire risk remain necessary to close the assurance gap	Ongoing
6.	Establish a fully resourced Green Plan delivery trajectory, including the route to the heat decarbonisation plan and defined delivery, finance and governance arrangements.	Chief Strategy Officer/ Director of Estates and Facilities	2030	The Trust Board approved the refreshed Green Plan in November 2025 and governance has subsequently been strengthened through establishment of a Green Plan Oversight Group and dedicated Sustainability Manager capacity. Work has progressed on sustainability opportunities, including development of the Trust-wide Travel Plan, engagement with Cornwall Council on the Langarth heat network and exploration of geothermal and other decarbonisation opportunities. Executive review has nevertheless confirmed that the Trust remains off trajectory against elements of the Green Plan, particularly heat decarbonisation, waste, travel and transport. The focus is therefore moving from establishing governance to delivering a financially sustainable decarbonisation trajectory and securing external funding opportunities	Ongoing

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Links to Extreme Risks on Corporate Risk Register (CRR) – Physical infrastructure and supply chain					
CRR reference	**Description**	**Exec Lead**	**Current risk score**	**Target risk score**	**Review date**
10027	T6 water Ingress	Rebecca Whittaker	12	4	Dec-26
10024	Risk of infection due to outdated/missing Ventilation Systems	Ryan Hill	16	8	Jan-35
9937	Insufficient electrical capacity at RCH to meet the growing demands of the Trust (NBPR)	Mr Richard Parris	16	4	Feb-28
9663	Risk to patient safety due to T1 recovery water ingress	Rebecca Whittaker	12	4	Sep-29
9573	Failure to meet statutory timescales for disclosures made under Data Protection Act (Subject Access Requests)	Mark Scallan	20	9	Sep-26
9469	SECSY_001 Access Control & ID Badge System - End of Life August 2025	Miss Natasha Quick	20	12	Apr-27
8858	Failure of Sterile Services Department (Engineering Support & Infrastructure) (EPRR)	Mr Richard Parris	15	8	Apr-27
8040	There are underlying unsafe conditions to the building infrastructure that have an impact on Fire Safety EPRR	Gary Martin	16	8	Mar-29
7302	Environment Agency/CQC/HSE Compliance re Radioactive Materials - Condition of Premises	Philip Bond	16	8	Mar-27
1250	Medical Gases not compliant with HTM02	Mr Richard Parris	12	4	Sep-26

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Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 16.2

Title of Report: Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Process 2026

Executive Director Lead: Robin Jones, Chief Operating Officer, Acting Deputy Chief Executive and Accountable Emergency Officer (AEO) for EPRR

Author and Job Title: Matt Overton, Head of EPRR

Email Address: matthewoverton@nhs.net

Purpose of the Report:

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

NHS Trusts are designated as Category 1 Responders under the Civil Contingencies Act (2004) and are required to undertake a self-assessment against the core standards as set out in the NHS England EPRR Core Standards Matrix. This year RCHT has been assessed by the Integrated Care Board (ICB) as substantially compliant.

Consultation:

The outcome of the RCHT Core Standards Assurance Process was discussed at a meeting between the ICB and RCHT on 10th September. This paper was presented at Executive Leadership Team on 16th September and ARAC on 13th October.

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	Effective emergency preparedness and business continuity arrangements support protection of population health and continuity of access to essential services during incidents. Planning and testing should consider those most vulnerable to service disruption to minimise disproportionate impacts.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Addressing the outstanding business continuity exercises and Hazmat/CBRN training gaps will strengthen assurance over safe, effective care during incidents. Residual risks remain until these actions are completed, with monitoring through the EPRR Committee and ARAC.
Sustainable and efficient use of NHS resources by RCHT	Tested business continuity plans and embedding training within mandatory training and induction support effective use of staff and operational resources during incidents. The report does not identify additional financial requirements or quantify resource benefits.

Recommendation(s):

Reeve, Lynsey
30/10/2025 09:30:09

The Board is recommended to:

- **Note** substantial compliance against the EPRR Core Standards Assurance Process

- **Endorse** EPRR Committee and Audit and Risk Assurance Committee maintain oversight of actions to ensure movement to full compliance of all standards.

Neave,Lynsey
30/10/2026 09:31:09

EPRR Core Standards Assurance Process 2026

1. Situation

The 2026 EPRR Core Standards Assurance Process is showing RCHT as being substantially compliant with 2 partially compliant out of 62 standards.

2. Background

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet.

Royal Cornwall Hospitals NHS Trust is required annually to assess its performance against the Assurance Framework and issue a position statement against the set criteria. In 2025 RCHT was partially compliant with 5 partial compliant and 3 non-compliant out of 62 core standards in total.

3. Assessment

The 2026 EPRR Core Standards Assurance Process has 62 outcomes this year. RCHT is fully compliant with 60 of these outcomes and partially compliant against 2 namely:

Core Standard 48 - Business Continuity: Testing and Exercising

There are approximately 25 outstanding Business Continuity Plans (BCPs) for review/exercise in 2026. These will be subject to table top exercise before the end of December 2026.

Core Standard 64 – Hazmat/CBRN: Staff training (recognition and decontamination)

Only 18 out of 37 ED Receptionists (49%) have completed the training despite being offered additional hours to complete. Going forward this training will now be completed as part of annual mandatory training or on induction into the role for new starters. Mandatory training compliance is reported by ED as being good for this role.

CBRN is Chemical, Biological, Radiological and Nuclear.

4. Risk

That Business Continuity response could be sub-optimal and that ED Receptionists do not recognise the presentation of a patient in ED who is potentially contaminated.

5. Accountability

The EPRR Committee and ARAC will monitor the partially compliant standards to ensure it is completed. ARAC to next review at their meeting in February 2027.

Neave Cynsey
30/01/2026 09:31:09

6. Recommendations

The Board is recommended to:

- **Note** substantial compliance against the EPRR Core Standards Assurance Process
- **Endorse** EPRR Committee and Audit and Risk Assurance Committee maintain oversight of actions to ensure movement to full compliance of all standards.

Neave,Lynsey
30/10/2026 09:31:09

APPENDIX A: FULLY COMPLIANT EPRR CORE STANDARDS

Governance	Senior Leadership
Governance	EPRR Policy Statement
Governance	EPRR board reports
Governance	EPRR work programme
Governance	EPRR Resource
Governance	Continuous improvement
Duty to risk assess	Risk assessment
Duty to risk assess	Risk Management
Duty to maintain plans	Collaborative planning
Duty to maintain plans	Incident Response
Duty to maintain plans	Adverse Weather
Duty to maintain plans	Infectious disease
Duty to maintain plans	New and emerging pandemics
Duty to maintain plans	Countermeasures
Duty to maintain plans	Mass Casualty
Duty to maintain plans	Evacuation and shelter
Duty to maintain plans	Lockdown
Duty to maintain plans	Protected individuals
Duty to maintain plans	Excess fatalities
Command and control	On-call mechanism
Command and control	Trained on-call staff
Training and exercising	EPRR exercising and testing programme
Training and exercising	Responder training
Training and exercising	Staff Awareness & Training
Training and exercising	EPRR Training
Response	Incident Co-ordination Centre (ICC)

Active Until 30/10/2018 09:31:59

Response	Access to planning arrangements
Response	Management of business continuity incidents
Response	Decision Logging
Response	Situation Reports
Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events’
Response	Access to ‘CBRN incident: Clinical Management and health protection’
Warning and informing	Warning and informing
Warning and informing	Incident Communication Plan
Warning and informing	Communication with partners and stakeholders
Warning and informing	Media strategy
Cooperation	LHRP Engagement
Cooperation	LRF / BRF Engagement
Cooperation	Mutual aid arrangements
Cooperation	Information sharing
Business Continuity	BC policy statement
Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives
Business Continuity	Business Impact Analysis/Assessment (BIA)
Business Continuity	Business Continuity Plans
Business Continuity	Business Continuity Audit
Business Continuity	Data Protection and Security Toolkit
Business Continuity	BCMS monitoring and evaluation
Business Continuity	BCMS continuous improvement process
Business Continuity	Assurance of commissioned providers / suppliers BCPs
Hazmat/CBRN	Governance
Hazmat/CBRN	Hazmat/CBRN risk assessments

Maeve.Lynse
30/10/2023 09:31:03

Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure
Hazmat/CBRN	Hazmat/CBRN planning arrangements
Hazmat/CBRN	Waste disposal arrangements
Hazmat/CBRN	Preventative Programme of Maintenance
Hazmat/CBRN	Equipment and supplies
Hazmat/CBRN	Decontamination capability availability 24/7
Hazmat/CBRN	Hazmat/CBRN training resource
Hazmat/CBRN	PPE Access
Hazmat/CBRN	Exercising

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 17

Title of Report: Remuneration and Appointments Committee Assurance Report to the Board – October 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 August 2026 meetings.

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

- Considered the Chief Executive Officer arrangements

Key Risks (please tick one or more):

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

Reputational ☐ **Legal / Regulatory** ☐

Impact:

Neave, Lynsey
30/10/2026 09:31:09

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 October 2026 meetings and any decisions taken on behalf of the Board as per the Committee's terms of reference.

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 18

Title of Report: Integrated Performance Report

Executive Director Lead: Robin Jones, Chief Operating Officer and Acting Deputy Chief Executive Officer

Author and Job Title: Robin Jones, Chief Operating Officer and Acting Deputy Chief Executive Officer

Email Address: robin.jones2@nhs.net

Purpose of the Report:

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

The Integrated Performance Report is a holistic view of the key indicators for Safety, Quality, Workforce, Finance and Performance. The report is divided into sections for the Board Sub-committees to review specific elements with a separate section for the Trust Board's consideration for assurance.

Consultation:

This report has been considered for assurance at the following; Executive Leadership Team meeting, Finance and Performance Committee, Quality Assurance Committee

Due to the People and Culture Committee meeting every other month this report has not been considered by the People and Culture Committee

Specific elements by Committee

The Quality Assurance Committee summary is:

- The committee reviewed deep dives on Fractured Neck of Femur and the Urgent Care Update which provided in depth scrutiny of the two areas of focus.
- The committee reviewed stroke performance continuing to have concern as to the performance of admission to the stroke unit within 4 hours and noted the improvement in access to CT.
- The committee noted there had been a small reduction in emergency readmissions for three months in a row triangulating this to the increased focus on length of stay reduction to reduce corridor care. This metric is a positive quality balancing indicator.

Neave Lyttle 30/10/2026 09:31:09

- The committee discuss duty of candour compliance and the numbers of formal complaints being received.

The Finance and Performance Committee summary is:

- A deep dive on the elective recovery 7 areas of focus was provided to the committee including outlining the additional scrutiny process used to support the 81% Referral To Treatment plan.
- The Committee received detailed financial papers which were discussed separately on the agenda
- The Committee noted that Orthopaedics is the most pressured service for delivery of the 18 week pathway, experiencing waits over 65 weeks and the largest contributor to the 52 week wait position.
- The committee discussed the urgent care indicators acknowledging the significant improvement in ambulance handover times.
- The committee noted that whilst there had been improvement of the 4 hour performance for the Emergency Department it remained behind trajectory.
- The committee noted that the 12 hour performance for the Emergency Department had also improved for the last three months and was on trajectory, however the Chief Operating Officer advised the committee that October performance for 12 hours had reduced.
- The committee requested that the infographic used to summarise the performance of the Trust had the 12 hour ED wait performance added to support overall transparency of that indicator and acknowledging it is a key area for improvement.

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:

Michelle Kinsey 30/10/2026 08:51:19

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 Integrated Performance Report has the purpose of providing the detail of performance and actions in support of access to services for all, quality and safety of those services, the workforce indicators and finance delivery. These triangulate to provide a balanced view of the overall Trust delivery which is then triangulated to the National Oversight Framework score and the current CQC ratings.
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:**

- **Discuss for assurance** the Trust Board section of the report
- **Discuss for assurance** the feedback from the Finance and Performance committee and Quality Assurance Committee

Neave,Lynsey
30/10/2026 09:31:09

NHS
Royal Cornwall Hospitals
NHS Trust

Integrated Performance Report (IPR)



September 2026

Neave,Lyn
30/10/2025 09:31:09

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,Lynsey
30/10/2026 09:31:09

A guide to SPC charts

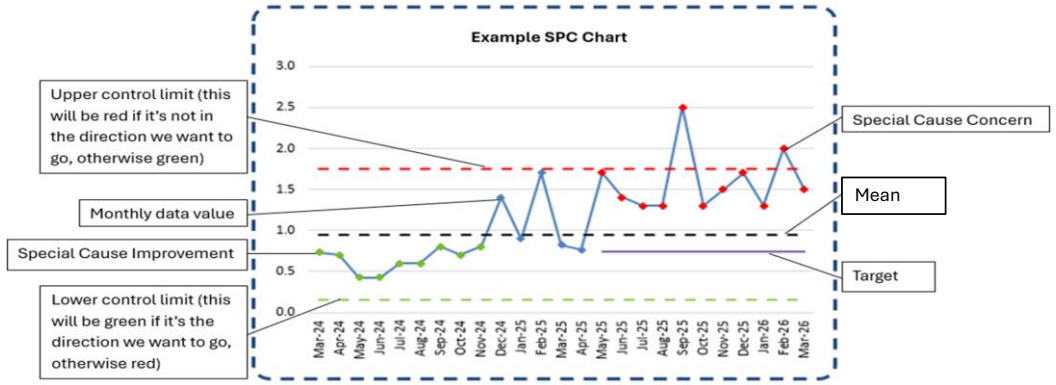
Within the Integrated Performance Report (IPR), statistical process control (SPC) charts are used where appropriate.

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.
- 2 out of 3 data points close to the warning limits of two standard deviations - this indicates where the data is not the norm for this process or measure.(red markers).
- 7 consecutive points in an upward or downward direction - implies a change in the process.
- 7 consecutive points above or below the mean - implies a change in the process



Neave,Lynsey
30/10/2026 09:31:09

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

Neave.Lynsey
30/10/2023 09:31:09

Executive Summary

OVERALL POSITION

At Month 6, the Trust is showing targeted operational and workforce improvement, but the overall position remains challenged by financial risk, urgent-care congestion, elective recovery and selected quality concerns. Progress now needs to translate into sustained delivery, stronger productivity and reduced reliance on temporary measures.

WORKFORCE

Recruitment and retention indicators improved in September. Total vacancies reduced from 10.07% to 9.25%, turnover from 7.27% to 7.08%, registered-nurse vacancies from 8.03% to 6.75%, and medical vacancies from 4.34% to 3.97%. Nursing fill was stable, with registered hours at 97.0% of plan and unregistered hours improving to 98.9%. Stress-related sickness reduced from 31.7% to 28.9%, although overall sickness increased to 5.43%. Appraisal completion recovered to 59.6% and health and safety training to 91.84%, but statutory and mandatory training slipped to 77.17%. Staff advocacy, confidence to speak up, attendance and senior ethnic-minority representation remain material priorities. The Board should seek evidence that lower vacancies are converting into more stable staffing and reduced bank, agency and additional-duty-hour expenditure.

FINANCE

The Trust reported a £2.23m adverse year-to-date position and a £21.4m forecast year-end risk, improved from £25.4m at Month 5. Financial Sustainability Programme delivery remains overly dependent on non-recurrent savings: only 16% has been delivered recurrently against a 72% plan, although the forecast shortfall improved to £10.5m. Capital delivery is also high risk and depends on £10.0m of mitigations.

18-WEEK RECOVERY

RTT 18-week performance is 71.5%, with the waiting list at 45,155. Breaches increased by 645, although 52-week waits reduced to 435. The 18-week recovery plan is being supported by the 100-day theatre programme, daily activity reporting, weekend working and weekly executive oversight. Theatre session utilisation improved to 85%, but delivery remains constrained by theatre capacity, sickness, vacancies and premium-session reliance; bookings must rise toward 450 patients per week.

OPERATIONS AND QUALITY

Ambulance handovers improved materially: mean handover time fell from 89 to 45 minutes and waits over 15 minutes reduced by around 10 percentage points to 76.33%, though both remain above target. Stroke care also shows improvement from earlier in the year: 56.6% reached the stroke unit within four hours, 91.23% spent at least 90% of their stay on the unit and CT within 12 hours remained strong at 98.15%. The SSNAP rating remains E, so the unit relocation, continuous thrombolysis pathway and national improvement collaborative are critical.

Quality remains mixed. Initial assessment and aggregated delay improved, corridor care reduced, pressure ulcers fell and there were no Never Events. However, ED crowding remains a major safety risk; falls with harm, delayed discharges, fractured-neck-of-femur performance, Duty of Candour compliance and C. difficile above tolerance require continued Board oversight. Mortality indicators remain within expected ranges, subject to focused action on the hip-fracture mortality alert.

Neave,Lynsey
30/10/2026 09:31:09

Trust Board Summary



Outstanding
Care for One+All

Neave,Lynsey
30/10/2026 09:31:09

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

	Sep-26	Target	2026/27
Elective theatre cases (for the 9 specialties in the theatres plan)	1432	1975	
Cancellations on the day for management reasons	69	0	
Agency - whole time equivalent (WTE) - Nursing	1162	0	
Agency - whole time equivalent (WTE) - Medical	128	0	
Agency - whole time equivalent (WTE) - Allied Health Professionals	49	0	
Agency - whole time equivalent (WTE) - Pathology	18	0	
Escalation spaces in use - Inpatient (at 8am snapshot)	897	0	
Corridor care spaces in use - Inpatient (at 8am snapshot)	413	0	
Corridor care spaces in use - ED (based on 24 hour period)	370	0	
RTT clock stops (working day stops) - admitted pathways	107	>2025/26 (123)	
RTT clock stops (working day stops) - non-admitted pathways	417	>2025/26 (418)	

CQC Ratings by Location (RI = Requires Improvement)

Domain	RCHT 2019	RCHT 2025	WCH 2026	SMH 2018	Penrice 2022/2017	Helston 2022	SASH
Safe	RI	RI	Good	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	R (2025)	Good (2018)	Not Rated
Medical Care	RI (2025)	Good (2018)	Good (2018)
Surgery	R (2019)	Good (2026)	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
30/10/2026 09:31:09

Summary Performance - Sep 2026

Board snapshot: 12 key metrics

Improving Stable Concern

NHS Oversight Framework

Segment 3 ↓

Corridor Care

26 /day ↓

New metric

ED & MIUs 4-hour performance

75% =

Total Aggregated Patient Delay (hours)

15,325 ↓

RTT 18-week performance

71.5% ↓

Waiting list size

45155 ↑

RTT 52 week waits

435 ↓

Cancelled Operations on the day

69 ↓

Diagnostics within 6 weeks

82.9% ↑

Cancer 28-day faster diagnosis

82.1% ↑

Fractured Neck of Femur patients operated on within 36 hours

56% ↑

Monthly agency spend

£0.59 m ↓

Vacancy rate

9.3% ↓

Neave,Lynsey
30/10/2026 09:31:09

Delivery against Annual Operating Plan (AOP)

The tables below show the Trust's year to date (YTD) delivery against the Annual Operating Plan (AOP).

It should be noted that the data below is impacted by uncoded activity due to backlogs in clinical coding and maternity pathways, and is therefo re subject to change.

From September 2026 Service Level Agreement (SLA) there will be further change due to new tarriffs being published due to nat ional inflation changes.

M6 year to date - as at 15th October 2026

Elective Recovery Fund:

ACTIVITY AND REVENUE BY MONTH

Patient Group	Actual Activity	Target Activity	Activity Variance	Activity Variance %	Actual Revenue	Target Revenue	Revenue Variance	Revenue Variance %
DESP	11658	12274	-616	-5%	£496,455	£504,313	-£7,858	-1.6%
Elective	39992	40618	-626	-2%	£45,361,209	£48,232,665	-£2,871,456	-6.0%
FU Outpatient Procedures	41876	40845	1031	3%	£8,477,273	£8,407,732	£69,541	0.8%
New Outpatient	113603	113383	220	0%	£23,279,233	£23,503,392	-£224,159	-1.0%
Total	**207129**	**207120**	**9**	**0%**	**£77,614,170**	**£80,648,102**	**-£3,033,932**	**-3.8%**

Blended / Block:

ACTIVITY AND REVENUE BY MONTH

Patient Group	Actual Activity	Target Activity	Activity Variance	Activity Variance %	Actual Revenue	Target Revenue	Revenue Variance	Revenue Variance %
A&E Attendances	58394	54585	3809	7%	£13,152,821	£12,547,394	£605,427	4.8%
Emergency Spells	26285	24628	1657	7%	£76,504,400	£78,404,132	-£1,899,732	-2.4%
FU Outpatient Attendances	159005	157470	1535	1%	£18,348,390	£18,265,490	£82,900	0.5%
Maternity Pathway	5085	5689	-604	-11%	£12,902,138	£14,847,388	-£1,945,250	-13.1%
Total	**248769**	**242372**	**6397**	**3%**	**£120,907,749**	**£124,064,404**	**-£3,156,655**	**-2.5%**

Neave, Lynsey
30/10/2026 09:31:09

NHS Oversight Framework - Q1 2026/27 RCHT Overview

The NHS Oversight Framework provides a consistent and transparent way for NHS England to assess Trust performance against a f ocused 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

On 10th September 2026 segmentation scores for Q1 were published, with RCHT dropping down to segment 3 (below average) with an averag e score of 2.37 (down from 2.29), having been in Segment 2 (above average) in Q4 2025/26. It should be noted however that Q1 2026/27 results are not directly comparable with previous quarters because the new 2026/27 framework uses updated metrics and fixed thresholds, and therefore any comparison with segmentation results from 2025/26 must be considered in this context.

The Trust ranked 60 out of 134 Trusts in Q1 (down from 30 in Q4). Trusts are ranked first by segment and then by average score within that segme nt, with rankings ranging from 1 to 134. A likely range of rank is also published for each trust, representing the range an organisation's rank could fall in, with 95% certainty, depending on the 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 bet ween 19 – 108 in Q1, demonstrating that we perform well in some areas but poorly comparatively in others.

Of all the scored metrics, there are 7 metrics where metric scores for RCHT lie between 3.00 – 4.00 in Q1 (worst scores): 4 of these are the 4 Staff Survey metrics (scores range 3.82 – 3.95, annual scores); Percentage of patients spending over 12 hours in department (3.80, quarterly score); Percentage of clinical trials set up wit hin 90 days (4.00, quarterly score); Temporary staffing cost relative band (3, quarterly score).

In the Access to Services domain, there is opportunity to achieve a score of 1.00 (best score), for 6 out of the 9 metrics in the domain by meeting the national standard (details in table below). In Q1, the Trust only met the standard for 1 of these 6 metrics (percentage of patients waiting over 52 weeks for community services).

RCHT performed well and achieved the best available score of 1.00 for the following metrics in Q1: Percentage of patients wai ting over 52 weeks for community services (quarterly score); 30-day readmission rate band (annual score); Breadth and depth of clinical audit outliers (quarterly score); Combined finance score (quarterly score) ; Relative cost difference (National Cost Collection Index) (annual score). The Trust also scored favourably for Data Quality Maturity Index which is a new metric this year.

Targeted areas of focus and actions that are being progressed to have the most significant impact on our overall segmentation score include: workforce and culture; ED 12 hour performance (incorporating the urgent care indicators); diagnostic performance; Referral to Treatment (RTT); Financial Sustainability Programme (FSP).

In September the Chief Operating Officer will be developing and implementing a performance methodology of 'delivery boards' w hich will be run in partnership with the Chief Finance Officer. The Delivery Boards have a dedicated focus with individual Divisions on the finance and performance indicators which will strengthen delivery of the financial controls (including Financial Sustainability Programme delivery) and Operational delivery of key access standards. This is in response to the Trust being off plan and listening to feedback from Divisional Teams as to areas of support. All Executive Directors will be able to attend the Delivery Boards as required. The Delivery Boards will also look to challenge and reduce duplication of meeting request for t he teams to enable them to have time back for delivery, again listening to feedback to give Divisional teams more delivery time.

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NHS Oversight Framework - Q1 2026/27

Domain - Finance, productivity and innovation
Quartile 1 - highest scoring 25%
Average score 1.84

Metric	Sub-domain	Value	National benchmark	Score	Rank
Variance year-to-date to financial plan	Finance	**0.01%**		1	28
Planned surplus/deficit	Finance	**0%**		1	8
Combined finance score	Finance			1	
Percentage of clinical trials set up within 90 days	Innovation	**14.29%**		4	100
Data Quality Maturity Index score	Innovation	**96.40**		1.36	12
Relative difference in costs	Productivity	**96.93%**	100%	1	46

Domain - Effectiveness of care and population health
Quartile 2 - second highest scoring 25%
Average score 1.87

Metric	Sub-domain	Value	National benchmark	Score	Rank
Percentage of patients readmitted within 30 days of discharge – comparative band	Effective discharge			1	
Summary Hospital-level Mortality Indicator	Outcomes			2	
Delayed inductions rate	Outcomes	**33.10 per 1000**		2.60	64
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Preventing ill health	**39.45%**	0%	1.88	43

Domain - Access to Services
Quartile 2 - second highest scoring 25%
Average score 2.35

Metric	Sub-domain	Value	National benchmark	Score	Rank
Percentage of patients treated for cancer within 62 days of referral	Cancer care	**78.60%**	80%	2.08	24
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Cancer care	**79.29%**	80%	2.23	61
Percentage of diagnostic referrals waiting over 6 weeks	Diagnostics	**18.65%**		2.66	73
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Elective care	**74.30%**		1.35	16
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Elective care	**1.07%**	0%	2.97	65
Percentage of patients waiting over 52 weeks for community services	Elective care	**0%**	0%	1	1
Percentage of patients waiting less than 18 weeks for community care	Elective care	**73.06%**	78%	2.35	53
Percentage of emergency department attendances spending over 12 hours in the department	Urgent care	**18.03%**		3.80	114
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Urgent care	**76.30%**	82%	2.69	55

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NHS Oversight Framework - Q1 2026/27

Domain - Patient Safety
Quartile 3 - third highest scoring 25%
Average score 2.38

Metric	Sub-domain ▲	Value	National benchmark	Score	Rank
Breadth and depth of clinical audit outliers Score	High quality care			1	
NHS Staff survey – raising concerns sub-score	Safe culture	**5.86 out of 10**		3.84	127
Rate of E. coli	Safe outcomes			3	
Rate of C. difficile	Safe outcomes			1	
Number of MRSA bacteraemia cases	Safe outcomes	**4 count**	0 count	2.93	

Domain - People
Quartile 4 - lowest scoring 25%
Average score 2.87

Metric	Sub-domain ▲	Value	National benchmark	Score	Rank
National Education and Training Survey satisfaction rate	People and culture	**81.17%**		1.70	16
Sickness absence rate	People and culture	**5.50%**		2.43	76
NHS staff standards score	People and culture	**7.27 out of 10**		3.82	126
Healthcare Worker Flu Vaccination Rate	People and culture	**50.30%**		2.33	68
NHS staff survey engagement theme sub-score	People and culture	**6.27 out of 10**		3.91	130
Temporary staffing agency	Workforce			2	
Temporary staffing bank	Workforce			4	
Temporary staffing cost relative band score	Workforce			3	

Domain - Experience of Care
Quartile 3 - third highest scoring 25%
Average score 2.98

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
CQC inpatient survey satisfaction rate	Experience			2	
NHS staff survey advocacy rate Score	Experience	**5.59 out of 10**		3.95	132

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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	73.05%	65.81%	84.30%	Higher value is better	Aug-26	Last 2 years
Capped elective theatre utilisation % (monthly)	87.6%	80.7%	84.7%	Higher value is better	Aug-26	March 2025 Prior to this Trust fluctuates between upper interquartiles range and best quartile. 6th best Trust out of 128 in August 2026.

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 (sdcs)	75.5%	74.7% (Benchmark 78.0%)	80.4%	Higher value is better	Sep-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	0.99%	0.96%	0.00%	Lower value is better	Aug-26	January 2026. Prior to this Trust fluctuates between interquartiles range or best quartile over the last 2 years.
All cancers: treated within 62 days %	78.7%	73.8% (Benchmark 80.0%)	85.7%	Higher value is better	Aug-26	Slipped back in to interquartiles range in August 2026 following 3 months in best quartile. Prior to January 2026, predominantly in best quartile (with occasional upper interquartiles range) over the last 2 years
Suspected all cancers: diagnosed or ruled out within 28 days %	82.1%	80.1% (Benchmark 80.0%)	87.1%	Higher value is better	Aug-26	June 2025. Prior to this Trust fluctuates between interquartiles range or best quartile over the last 2 years.
Total (all 15 diagnostic tests/procedures): % waiting >6 weeks	18.6%	19.4% (Benchmark 14%)	4.5%	Lower value is better	Aug-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 (sdcs)	47.2%	61.8%	74.3%	Higher value is better	Sep-26	December 2025. Prior to this Trust fluctuates between lower interquartiles range or worst quartile over the last 2 years. Sixth worst performing Trust nationally in August 2026
ED >12 hour wait % type 1&2 (ecds)	14.3%	10.1%	2.7%	Lower value is better	Sep-26	September 2025. Prior to this Trust fluctuates between interquartiles range or worst quartile over the last 2 years.

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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
The Division continues to work collaboratively with Trust colleagues, Peninsula networks and system partners to strengthen diagnostic, cancer and support services. Development of Community Diagnostic Centre (CDC) pathways remains a key focus, supporting improved patient access and helping to deliver elective recovery ambitions. The Division is also working closely with corporate and operational teams to prepare for eCare implementation, ensuring outpatient validation, pathway redesign and administrative processes are aligned to maximise benefits from the new system.

Strategic Plans
The Division remains focused on maintaining strong elective and diagnostic performance whilst supporting organisational financial recovery. Priorities include further expansion of CDC activity, increasing utilisation of Patient Initiated Follow Up pathways, improving outpatient productivity and strengthening cancer pathways through improved diagnostic turnaround times and more efficient use of available capacity. Work also continues to develop sustainable workforce models across diagnostics, pathology, oncology and pharmacy services. The workforce consultation process (Phase 2) of the Clinical Administration Review is underway involving significant engagement by the project team with affected staff undertaking one to one meetings and job alignment. The case for sustainable strategic model for Cancer Services remains under review in Division. Consultation with the Trust Chief Strategy Officers team has commenced and the plan to launch "Round Table" discussions with key stakeholders to strengthen plans within the case. Divisional teams critical to supporting ending corridor care are engaged in the Clinical Vision of Flow programme and our Pharmacy team have initiated Near Patient Dispensing to expediate discharge in front door areas with a view to expansion.

Successes
Operational performance remains strong. Referral to Treatment (RTT) standards continue to be achieved across specialties, with no 52-week waits reported, while community diagnostic activity and income continue to exceed plan. Outpatient waiting lists have reduced and pathway transformation programmes are delivering improvements in access and productivity. The Division has continued to support innovation through approval of new models of care, including development of a CDC-based Non-Site-Specific Cancer Pathway and alternative medicines management pathways that improve patient experience whilst releasing outpatient capacity. The Divisional Leadership Team has welcomed to role a Head of Nursing and Allied Health Professions; strengthening professional and operational leadership of Nursing and Allied Health Professions (AHP) colleagues with an initial focus on inpatient flow. September 30th 2026 marked the end of Corridor Care on Lowen Ward. The Division Business Manager (also new to role) is assisting the senior leadership team to mature it's business and governance processes and enabling clearer reporting and forward planning for the Divisional team.

Concerns and Risks
The Division continues to manage several significant risks. Cancer services continue to experience pressures relating to increasing demand, workforce shortages and diagnostic constraints. The ongoing impact of the ULTRA Laboratory Information Management System implementation continues to create operational pressure within Pathology and Clinical Microbiology, affecting turnaround times, service resilience and staff experience. A new risk has been highlighted and is progressing through Governance channels related to access to the Molecular Radiotherapy Service due to the treatment suite availability at times of increased inpatient pressures. The Division faces challenges in the delivery of it's financial plan, but continues to focus on schemes to improve recurrent savings and financial sustainability.

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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 Tru st.

Summary from Roz Davies, Divisional Director

September Performance Overview

In line with seasonal trends ED attendances were lower in September than in August however year on year growth remained high. In September, the department saw 779 (11.7%) more patients than last year. Despite this sustanined pressure the average ambulance handover time halved to 45 minutes and 4 hour performance continued to increase. The proportion of all patients and mental health patients spending more than 12-hours in the ED decreased. The medical emergency take remained on MRAT and did not 'drop' to the Emergency Departme nt.

Corridor care remained a challenge throughout September in both our inpatient and hospital corridors however the Division is delighted that the former has now ceased. The use of the Medical Day Unit as escalation space has also ceased.

Performance has been supported by the gatekeeping of emergency medical admissions by the *Take Controller.* The Division is also working hard with the Trust Estates team to prepare the Tremenel Unit space to house the Medical Same Day Emergency Care unit (SDMA) from early November. This larger space together with increased use of ' hot clinics' will offer improved streaming opportunities and alternative to ED presentation and inpatient admission.

Speed of discharge remains a barrier to flow with fewer than 20% of patients leaving the hospital before midday. This is a bo ttleneck to Emergency Department outflow and sees longer waits for admission and crowding. The Division is actively engaging with clinical teams to increase the use of Criteria Led Discharge in an effort to increase timely discharge.

Alongside work on our emergency and urgent care pathways the Division is focused on restoring elective care performance (RTT) which despite strong performance in many specialties fell below the 81% minimum national standard in September. The Division has taken significant strides in restoring performance in a number of pr eviously challenged areas: Clinical Neurophysiology and Sleep Medicine saw the largest reductions in patient tracking list (PTL) size in the Trust in month. Diagnostic performance on these two modalities now stands at 82% and 96.8% respectively.The Endoscopy backlog has been cleared paving the way for improved diagnostic performance and supporting surgical specialties to deliver timely pathways. Echocardio graphy is a key area of focus for the Division. In spite of expanded access via Bodmin and West Cornwall Community Diagnostic Centres (CDCs) performance has fallen. The Division is working with the CDC at Camborn e Redruth Community Hospital (CRCH) to offer echocardiography. This would increase capacity by 50 per week.

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Divisional Update - Surgery and Peri-Operative Medicine

Strategic Intent
To deliver safe, equitable and sustainable perioperative care by combining operational excellence with long-term service transformation.
Our aim is to create an integrated perioperative system in which clinical, operational and nursing teams take shared responsibility for patient outcomes, flow, capacity, productivity and continuous improvement.

Outstanding Emergency Care | Outstanding Elective Care | Innovative Community Care

Overall Position
The Division remains off plan for elective performance and finance, although there are early signs of improvement and increasing clarity around the actions required for recovery.
The M6 financial forecast has improved by approximately **£652k, from £5.67m to £5.02m adverse**. This reflects tighter control of agency, additional duty hours (ADH) and non-pay expenditure, but the underlying position remains materially challenged, particularly through pay pressures, premium workforce expenditure and historic/current financial sustainability programme (FSP) under-delivery. The next phase must therefore move beyond short-term expenditure control towards sustainable structural recovery.
Elective recovery remains constrained by workforce availability across theatres, anaesthetics and administrative/booking teams, alongside opportunities to improve utilisation of the capacity already available. The immediate priority remains to restore executable capacity, maximise productivity from that capacity and ensure that available theatre time is consistently filled with appropriately prepared patients.

Elective Recovery & Productivity
Elective recovery requires both stronger day-to-day operational control and redesign of the end-to-end elective pathway.

*The **100-Day Theatre Challenge**,* led operationally within the Division, is providing the immediate focus on delivery: list utilisation, booking, starts and finishes, cancellations, workforce deployment and the operational actions required to maximise activity from the capacity available to us. This is increasingly providing the daily and weekly grip required to understand where activity is being lost and intervene earlier.
Alongside this immediate recovery work, two complementary programmes are addressing the underlying pathway:

Ready to Operate is moving the Division from a reactive booking model towards a forward, procedure-specific view of demand and patient readiness. The aim is to understand the theatre requirement at least ten weeks ahead, identify the required Ready pool, quantify the gap and actively pull appropriate patients through pre operative assessment (POA) and optimisation rather than waiting for patients to arrive within the pathway.

StartWell is strengthening the reliability of theatre-day delivery, ensuring that appropriately prepared lists translate into productive operating sessions and that avoidable variation at the beginning of the operating day is reduced.

Together these provide an increasingly coherent elective operating model:

Ready to Operate → Booked & Planned → StartWell → Productive Theatre Day → Recovery & Flow
with the **100-Day Challenge providing the immediate operational grip across that pathway.**

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Divisional Update - Surgery and Peri-Operative Medicine

Financial Recovery & Grip

Financial and operational recovery are being managed as a single agenda:
What are we spending → what capacity does it provide → what activity should it deliver → what prevents delivery → what needs to change?

Service-level financial review will increasingly distinguish structural pressures from premium workforce expenditure, productivity opportunities and controllable variance. The aim is not simply to reduce expenditure, but to ensure that available resource is translated into sustainable clinical capacity and activity.

Leadership, Accountability & Transformation
Divisional grip

The Division recognises the seriousness of its current performance and financial position and is strengthening its internal mechanisms for recovery.
DECOR now brings clinical, operational, nursing and financial leadership together around Quality | Workforce | Performance & Productivity | Finance, supported by specialty deep dives and clearer ownership of actions.
The 100-Day Challenge provides immediate operational grip, while Ready to Operate and StartWell are addressing the underlying elective pathway and reliability of theatre delivery.
Know the position. Understand the problem. Own the response. Deliver the change.

Accountability and Divisional Integrity
Increased Executive scrutiny and support are understandable in the current environment. However, accountability and authority must remain aligned.
The Divisional Chair and senior leadership team are accountable for the quality, operational and financial performance of the Division. Material interventions within Divisional services should therefore be discussed with, commissioned through and accountable to that leadership structure.
Direct operational management through parallel Executive-sponsored arrangements, without prior agreement with the Divisional senior leadership, risks fragmenting accountability, undermining leadership and weakening the cultural transformation required for sustainable improvement.
Executive and corporate support is welcomed, but should strengthen the Division's ability to lead its recovery rather than substitute for it.
We are not asking for less accountability. We are asking for accountability and authority to sit together.

Forward View
Immediate recovery and longer-term transformation must continue together. Current priorities are restoring executable theatre capacity, improving productivity, strengthening the elective pathway, developing St Austell Surgical Hub (SASH), workforce redesign and delivering sustainable financial recovery.
Current position: OFF PLAN
Direction of travel: RECOVERY ACTION UNDERWAY – INTERNAL GRIP STRENGTHENING
Confidence: MODERATE
Operational excellence creates the freedom to transform.

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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 Chris Warren , Clinical Chair

The Division remains focused on delivering safe, high-quality perinatal services, supporting financial sustainability and RTT recovery, and providing strategic operational leadership in the development of the New Hospital Programme.

Gynaecology RTT performance continues to present a challenge, with incomplete pathways remaining static at approximately 52%. Improvements have been constrained by consultant and middle-grade obstetric staffing gaps. The middle grade staffing has improved in October with the arrival of a deanery trainee and staff on phased return from sickness. The situation is somewhat improved. Consultant on call gaps remain a strain on the team, and an investment case related to Ockenden and Amos is being prepared, which will resolve these gaps and limit additional duty hours (ADH) costs.

The Neonatal Specialty remains on trajectory to achieve 68.28% Qualified in Specialty (QIS)-trained staffing by September 2027.

The Division is actively engaged with the Integrated Care Board (ICB) and the Strategy Team to better understand and shape the future commissioning arrangements for Community Paediatric Services, with a focus on achieving the best outcomes for patients and families. We are awaiting an ICB response to the latest RCHT and CFT joint proposal following the recent joint workshop.

The Perinatal team continue their focus on the 100 day sprint and there is great work occurring within Neonatal and Maternity/Obstetric Services with ever more Perinatal working being developed. In order to address the Maternity Triage compliance as part of the Amos, an estates review is planned to see what is possible prior to the newbuild. Dedicated obstetric staffing model is required and this will be developed and in line with increasing elective c-section capacity.

We are reviewing ward design templates (1:200) for the Women and Children Newbuild, with New Hospital Programme (NHP) and the strategy team we are developing the workforce strategy to feed into the outline business case (OBC). As well as updating the operational policies for each specialty in line with NHP2.0.

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E-Care Update

Programme Director's Update: October 2026

Programme RAG status remains Amber this month.

Programme staffing is stable, key roles have been filled. NHSE Tiger Teams is engaged to support Reporting workstream.
eCare vendor (Oracle Health) is in a "Time & Materials" contracting status until November 2026. The next contracted iteration is currently in negotiation.

Areas with continuing Risk:
* Reporting: Statutory/Mandatory reports needed at Go Live continue to be developed on a very tight timeline. NHSE-sponsored support via Tiger Teams has been deployed to support this effort and to align the Reporting delivery plan to the larger Programme plan, they are currently behind on their plan and have implemented a Recovery Plan. Maternity Reporting has more clarity about its Reporting requirements, a plan is to be agreed. Overall Reporting workstream remains at Amber status this month.
* Outpatient Validation & Rebuild: Approaching completion before end of October, overall plan is consuming 1 of 2 weeks contingency, other Programme activities have had to modify plans to accommodate.
* Progamme conducted a “mini-load” (small Trial Load) to validate Outpatient Rebuild and other Programme work in advance of Trial Load 4.
* Diagnostics: Review complete, plan in place for key areas needing remediation, 4 of 5 areas are at Green status, 1 of 5 areas are at Amber status.
* Programme is preparing for Integration Testing 3, Trial Load 4 in November.
* Cutover Activity Preparations have commenced this month and are increasing in volume and scope.
* Activity Management options are under consideration at Programme Board in October 2026.
* Training Plan continues to evolve, awaiting practice domain confirmation; training resources remains a challenge with mitigations awaiting mitigation.
* Organisation plan to release staffing for training has been drafted.

Forward View for November 2026:
* Members of eCare team attending the Airedale Go Live in October for Lessons Learned to apply to eCare.
* NHSE Level 4.0 Audit report should be available in November 2026.
* 30/60/90 Day Plan Review to be stood up in November.
* Operational Readiness activities will likely outline a series of Go/No Go decision points across the remainder of the Programme.

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Trust Board Overview - Triangulation of Issues

TRUST BOARD SUMMARY – INTEGRATED POSITION

The Trust is showing early improvement in several priorities, but remains off plan overall and in NHS Oversight Framework Segment 3. The central issue is the interdependence of workforce capacity and culture, operational flow and productivity, quality, and financial sustainability: progress will not be sustained without coordinated delivery across all four.

WORKFORCE, CAPACITY AND FINANCE

Recruitment and retention improved: total vacancies reduced from 10.07% to 9.25%, turnover from 7.27% to 7.08%, registered-nurse vacancies from 8.03% to 6.75%, and medical vacancies from 4.34% to 3.97%. Nursing fill is stable at 97.0% for registered and 98.9% for unregistered hours. However, sickness rose to 5.43%, mandatory training fell to 77.17%, appraisal completion remains low at 59.6%, and staff advocacy and speaking-up confidence remain concerns. These factors constrain clinical capacity, contribute to premium staffing and weaken delivery resilience.

This is reflected financially: Month 6 is £2.23m adverse year to date, with a £21.4m forecast risk. The Financial Sustainability Programme remains dependent on non-recurrent measures, with only 16% of savings recurrent against a 72% plan. The Board should require evidence that lower vacancies are converting into lower temporary staffing costs, safer rosters and increased activity. Capital remains high risk and dependent on £10.0m of mitigations.

FLOW, ACCESS AND QUALITY

Urgent-care performance improved despite higher demand. Mean ambulance handover time reduced from 89 to 45 minutes, four-hour performance improved for a fourth month, initial assessment reduced from 37 to 32 minutes and aggregated delay fell to 15,325 hours. Inpatient corridor care has ceased but must be noted corridor care space still utilised in ED and remains a priority to end the use of all corridor care space by the end of October. However, ED 12-hour waits remain in the worst quartile, escalation capacity is routinely full and delayed discharges increased. Flow remains both an operational and safety risk, requiring sustained delivery of Criteria Led Discharge, Same Day Emergency Care and system action on mental-health and discharge pathways.

Elective recovery is also dependent on workforce and productivity. RTT 18-week performance is 71.5%, the waiting list is 45,155 and breaches increased, although 52-week waits reduced to 435. Theatre utilisation improved to 85%, but activity remains below trajectory. The 100-day theatre challenge, Ready to Operate and StartWell provide a coherent recovery model; assurance is needed that capacity is staffed, patients are prepared and gains reduce backlog and premium-session costs. Diagnostics and cancer performance remain mixed.

QUALITY, CULTURE AND TRANSFORMATION

Stroke care shows improvement—91.23% spent at least 90% of their stay on the stroke unit and CT within 12 hours was 98.15%—but four-hour admission remains 56.6% and the SSNAP rating is E. Falls with harm, fractured-neck-of-femur performance and mortality alert, Duty of Candour compliance, complaints and C. difficile above tolerance require oversight. Conversely, pressure ulcers reduced, there were no Never Events and overall mortality remains within expected ranges.

eCare remains Amber, with reporting, training and operational-readiness risks. The Board should maintain one recovery framework linking divisional accountability, recurrent savings, workforce stability, patient flow, elective productivity, quality outcomes and eCare readiness, with benefits evidenced rather than actions alone

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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 – Ian Dean, Chief Finance Officer

Revenue

Month 6 reported a £2.23m adverse year-to-date position, with a forecast £21.4m year-end risk, improved from £25.4m at Month 5 but still driven by financial sustainability programme (FSP) under-delivery, escalation and other cost pressures.

Temporary staffing remains a key pressure, with both agency and bank expenditure above plan, although there are early signs of reduced underlying bank usage and agency utilisation.

FSP delivery is broadly in line with the year-to-date plan but remains heavily reliant on non-recurrent measures, with only 16% of savings delivered recurrently against a planned 72%. The forecast FSP shortfall has improved to £10.5m, from approximately £13.5m at Month 5.

Financial recovery actions continue, with strengthened controls over recruitment, agency and bank staffing, escalation capacity and non-pay expenditure.

Capital

The capital programme remains balanced only through £10.0m of mitigations, including £5m of capital brokerage, and delivery therefore remains high risk. £1.5m of brokerage has been secured, with a further £2.5m of eCare funding under discussion.

Month 6 capital expenditure is £5.8m behind plan, reflecting delays across several major programmes, including Women and Children's, Estates and Digital Health.

Capital risk remains 20 (Extreme). Proposed reprioritisation of £1.26m would reduce the remaining mitigation requirement to £1.4m, subject to confirmation of the potential eCare funding.

Confirmation has also been received of £1.149m Public Dividend Capital funding for the Extended Emergency Medicine Ambulatory Care (EEMAC) and Truro Urgent Emergceny Care (UEC) schemes.

Performance – Robin Jones, Chief Operating Officer

Operational performance shows selective improvement, but urgent-care flow and elective capacity remain the principal concerns to bring to the attention of the Committee and Board. Ambulance handovers improved materially in September: the proportion waiting over 15 minutes fell by around 10 percentage points to 76.33%, while mean handover time reduced from 89 to 45 minutes. Both remain above target. All-type ED/MIU four-hour performance improved for a fourth consecutive month to 75.47%, despite Treliske attendances being 12% higher than September 2025; however, Treliske performance remains low at 47.17%. West Cornwall deteriorated for a second month to 84.59%, with sickness and workforce resilience constraining delivery.

Long waits in ED remain a significant quality and operational risk. The proportion of Treliske patients spending more than 12 hours in ED improved to 14.31%, and mental-health waits over 12 hours reduced from 29% to 22%, but both remain unacceptable and the Trust benchmarks in the worst quartile for 12-hour waits. Risk 9048 (ED crowding) remains live: escalation capacity is routinely fully utilised, limiting resilience to demand surges. Priorities are earlier discharge through Criteria Led Discharge, consultant triage at the medical single point of referral, active three-hour pathway management and joint action with CFT on mental-health assessment delays.

Planned-care recovery is mixed. The total waiting list increased marginally to 45,200 and 18-week breaches rose by 645 (5.3%), although 52-week breaches reduced by 19 to 435. Inpatient elective activity reached 96.03% of plan, but only 1,446 operations were completed against a trajectory of 1,975, leaving an 803-case backlog. Session utilisation improved to 85%; weekend working, the 100-day theatre programme and weekly executive reviews are intended to lift bookings to 450 patients per week. Delivery remains exposed to theatre capacity, sickness, vacancies and reliance on premium sessions. New theatre activity targets have been set with daily reporting commening as part of the 100 day theatre plan and overall RTT recovery.

The committee will recieve an additional report on the 18 week RTT delivery.

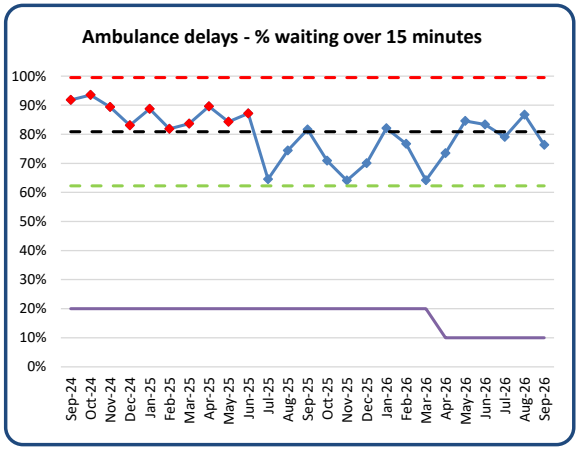
Diagnostics activity was 95.95% of plan and 82.85% of patients received a key test within six weeks. Recovery is uneven: sleep studies reached 98.6% and the endoscopy backlog was cleared, while echocardiography, equipment downtime and radiology sickness remain constraints. Cancer Faster Diagnosis performance was 82.13% and remains above the 80% standard, but 31-day treatment at 91.46% is below the 96% target and 62-day performance at 78.73% requires second-half over-delivery. Breast, lung and head-and-neck pathways require particular focus, with histology, outpatient, theatre and tertiary-transfer capacity the key dependencies.

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Finance and Performance - Urgent and Emergency Care

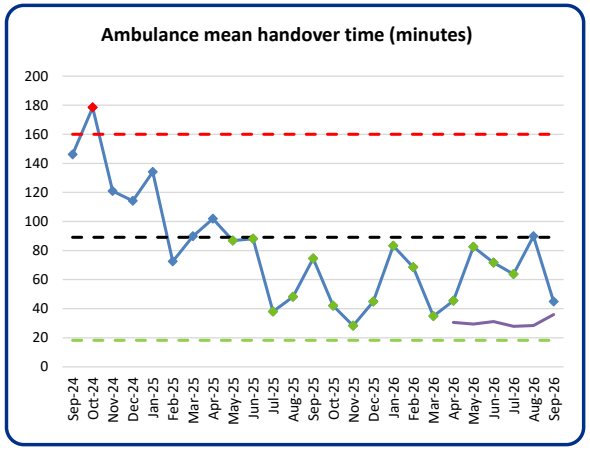
Lead Division - Medicine

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26

76.33%



Sep-26

45

Background, what the data is telling us, and underlying issues

Ambulance handover performance improved in September with the proportion of patients waiting over 15 minutes for offload falling by 10% and the mean handover time halving from 89 to 45 minutes. The Division recognises that both remain above target.

Despite a focus on driving early discharge from the inpatient wards only 14% of patients left the hospital before midday in September. This constrains flow out of the Emergency department. The Division continues to target increasing discharges before midday with a renewed focus on Criteria Led Discharge (CLD).

Improvement actions planned, timescales, and when improvements will be seen

Initiatives in development:

Criteria Led Discharge programme to improve medical engagement and increase early inpatient discharge and flow out of the Emergency Department.

From September all patients referred for emergency admission are triaged by the Medical Single Point of Referral consultant in line with NHSE guidance to prevent avoidable admission.

Working in colaboration with the ambulance service there is a renewed determiniation to acheive the 15 minute standard with a maximum of 45 minutes, the initial impact can be seen on the chart

Risks to delivery and mitigations

Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

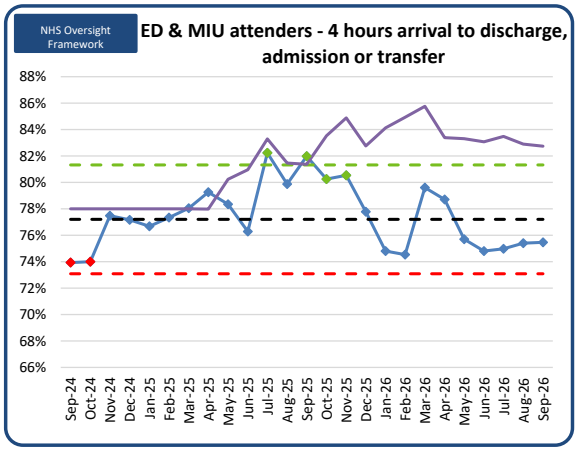
Risk description - The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

The Trust is operating continually with escalation spaces fully utilised giving minimal flexibility to any surge in demand. This is also a financial pressure.

Neave,Lynsey
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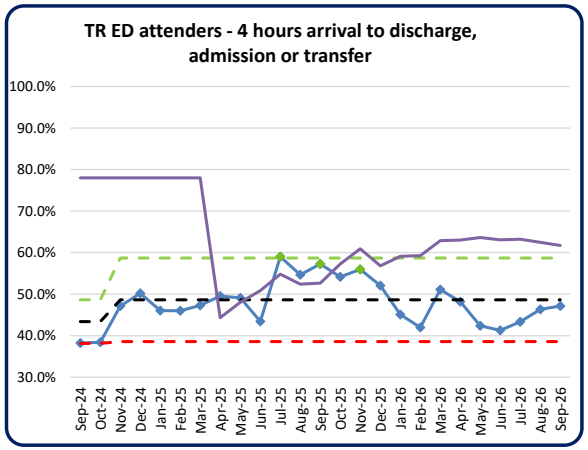
Finance and Performance - Urgent and Emergency Care

Lead Division - Medicine



Sep-26
75.47%

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26
47.17%

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 but performance continued to rise incrementally for the 4th consecutive month. Although attendances were lower in September than in August in line with historic trends, the number of patients who attended Treliske ED in September was 12% higher than in September 2025. This continues the trend of significantly increased attendances over the previous 3-months compared to 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 (September 2026), 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).

Whilst the 4 hour standard is not being acheived for the third month in sucession it has improved, noting not sufficiently to acheive trajectory

Neave, Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

The Emergency Department team are actively targetting patients at 3 hours wait in the department to ensure that all diagnostic tests and actions are underway to give the best chance of reaching a decision to admit, discharge or transfer within 4 hours of arrival.

Following last-month's implementation of the Take controller, the medical emergency take has been maintained in Medical Review and Triage (MRAT) without needing to 'drop' to the Emergency Department.

The Division held a meeting with integrated neighbourhood team (INT) partners in early October to move the 'closer to home' agenda for frail elderly patients forward. This represents a step forward in developing shared-care pathways for this patient cohort. This follows work already started by the Eldercare teams in partnership with primary care moving to a preventative review model.

Risks to delivery and mitigations

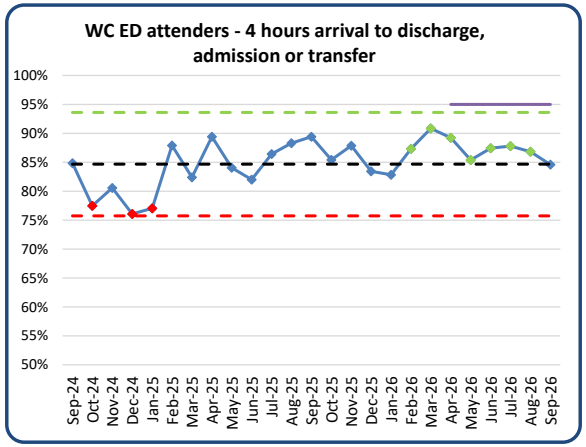
Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

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.

Finance and Performance - Urgent and Emergency Care

Lead Division - Medicine

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26

84.59%

Background, what the data is telling us, and underlying issues

September saw a second month of deteriorating performance with the number of patients meeting the 4-hour standard falling to 84.59%. This is the lowest performance of the year to date and is an area of focus for the Division. Workforce resilience has been a particular challenge at West Cornwall. It is hoped that the recruitment actions will strengthen the team, in turn improving access for patients.

Improvement actions planned, timescales, and when improvements will be seen

From September, increased senior nurse leadership put in place at West Cornwall to drive performance. Early October performance shows positive results.

Daily performacne reviews for key urgent care standards have been implemented, which includes West Cornwall 4-hour

Risks to delivery and mitigations

Nurse sickness remains a challenge. The Division is actively tackling absence issues. Additional management capacity is now available to support absence management with the start of the 2nd Deputy Head of Nursing.

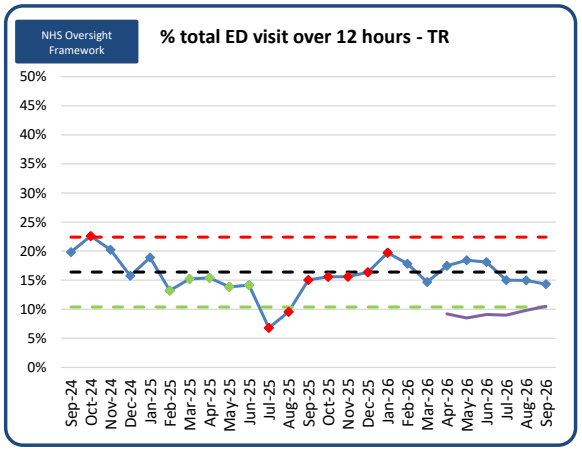
West Cornwall Hospital continues to be impacted by relatively high proportion of the bed base being occupied by No riteria to Reside patients

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Finance and Performance - Urgent and Emergency Care

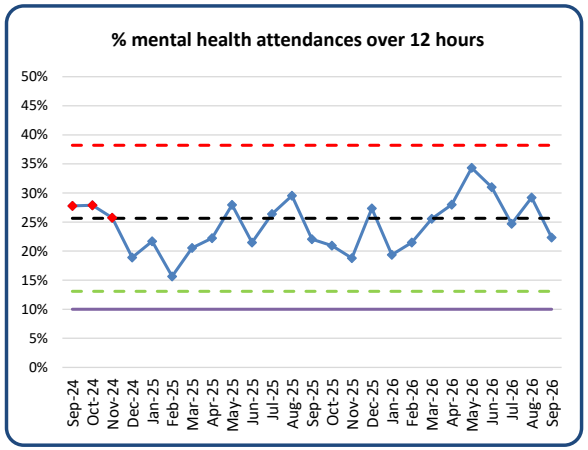
Lead Division - Medicine

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26

14.31%



Sep-26

22%

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. In September, the proportion of patients waiting in excess of 12-hours improved incrementally to 14.31% but remains significantly above target. RCHT was in the top (worst) quartile for 12 hour waits in the Model Hospital benchmarking.

The Division is pleased to have ceased the use of inpatient corridor care throughout the hospital wards. Escalation beds in the Medical Day Unit have also closed. This reduces outflow from the Emergency Department.

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.

Whilst the proportion of Mental Health patients waiting over 12 hours in the ED reduced (improved) in September from 29% to 22% this still means that more than 1 in 5 patients with a mental health presentation spent more than 12 hours in the ED.

Neave, Linsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

As described above, the ED Flow Coordinators have a renewed focus on pathway tracking to ensure patients move through the ED pathway in a timely manner.

The Trust is working with CFT on timeliness of Mental Health Assessment which often leads to extended department stays.

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.

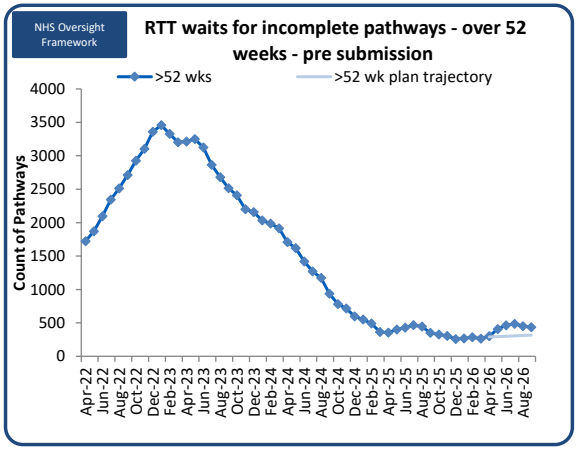
Delays in Mental Health Act (MHA) Assessments being undertaken for ED patients.

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 also contribues to delays; this has been escalated to the Integrated Care Board (ICB) who commission the transport services.

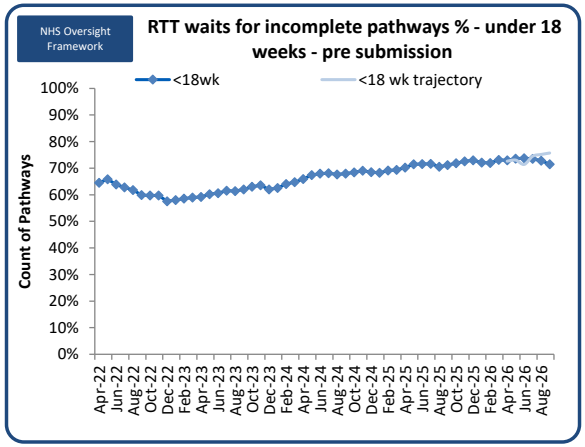
Finance and Performance - Planned Care

Lead Division - Surgery and Peri-Operative Care

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26
435



Sep-26
71.48%

Background, what the data is telling us, and underlying issues

The Total PTL Size has increased by 44 (0.1%) to 45,200. Resulting in an end position of 72% incomplete performance compared to August position of 73%

The Total Number of 18 Week Breaches has increased by 645 (5.3%)
The Total Number of 52 Week Breaches has decreased by 19 (-4.3%)
The Total Number of 78 Week Breaches has decreased by 1 (-20.0%)

The 3 Treatment Functions with the largest reduction in PTL Size

1:(401) Clinical Neurophysiology (-97)
2:(347) Sleep Medicine Service (-65)
3:(120) ENT (-61)

The 3 Treatment Functions with the largest increase in PTL Size
1:(145) Oral and Maxillofacial Surgery Service (202)
2:(400) Neurology (105)
3:(103) Breast Surgery (84)

Improvement actions planned, timescales, and when improvements will be seen

The Divisions are working closely with the Deputy Chief Operating Officer (DCOO) to implement recovery plans to improve the incomplete position to 81%. This plan is reviewed daily, and the plan is held centrally by the Deputy COO.

There is a weekly theatre review meeting with the COO and Chief Finance Officer (CFO) in place so check and challenge can occur along with early decision making on any additional actions highlighted.

100 day challenge midway through its term is helping stabilise and improve theatre productivity.

Ophthalmology consultant being supported back to independent operating with plans in place for mid-November.

Trauma locum commenced and is back filling lists that would have previously been stood down.

Treatment room at West Cornwall Hospital (WCH) now being used by the hand surgeons for high volume low complexity (HVLC) local lists.

Risks to delivery and mitigations

The most significant pressures continue to relate to:

Theatre capacity and specialist workforce (Surgery, Gynaecology, Trauma and Orthopaedics).

Outpatient access delays constraining pathway flow (Cardiology, Musculoskeletal (MSK)).

Diagnostics bottlenecks (Echocardiography)

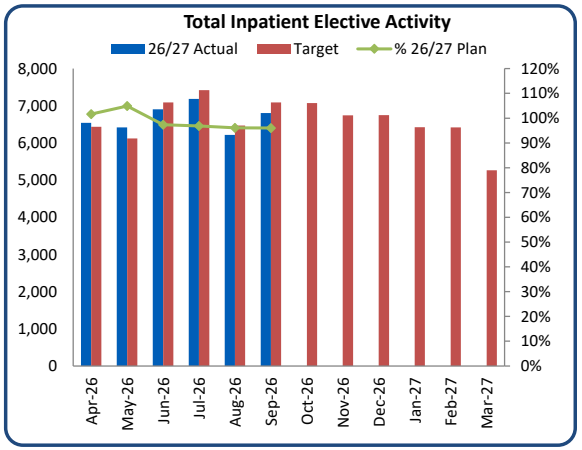
Clinician engagement for making the changes to clinical practice for new to follow up ratio changes to enable overall outpatient improvements.

Neave Lyne
30/10/2025 13:39:19

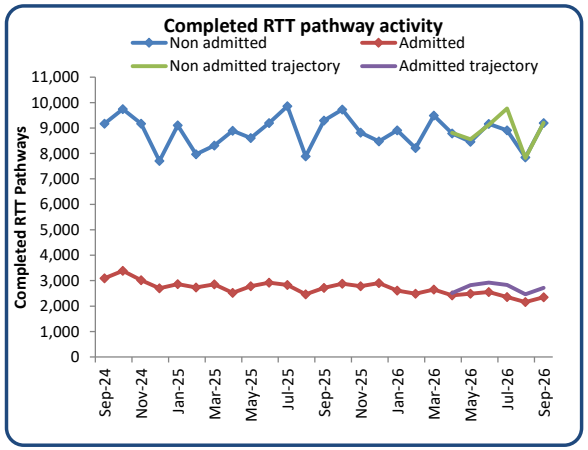
Finance and Performance - Planned Care

Lead Division - Surgery and Peri-Operative Care

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26	
Target	7087
26/27 Actual	6,806
26/27 Plan %	96.03%



Sep-26	
Admitted	2351
Non admitted	9194

Background, what the data is telling us, and underlying issues

Inpatient elective activity in September, though improved from the August position, remains behind plan. Orthopaedics continues to be challenged due to the trauma demand as well as overall capacity issues. General surgery and oral and maxillofacial (OMF) are also being highlighted as having capacity issues due to lack of theatre capacity along with vacancies within the consultant body.

Gynaecology theatre session utilisation has improved and are consistently achieving the service level agreement (SLA) target. There remains limited options to improve theatre productivitly due to available theatre estate.

Non-admitted trajectory has improved in September following additional clinics being scheduled on Saturdays as part of the overall recovery plan to achieve 81%

Neave, Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvement will be seen

Working with the theatre teams for reintroduction of weekend working targeting general surgery, gynaecology and ophthalmology by the end of October.

Using the 100-day challenge to stabilise theatres to reduce cancellations on the day, improve session utilisation and maintain high touch time percentage. Improvement to be shown by the end of November.

Task force for per-assessment improvement implemented to focus on optimising orthopaedic patients on the waiting list. Supporting recruitment of consultants in upper GI and Ophthalmology to increase session utilisation.

Full recovery plans from each of the surgical specialities in place targeting extra clinics of new patients to help the non-admitted position.

Gynaecology have requested to increase weekend operating by 1 day a week where theatre staffing allows to increase RTT performance.

Risks to delivery and mitigations

Demand exceeding capacity continues, particularly in trauma and orthopaedics (T&O), Oral surgery, Ear Nose and Throat (ENT) and Gynaecology.

Balancing cancer/clinically demand urgently against long waiters.

Theatre capacity limitations due to current workforce absence, this also results in high dependency on staff picking up extra shifts to mitigate gaps.

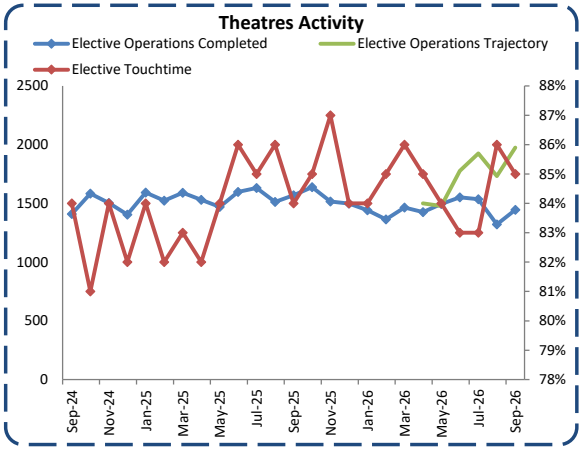
Workforce fragility due to rising sickness levels and delays to recruitment start dates. All HR processes to manage sickness are in place.

Reliance on additional/premium sessions (weekends, extra lists) not fully sustainable. Demand and capacity work alongside development of workforce plans commenced.

Admin consultation impacting on booking team vacancy factor. Bank and overtime being used to help support the gaps.

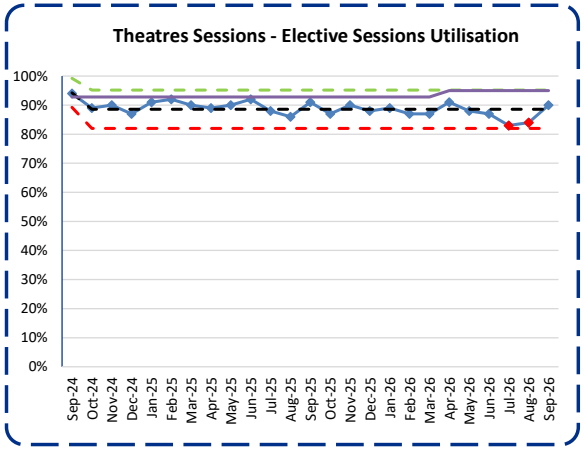
Finance and Performance - Planned Care

Lead Division - Surgery and Peri-Operative Care



Sep-26	
Elective Operations Completed	1446
Elective Touchtime	85.00%

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26	
Elective Session Utilisation	85.00%

Background, what the data is telling us, and underlying issues

At the end of September 1446 elective operations had been completed in total, 1432 of which were in the 9 specialties included in the operational plan, against the plan trajectory of 1975. This results in a requirement to be booking at least 85 patients a day going forward to achieve 26/27 plan and make an impact on the variance of the back log of 803 patients. This doesn't consider the increase in productivity needed to achieve our financial sustainability programme (FSP) target in surgery which results in additional 5 patients a day being required to be operated on to achieve both targets.

Elective session utilisation has hit 85% in response to the focus that has been made to ensure that back fill of lists occurs. There have been continued issues with sickness amongst the theatre staff which has meant that theatre lists have had to be cancelled.

Neave,Lynsey 30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

Using the 100-day methodology we are running a programme through September to end of November to help stabilise theatres and ensure weekly monitoring of the booking position to ensure that we are aligned with the activity plan.

This focused attention has seen the session utilisation improve and there has been good engagement from the theatre leads to help improve the KPIs that drive theatre productivity.

We have reintroduced targeted work at the weekends for specialities that are struggling for capacity to help with long waiters being operated on.

Weekly theatre review meetings with the Chief Operating Officer (COO) and Chief Finance Officer (CFO) in place to ensure executive support is available to the senior leadership team (SLT) of surgery.

With a combination of the 100 day plan and this support, improvement to theatre booking of 450 patients a week to achieve the plus plan is on trajectory for the end of October.

Risks to delivery and mitigations

Weekend working relies on both surgical and anaesthetic uptake. Ensuring that sufficient notice on these lists are running is being given to help ensure better uptake of lists.

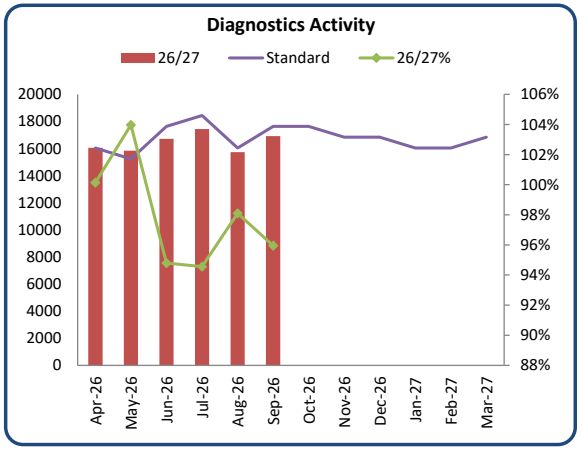
Sickness rate within the theatre team continues to be monitored closely. There is a focus on supporting long term sick members of the team and individual return to work meetings, to ensure any support required is provided.

Vacancies within the booking team have added stress to those in post. Using bank and overtime where possible to help.

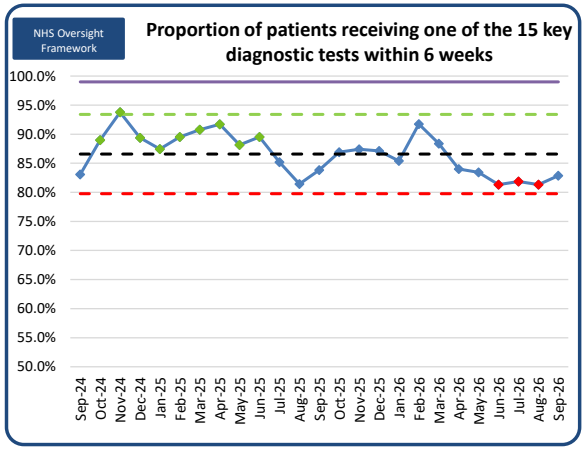
Finance and Performance - Planned Care

Lead Division - Clinical Support and Cancer Services

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26	
26/27	16,924
26/27%	95.95%



Sep-26
82.85%

Background, what the data is telling us, and underlying issues

Overall diagnostic activity remains behind plan both in terms of activity and performance. Performance has been strong or improving however this has not been replicated in Echo which is seen in the overall scoring metrics.

Activity across DEXA, CT, MRI and Ultrasound reduced during the period due to unplanned equipment downtime and sickness in radiographic workforce. Radiologist sickness also impacted reporting capacity, resulting in extended Nuclear Medicine reporting turnaround times (RTAT). Cardiac Stress MRI remains a challenge due to demand and capacity.

Sleep studies, at just 26.3% in April 2026 improved further on August with just two patients missing the 6-week target in September. Performance was 98.6%.
Neurophysiology improved to 82%
The Endoscopy backlog has now been cleared to pave the way for improved performance.

Neave, Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

The Division is now focused on improving performance for echocardiography which remains challenged despite full mobilisation of Community Diagnostic Centre (CDC) capacity at Bodmin & West Cornwall Hospital (WCH). Camborne Redruth Community Hospital (CRCH) CDC capacity is a work in progress to increase echo capacity by 50 each week.

CDC activity remains on plan, through full utilisation of CDCs across Radiology services with CT, MRI and X-ray activity now being delivered through the InHealth CDC and further growth planned. DEXA capacity at Bodmin CDC has increased following diary redesign. Straight-to-booking pathways are progressing to support Faster Diagnostic Standard (FDS) performance. A joint Cardiology and Radiology recovery plan is being developed to address the Cardiac Stress MRI. Reporting capacity is expected to improve this month following phased radiologist returns, supporting recovery in reporting turnaround times (RTAT).

Risks to delivery and mitigations

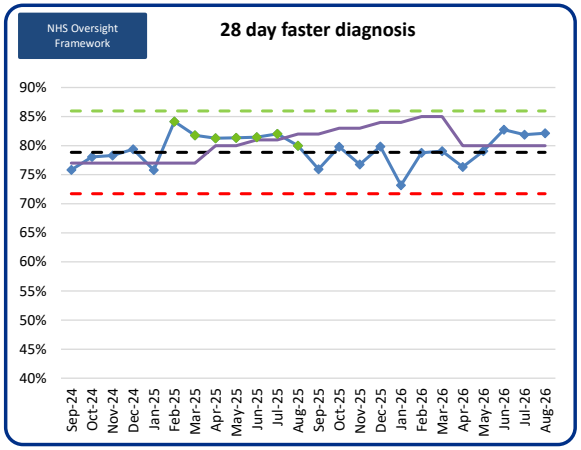
Risk of inconsistent system flow across sites - services remain an issue, however actions to address this are in place via the weekly RCH - In Health ops meetings.

Recruitment and workforce pressures continue to impact service delivery with sustained sickness absence and a number of successful candidates withdrawing prior to appointment, creating ongoing staffing challenges, particularly within the TAG service. CDC utilisation continues to increase, with CT, MRI and X-ray activity now established through the InHealth CDC. Governance and protocol alignment issues have largely stabilised, enabling further growth in activity and supporting additional diagnostic capacity across Cornwall.

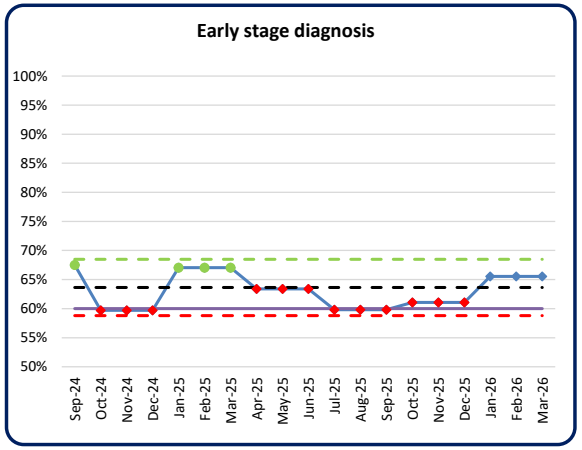
Finance and Performance - Cancer

Lead Division - Clinical Support and Cancer Services

Lead Executive - Robin Jones, Chief Operating Officer



Aug-26
82.13%



Mar-26
65.55%

Background, what the data is telling us, and underlying issues

The Trust's 28 day Faster Diagnosis Standard (FDS) position improved between May and June but dropped back slightly to 81.9% in July and has remained above 80% in August at 82.1%. The Trust is still outperforming the England average of 78.4%. The national target from April is 80% and the expectation is that the year end position shows an average performance at or above this. The latest year-to-date position on FDS shows an average of 81.6%.

We predicted a performance dip due to capacity within histology impacting multiple pathways pushing outcomes beyond the 28 day target. However, the Trust also benefited from higher performance of its breast pathway following a recovery period. August for breast overall showed a small decrease in performance with 92.1% against a national position of 88.1%. However, in August the breast symptomatic performance was higher than the national average for the first time since May 2025.

September histology turnaround time is predicted to remain below target as backlogs are cleared following Elective Recovery Fund (ERF) funding approval but October will show an improving trajectory.

Neave Lynsey
30/10/2025 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

To achieve an 80% average, the Trust must continue to exceed the 80% FDS from now until year end. Larger volume sites will need to maintain short booking windows and sufficient capacity to manage demand fluctuations. This is primarily skin, colorectal and breast which make up over 70% of FDS activity.

Histology additional funding needs to continue to clear the backlog and move into a sustainable position.

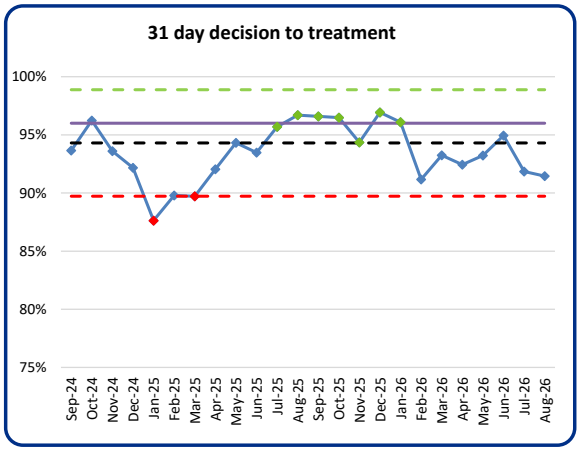
Risks to delivery and mitigations

There continues to be a risk with the admin review that staffing capacity and focus is reduced as this may affect booking, timely outcomes and typing of patient correspondence which are all essential for strong FDS performance.

Finance and Performance - Cancer

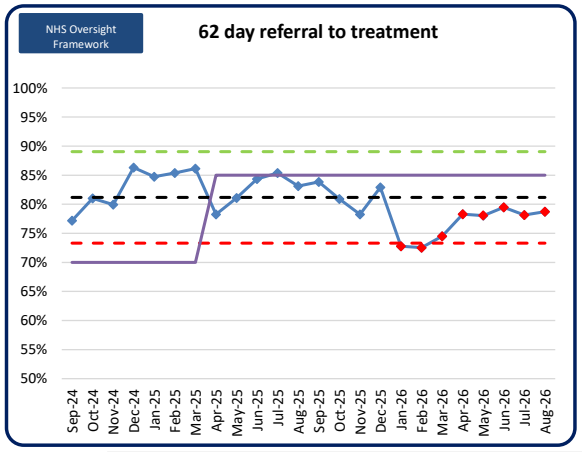
Lead Division - Clinical Support and Cancer Services

Lead Executive - Robin Jones, Chief Operating Officer



Aug-26

91.46%



Aug-26

78.73%

Background, what the data is telling us, and underlying issues

Cancer 62 day performance has remained relatively static year-to-date between 78-79% with August reporting 78.3%. The Trust continues to track consistently above the national target with national performance at 71.9% in August. We need to achieve 80% for 2026/7 and this requires over delivery in the second half of the year to mitigate the slight under performance in the first half.

The Trust exceeded its breach allocation by approximately 7 per month in the first six months and this means a reset to achieve 11 less breaches per month for the second half of the year to end in a strong position.

There were three sites where performance in August was below the national average: breast, head and neck and lung. Breast is 10% below the national average (60.5% against 70.4% nationally). We are just outside the bottom quartile ranking 88th out of 120 providers. Head and Neck were 0.3% below the national average so ranked 55th out of 115 providers. Urology was 3.5% under the national average at 64.5% against 67.9% national average which ranked the Trust 81st out of 118 providers.

Head and Neck performance is due to a combination of complex pathways and capacity. MaxFax did not have capacity at the front-end of the pathway which resulted in patients with a confirmed cancer waiting longer than 62 for their first treatment. This will continue until the end of 2026 as additional new patient capacity was not available until October 2026.

Sustainable breast capacity across the pathway is a breach theme. FDS has improved but there are still challenges with theatre capacity and surgeon availability which need resolution.

For 31 day decision to treatment, the Trust has closely mapped to national performance since the beginning of the year but has switched from being above to below the England average. In August the Trust reported 91.5% performance against national average of 92.5% which ranks the Trust 102nd out of 134 providers. The breast pathway accounts for 32 out of the 62 breaches in August split evenly between radiotherapy and surgery. A further seven breaches which are reported under skin are attributable to breast who provide oncoplastic surgery for melanomas and SCCs.

Radiotherapy continues to be below the England average and in August was 51st out of 65 providers. January 2026 was the last time local performance was above England average and met the performance standard.

Surgery saw a steep drop from 93.9% in June to 85.8% in July which was below the England average but it has recovered slightly in August to be just above the national average of 87.1% at 87.7%. This ranks the Trust 90th out of 132 providers.

Surgery performance was mostly within the breast surgery team where they provide surgery for breast cancer and onco-plastic skin cancer. These two areas accounted for 24 out of 37 breaches with the remainder in colorectal, urology and skin.

Improvement actions planned, timescales, and when improvements will be seen

To improve the 62 day performance, it is essential for sites to improve and hold the 28-day FDS, thereby facilitating increased opportunities for treatment scheduling within 62 days. Sites where first treatment is at a tertiary centre or another speciality within the Trust such as lung, need to ensure patients are referred by day 38 or earlier. Lung FDS is considerably higher than the national average at 88.2% against 77.7% but once diagnosed, delays to further diagnostics and treatment scheduling has resulted in shared breaches with University Hospitals Plymouth (UHP) which drops the Trust's 62 day performance to 52.7%.

Changes to the lung pathway in respiratory will start to show improvement in Q3 but further work is needed to shorten the wait if first treatment is radiotherapy. This is due to more complex radiotherapy being delivered which takes longer to plan.

There is a need to urgently review the breast pathway from referral to treatment due to instability in capacity and delays to pathway steps once diagnosed. This would include outpatients, diagnostics and theatre capacity. This would support performance improvement and sustainability across all three cancer targets.

Urology and colorectal have seen less uptake for additional activity over the summer but urology has improved from July to August and remains consistently above national average. Colorectal has also improved from July to move back above national average with 31 day achieving 94.6% against a national average of 93.5%.

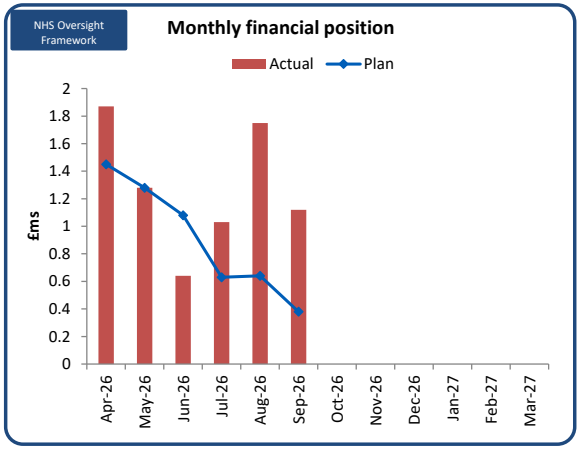
Risks to delivery and mitigations

Breast need to undertake further review of outpatient and theatre capacity to manage the demand from Urgent Suspected Cancer (USC) referrals and screening. This is compounded by a flow of oncoplastic skin demand. Current booking for many patients is beyond target. The Peninsula Cancer Alliance (PCA) have offered help with reviewing the breast pathway and have set up fortnightly support meetings.

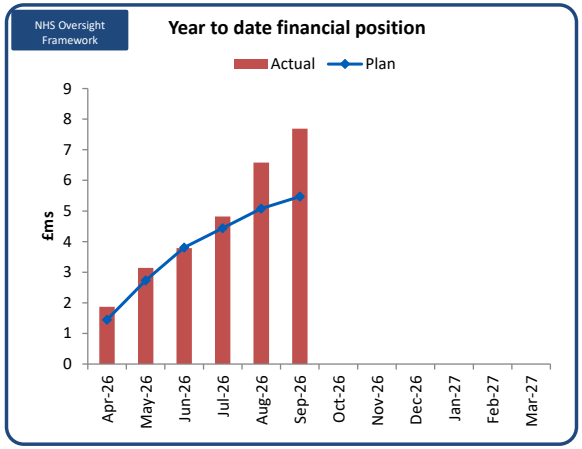
Action agreed - Cancer Services to meet with Surgery to review plans and appropriate actions given level of impact to date.

Finance and Performance

Lead Executive - Ian Dean, Chief Finance Officer



Sep-26
1.12



	Sep-26
Actual	7.69
Variance	2.22

Background, what the data is telling us, and underlying issues

The Trust reported a deficit of £1.12m in September, £0.73m adverse to plan. This increased the year-to-date variance to £2.23m adverse to the plan. The adverse position continues to be driven primarily by pay pressures, including temporary staffing, medical staffing and escalation capacity. These pressures were partly offset by favourable non-pay and income performance and the year-to-date benefit from reserves.

Improvement actions planned, timescales, and when improvements will be seen

Strengthened financial controls were issued in September, covering workforce, medical pay, agency staffing, recruitment, rostering, medicines and non-pay expenditure. Monthly divisional financial recovery and assurance updates, monthly non-pay reviews, weekly monitoring of bank, agency, escalation capacity and non-pay orders, and weekly Executive review are being used to strengthen accountability and identify corrective action. The impact of these measures will be monitored through weekly indicators and subsequent monthly financial positions.

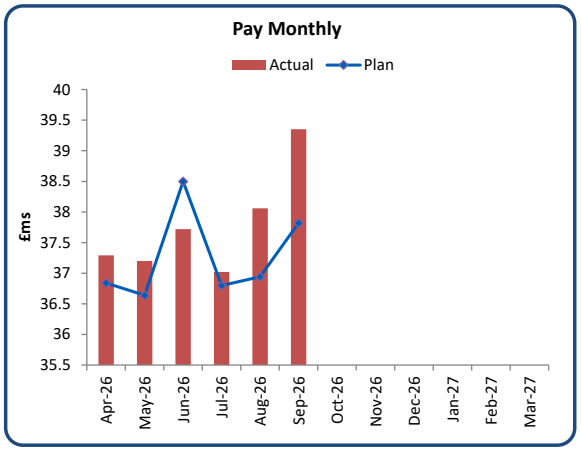
Risks to delivery and mitigations

The latest formal forecast continues to identify a material full-year risk of approximately £21.4m. Key risks include the deliverability and recurrency of the Financial Sustainability Programme, temporary staffing and escalation expenditure, variable income exposure and continuing non-pay volatility. A separate Financial Recovery Plan sets out the actions being taken to mitigate these risks, supported by Executive oversight, divisional assurance and enhanced monitoring.

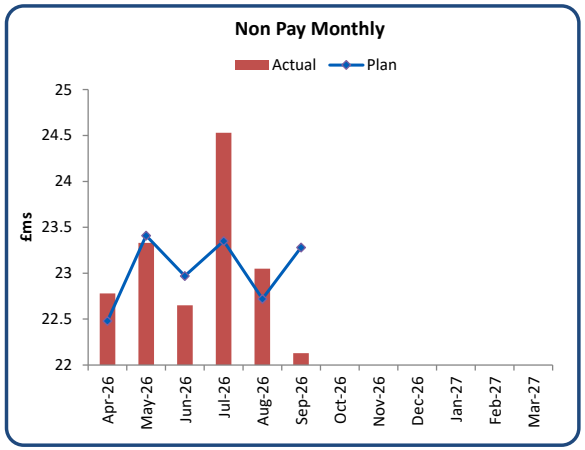
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Finance and Performance

Lead Executive - Ian Dean, Chief Finance Officer



Sep-26
39.35



Sep-26
22.13

Background, what the data is telling us, and underlying issues

Pay:

Pay expenditure was £1.54m adverse to plan in September, increasing the year-to-date adverse variance to £3.10m. Expenditure increased from £38.49m in August to £39.59m in September. This reflected the second phase of the resident doctor pay award, increased variable staffing costs and growth in substantive staffing, particularly across nursing and healthcare support roles. The five-week payroll month also increased reported bank expenditure, although medical bank costs, which are reported on a calendar-month basis, reduced.

Non-Pay:

Non-pay expenditure was £1.15m favourable to plan in September, reducing the year-to-date adverse variance to £0.25m. Expenditure decreased from £23.27m in August to £22.32m in September, mainly due to lower spending on drugs and high-cost devices. These areas remain inherently variable, so the in-month improvement should not yet be assumed to represent a sustained reduction in the underlying run-rate.

Improvement actions planned, timescales, and when improvements will be seen

Pay:

Pay controls focus on vacancy management, recruitment approvals, establishment control, rostering, medical pay and reducing reliance on temporary staffing and escalation capacity. Non-pay controls include monthly divisional reviews, tighter approval requirements and weekly monitoring of the number and value of orders. Performance will be tracked through weekly indicators and monthly divisional assurance reporting.

Non-Pay:

Monthly divisional non-pay reviews have been introduced, with weekly monitoring of the number and value of non-pay orders being developed. These arrangements will support earlier identification of emerging pressures, targeted challenge of expenditure and stronger accountability for recovery actions throughout the remainder of the financial year.

Risks to delivery and mitigations

Pay:

The principal risks remain sustained operational pressures, continued use of escalation capacity and temporary staffing expenditure above the planned reduction trajectory. Workforce growth and higher Junior Doctor costs have also increased the underlying pay run rate. Mitigations include strengthened workforce controls, weekly monitoring of bank, agency and escalation usage, and continued Executive and divisional scrutiny of recovery actions.

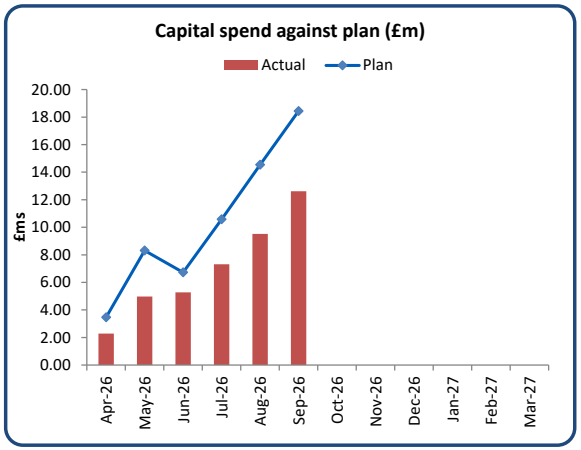
Non-Pay:

Non-pay remains volatile, particularly across drugs, high-cost devices and prostheses, utilities and infrastructure-related expenditure. Although costs reduced in August, the movement reflects variable expenditure and may not represent a sustained improvement. Monthly non-pay reviews, weekly order monitoring and targeted recovery actions are being used to strengthen control and reduce full-year exposure.

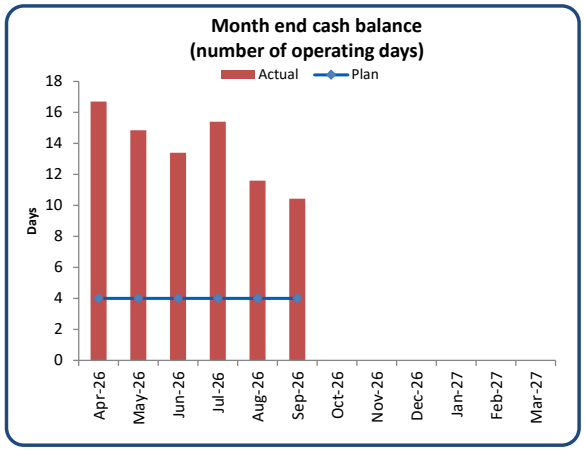
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Finance and Performance

Lead Executive - Ian Dean, Chief Finance Officer



Sep-26
12.62



Sep-26
10

Background, what the data is telling us, and underlying issues

Capital Spend: the data is telling us that we have spent less than we expected to by this point of the year. This is caused by our CDEL capital budgets not being approved until month 4 and so several projects were not authorised to commence spending against their budgets. We also have some non-CDEL projects that are delayed.

Cash Balance: The Trust ended September with a cash balance of £29.2m, compared with £31.4m at the end of August. This was £0.6m below the latest forecast of £29.8m but remained £7.7m above the original NHS England plan of £21.5m. Adverse cash movements from the operating deficit and the difference between capital expenditure and associated funding were partly offset by favourable working-capital timing. This continues the Trust to report cash days in excess of the benchmark 4 days.

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Improvement actions planned, timescales, and when improvements will be seen

Capital Spend: CDEL capital budgets have now been approved (at the start of July) so we expect spend to pick up and to see improvements over the coming few months. Non-CDEL projects are expected to catch up but are consistently monitored; if this view changes we will work to reprofile this funding across financial years in order to align with expected spend profile.

Cash Balance: Cash will be managed through routine forecasting and liquidity monitoring, with particular focus on the revenue position, capital expenditure, associated funding, creditor payments and the timing of income recognition.

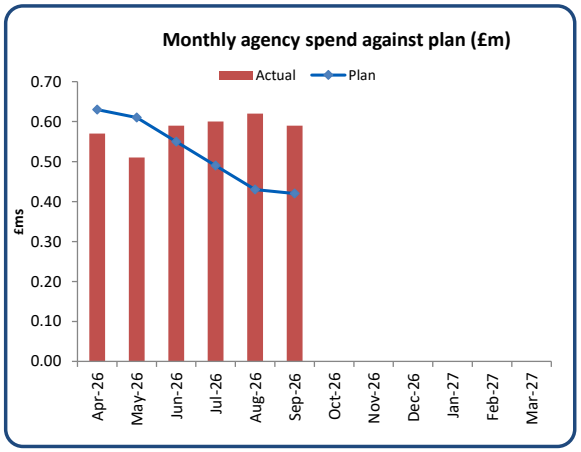
Risks to delivery and mitigations

Capital Spend: we have a 5% over programming mitigation built into the capital programme, this is something we include every financial year and are always successful in delivering.

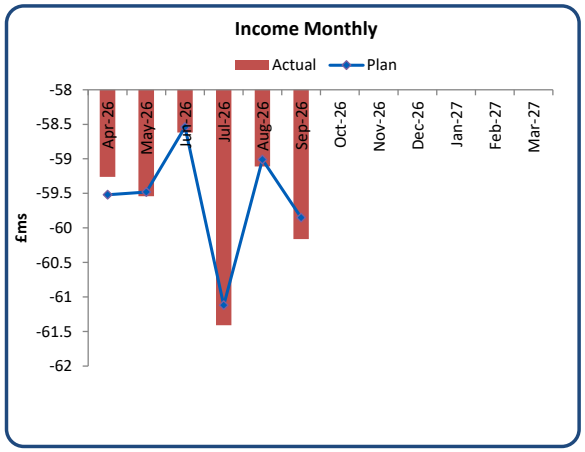
Cash Balance: The principal cash risk is that continued operating deficits, capital expenditure and creditor payments reduce liquidity more quickly than forecast. The higher opening cash balance provides some mitigation, but sustained improvement in the revenue position and close management of cash movements remain essential.

Finance and Performance

Lead Executive - Ian Dean, Chief Finance Officer



Sep-26
0.59



Sep-26
-60.16

Background, what the data is telling us, and underlying issues

Agency:
Agency expenditure was £0.59m in September, £0.18m adverse to plan, and has remained broadly consistent since June despite the planned reduction trajectory. The in-month variance comprised £0.05m within non-medical clinical staffing and £0.13m within Medical and Dental staffing. Year-to-date expenditure was £3.48m, £0.37m adverse to plan. Reductions in nursing and other non-medical agency costs have been offset by increased medical agency expenditure.

Income:
Income was £0.17m favourable to plan in September, improving the year-to-date favourable variance to £0.52m. This includes continued improvements in overseas and divisional income, including catering and car parking. However, the reported position continues to assume variable activity income is delivered in line with plan while uncoded activity is reviewed and discussions continue with the Integrated Care Board.

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Improvement actions planned, timescales, and when improvements will be seen

Agency:
Agency controls focus on recruitment, approval processes, rostering, establishment management and alternative staffing arrangements. Weekly agency metrics and divisional recovery reporting will be used to monitor movement towards the planned trajectory.

Income:
Income and activity performance will continue to be reviewed jointly by finance and operational teams, including uncoded activity, Elective Recovery Fund performance and the application of updated tariffs.

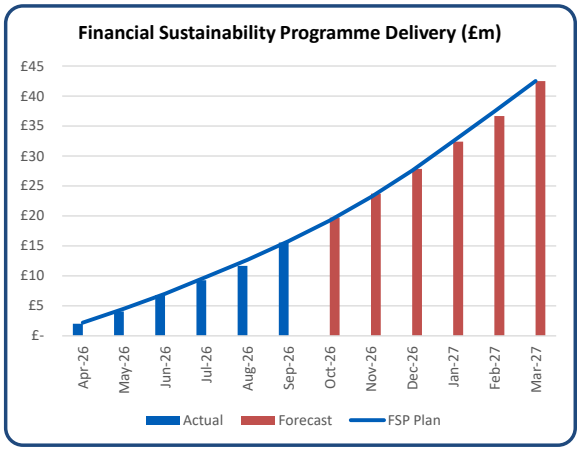
Risks to delivery and mitigations

Agency:
Agency expenditure remains above plan and materially above the level required by the year-end reduction trajectory. Without a sustained reduction, it will add further pressure to the financial position.

Income:
The principal income risk is that under-delivery of variable activity during Months 1 to 6 may not ultimately be funded. This risk is not currently reflected in the reported position or forecast and requires continued review and dialogue with the Integrated Care Board.

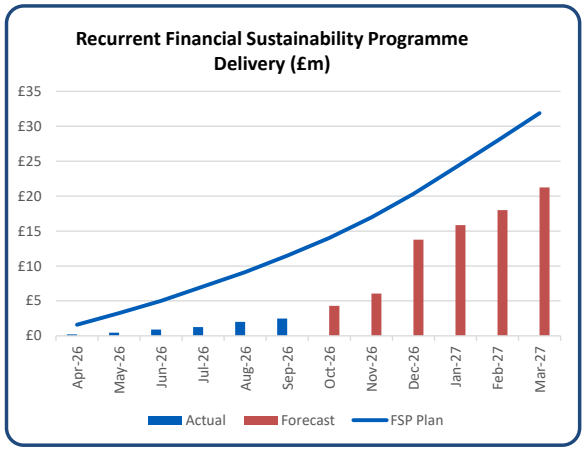
Finance and Performance - Financial Sustainability Programme

Lead Executive - Ian Dean, Chief Finance Officer



	Sep-26
Delivery %	98%
Delivery £	15.56

	Forecast Full Year
Delivery %	100%
Delivery £	42.50



	Sep-26
Delivery %	22%
Delivery £	2.50

	Forecast Full Year
Delivery %	67%
Delivery £	21.25

Background, what the data is telling us, and underlying issues

The Financial Sustainability Programme delivered £3.9m in September, increasing cumulative delivery to £15.55m against a plan of £15.81m and reducing the year-to-date shortfall to £0.26m. Month 6 delivery benefited from the planned quarterly review of reserve efficiencies and the acceleration of an income efficiency that had been forecast for a later month. This improved the September position but did not provide an additional benefit to the full-year forecast.

Although overall delivery is broadly in line with the year-to-date plan, it remains heavily reliant on non-recurrent measures. Recurrent schemes account for £2.50m, or 16% of savings delivered, compared with a planned recurrent share of 72%. The latest forecast is £31.98m against the £42.50m requirement, leaving a forecast shortfall of £10.52m. Forecast recurrent delivery is £11.57m, equivalent to 27% of the total programme target and below the 75% requirement.

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Improvement actions planned, timescales, and when improvements will be seen

Chief Finance Officer (CFO)-led review, programme gateway assurance and targeted scheme challenge continue to focus on improving delivery confidence, increasing recurrent savings and accelerating implementation. Recovery plans are required for areas of forecast under-delivery. Work has also commenced earlier on the 2027/28 programme, supported by focused scheme-development sessions and strengthened financial controls, to improve scheme maturity and operational ownership.

Risks to delivery and mitigations

The principal risk is the quality and sustainability of delivery rather than the year-to-date headline alone. Material forecast under-delivery remains within mulitple workstreams. Reliance on non-recurrent and technical measures increases the underlying deficit and the opening challenge for 2027/28. Enhanced governance, Executive oversight and the development of additional recurrent opportunities remain the key mitigations.

Quality Assurance Committee Section



Outstanding Care for One+All

Neave,Lynsey
30/10/2026 09:31:09

Quality Assurance Committee Specific - Executive Review

Executive Director Summary, key issues to highlight

Quality – Bernadette George, Acting Chief Nursing Officer

Nursing workforce fill remains broadly stable: registered nurse hours were 97.0% of plan in September (96.8% in August) and unregistered hours improved to 98.9% (97.5%). Overall falls rose slightly to 4.58 per 1,000 bed days, while moderate/severe-harm falls remained elevated at 0.32; focused prevention and learning from harm therefore remain priorities. New pressure ulcers reduced to 1.50 per 1,000 bed days from 1.70.

There were no Never Events in September, although two patient safety incident investigations were opened. Duty of Candour compliance was 77.8%, down from 82.4%, and requires sustained divisional follow-up. Patient feedback shows timely acknowledgement of complaints at 100% and improved response within the agreed timescale to 77% from 65%; however, formal complaints increased to 66 from 42 and thematic review is required.

Infection prevention remains the principal exception: cumulative *C. difficile* cases were 45 against a tolerance of 42. E. coli remained within tolerance at 37 against 41, while two MRSA cases and 13 Gram-negative bacteraemias were reported in September. Board oversight should remain focused on *C. difficile* recovery, harm reduction and timely learning and response.

Performance indicators, impact on quality – Robin Jones, Chief Operating Officer

The quality position is mixed, with improvement in several flow measures but material safety risks persisting across urgent c are, stroke, fractured neck of femur, falls and infection prevention. In urgent care, the 95th-percentile time to initial assessment improved from 37 to 32 minutes and aggregated patient delay reduced from 18,031 to 15,325 hours, but perfo rmance remains well outside the 15-minute standard. ED crowding risk 9048 remains a score 25. Expansion of Same Day Emergency Care in early November is expected to improve streaming and reduce avoidable admission.

Stroke performance remains a key concern. Only 56.6% of patients reached the stroke unit within four hours and the SSNAP rati ng has fallen to E, whilst acknowledging this is an improvment fromearlier in the year it is still below therequired standard. Conversely, 91.23% spent at least 90% of their admission on the stroke unit and CT within 12 hours rema ined strong at 98.15%. The planned unit relocation and extension of the thrombolysis pathway to continuous coverage are central recovery actions.

Fractured-neck-of-femur surgery within 36 hours improved from 48% to 56%, but remains inadequate; trauma -rota gaps and the mortality alert require close oversight of the formal improvement plan. Elective cancellations improved to 0.96%, with rebooking breaches reducing from 54 to 36, supported by the theatre 100 -day programme.

Patient flow continues to affect safety and experience. Corridor care reduced but remained substantial during September; inpa tient corridor care ceased in early October, while eradication within ED remains the objective. Average length of stay was within target at 3.39 days, although 100 patients were stranded over 21 days and delayed discharges rose to 99. Working jointly with the Chief Nursing Officer and Chief Medical Officer we are providing support 24 hours a day, 7 days a week to the ending of corridor care, this includes a process where approval is needed for a patient can be admi tted to a corridor space on a ward, this acknowledges that the ED corridor also needs to be clear
T

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30/10/2026 09:31:09

Quality Assurance Committee Specific - Executive Review

Executive Director Summary, key issues to highlight

Quality – Meridith Kane, Chief Medical Officer

#NOF (Fractured Neck of Femur)
Following receipt of an alert from the National Hip Fracture Database (NHFD) in August 2026, the Trust has undertaken a review led by the Trauma and Orthopaedic Service and Orthogeriatric Team, supported by Clinical Governance structures and the Divisional Leadership Team. The findings have been discussed through a specialty governance process and an improvement programme focused on the care of patients with hip fracture has been augmented. A comprehensive improvement programme has been developed with executive oversight and monthly governance monitoring. The key elements of the programme will form part of a quarterly Quality Assurance Committee (QAC) report submission. Progress will be monitored through a formal action plan with defined milestones, operational officers and escalation processes. Further areas for improvement will be identified through the trust performance against NHFD standards, mortality data and pathway metrics.

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. Following both regional and national visits to RCHT in September, a team from RCHT attended a TTASC Collaborative event in London on 15 October. This gave the team opportunity to receive data insights and to meet with and discuss case studies with teams from around the country. The learning will be brought back to Cornwall and shared with colleagues in the Trust.

Corridor Care
The weekly Clinical Vision of Flow (CVoF) meetings are chaired by Dr Merry Kane, with representation from all Divisions to track progress against the 11 priority UEC actions and implementation of the 21 GIRFT Clinical Operational Standards. Daily focus is given to support patient flow across the hospital, and the CMO/CNO/COO are supporting all 10pm site review calls. Further work to optimise flow is planned with ward moves to support an expanded Same Day Emergency Care pathway from early November. To take out (TTO) pharmacy support is in place on AMU and Roskear. Metrics are reviewed weekly at this meeting with oversight also at the weekly PPPP meetings.

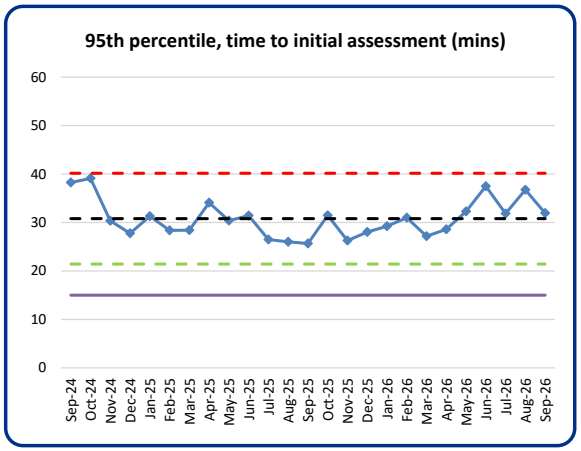
Mortality
Mortality indicators demonstrate that we remain within the expected range (HSMR, SHMI and Crude Mortality). #NOF has been flagged by the NHFD as a potential mortality outlier, and an action plan is in place to address the NHFD KPIs to address this. RCHT provided moderate assurance in a July 2026 mortality review internal audit; a mortality governance framework, with effective policies, data reporting, and screening processes, is in place. A team of designated senior clinicians to complete Subject Judgement Reviews (SJRs) has been recruited to address inconsistencies in the timeliness and quality of Subject Judgement Review (SJR) delivery, and all will attend training for this role. A migration to the RADAR system is also in progress, which will allow the process to be electronic, not paper based. Following divisional restructure, we are strengthening the quality and impact of mortality review processes, focusing on governance, clinician engagement and learning. Improvement work continues to standardise Specialty Morbidity and Mortality (M&M) meetings, led by the Trust Mortality Lead and Mortality Review Oversight Group. Information on the Trust's performance has also been shared with the Devon, Cornwall & Isles of Scilly Cluster Morbidity & Mortality Group.

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Quality Assurance - Urgent and Emergency Care

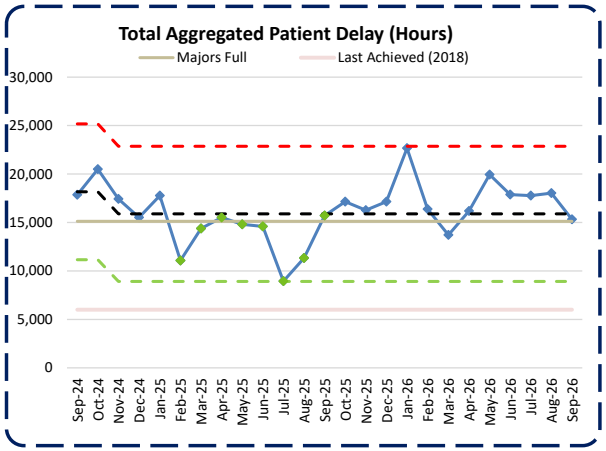
Lead Division - Medicine

Lead Executive - Meridith Kane, Chief Medical Officer



Sep-26

32



Sep-26

15,325

Background, what the data is telling us, and underlying issues

The 95th percentile, time to initial assessment reduced in September from 37 to 32 minutes. The Division recognises the work still to do to meet the national 15-minute standard.

Alongisde this, the total aggregated patient delay dropped from 18031 to 15325 hours.

Improvement actions planned, timescales, and when improvements will be seen

Work continues with the ED and Acute Medicine team to stream patients away from the Emergency Department where clinically appropriate.

The planned move to increase the Same Day Emergency Care (SDMA) unit is on track to be delivered in early November which will increase streaming opportunities and hot clinics as an alternative to same day care/admission to hospital.

Risks to delivery and mitigations

Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

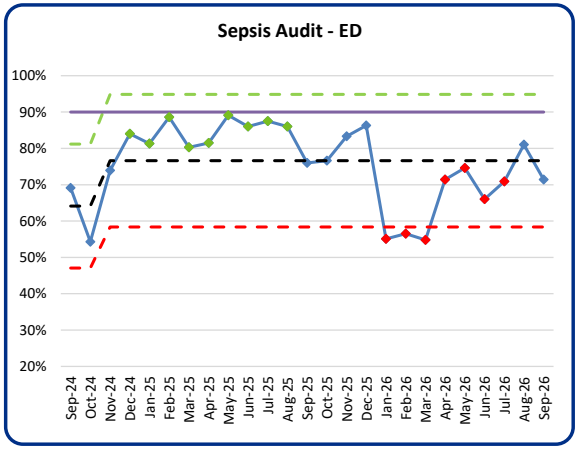
Risk description - The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

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Quality Assurance - Urgent and Emergency Care

Lead Division - Medicine

Lead Executive - Meridith Kane, Chief Medical Officer



Sep-26	
Antibiotics within 1 hr	71.40%

Background, what the data is telling us, and underlying issues

Performance against the standard fell back in September to 71.4% after a single month of improved performance. Despite the demand challenges that ED face the Division is clear on the importance of meeting this standard.

Improvement actions planned, timescales, and when improvements will be seen

Performance will be supported by the Deputy Head of Nursing and Sepsis lead for the Trust to ensure this clinical safety measure is met.

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.

The team have also been focusing on NEWS Score 3 for new confusion as this may also be underrepresented.

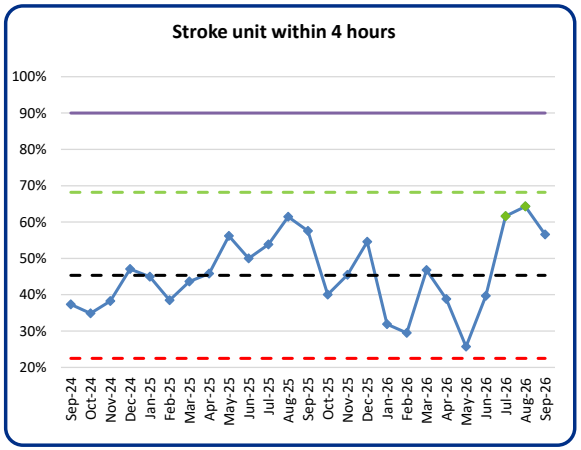
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Quality Assurance - Stroke

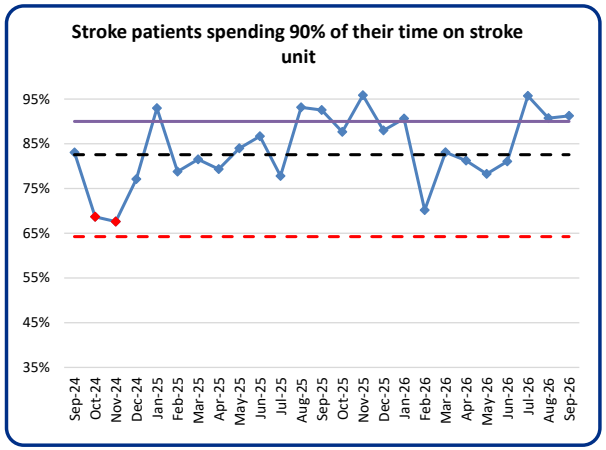
Current SSNAP rating = E
(Jan-March 2026)

Lead Division - Medicine

Lead Executive - Meridith Kane, Chief Medical Officer



Sep-26
56.60%



Sep-26
91.23%

Background, what the data is telling us, and underlying issues

Access to the Stroke ward fell in September with 30 of 54 admitted to the Stroke unit within 4 hours of arrival - 56.60%

All but 5 patients spent at least 90% of their admission on the Stroke unit in September (91.23%). This is a slight improvement on August and exceeds the national target of 90%.

This performance continues to support the changes made to inpatient bed ringfencing, the use of Same Day Medical Assessment (SDMA) and improved community stroke bed availability.

Improvement actions planned, timescales, and when improvements will be seen

The Stroke unit is due to move to the current SDMA template once this relocates to the Tremenel Unit in early November. The ward environment is thought to be more conducive to recovery.

The move to best practice thrombolysis pathway is in place in-hours 5-days per week with plans in place to extend to 24hr, 7-day coverage from October 2026.

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.

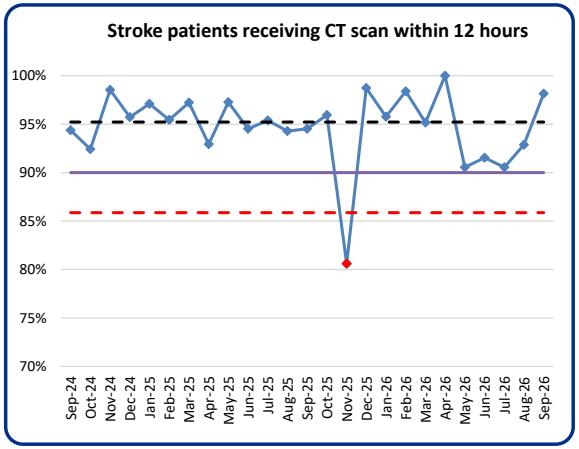
RCHT have been selected as one of the 12 sites working with the Thrombolysis and Thrombectomy in Acute Stroke Collaborative (TTASC) over the coming 12 months to implement a quality improvement project to improve thrombolysis and mechanical thrombectomy rates.

Neave,Lynsey
30/10/2026 09:31:09

Quality Assurance - Stroke

Lead Division - Medicine

Lead Executive - Meridith Kane, Chief Medical Officer



Sep-26

98.15%

Background, what the data is telling us, and underlying issues

RCHT has consistently performed strongly against this standard in line with SSNAP, meeting and exceeding the 90% minimum (with the exception of November 2025). Performance was the second best in 2 years in September with 54/55 (98.5%) patients receving a CT scan within 12 hours. Access to CT inline with these targets is a key priority for Radiology as part of its internal standards.

November 2025 marked an exception to performance in a particularly pressured month. On going, this target is balanced with overall demand from ED and urgent inpatient activity.

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. September performance continues to be above the 90% target.

Risks to delivery and mitigations

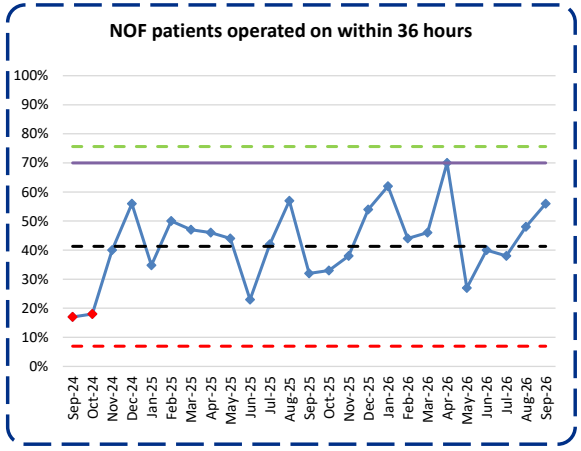
Risk to this target is always related to demand pressures and the ability to manage this capacity. Stroke and Trauma access to CT remain the highest priority.

Neave,Lynsey
30/10/2026 09:31:09

Quality Assurance - Fractured Neck of Femur (NOF)

Lead Division - Surgery

Lead Executive - Meridith Kane, Chief Medical Officer



Sep-26
56.00%

Background, what the data is telling us, and underlying issues

The percentage of neck of femur operations completed in September compared to August position of 48% has risen to 56%. This is a continued improving picture for this cohort of patients.

The locum for Trauma has commenced which has helped fill the known gaps on the trauma rota and consequently helped ensure that #Nof patients are prioritised to theatre. The second locum has withdrawn from post due to personal reasons, and the team are readvertising for this position. In the meantime, to support the trauma rota elective activity is having to be misplaced to ensure the trauma rota is covered.

Following the letter of concern received from the National Hip Fracture Database (NHFD) due to our mortality rate being 93.5% against the national average of 95% the team have met with the Chief Medical Officer (CMO) and implementation of action plan has commenced.

Neal, Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

Expansion of therapy services to improve rehabilitation provision and support a seven-day model of care.
Strengthening of weekend trauma medical and orthogeriatric cover.
Development of a dedicated Neck of Femur (NOF) nursing/coordinator role to improve pathway oversight and reduce delays.
Improvements to theatre productivity, including work to reduce turnaround times and optimise trauma list utilisation.
Daily review and executive escalation of patients approaching the 36-hour surgery standard.
Implementation of a structured mortality review process with thematic learning and improvement actions.
Monthly NHFD performance monitoring through Divisional Governance and Quality Assurance Committee reporting.
Introduction of daily frailty trauma board rounds, improved discharge processes and focused work to reduce length of stay.
Establishment of a dedicated weekly multidisciplinary team meeting for NOF patients.
Ring-fencing of designated #NOF beds within trauma wards where operationally feasible.
Ongoing review and implementation of the Trust NOF pathway.
Introduction of a fortnightly NOF working group to oversee performance, review key metrics and ensure delivery of improvement actions.

Risks to delivery and mitigations

Continued gaps on the trauma rota due to inability to recruit to the additional trauma locum post. Support being provided to ensure this recruitment process is fast tracked.

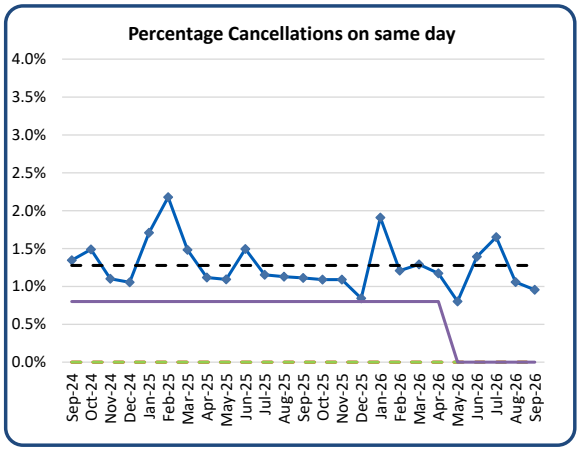
#NoF improvement plan is not delivering the agreed key performance indicators (KPI's). The fortnightly meeting needs to escalate any concerns to the senior leadership team (SLT) of the division.

The Trauam rota continues to have gaps which means that at times there are not enough surgeons to be allocated to a dedicated theatre for patients with #NOF in order to be operated on within the 36 hr target. To mitiagte this 1 trauma locum has been employed and commenced working and there is an advert out for the 2nd.

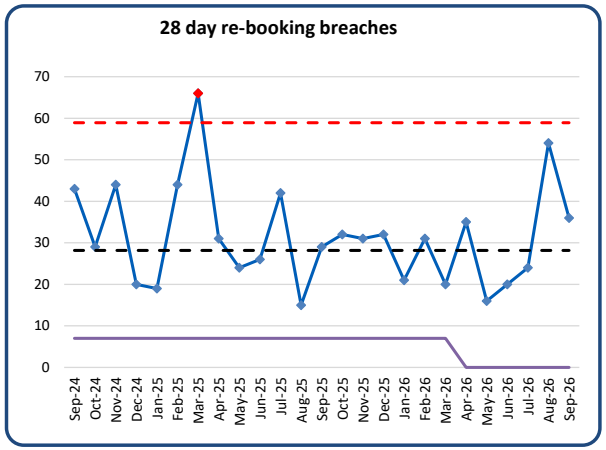
Quality Assurance - Elective Cancellations

Lead Division - Surgery and Peri-Operative Care

Lead Executive - Robin Jones, Chief Operating Officer



Sep-26
0.96%



Sep-26
36

Background, what the data is telling us, and underlying issues

The trend of decreasing cancellations on the day has continued from August's position of 1.06% to 0.96% in September. The aim of achieving no cancellations due to beds was achieved.

The main reason given for cancellations on the day this month was reported as insufficient time in theatre along with emergency priority. Patients being unfit and procedure not being needed was also highlighted.

Cancellations on the day continue to be reviewed at the weekly scheduling meeting for learning and thematic reviews as required.

The balance between rebooking the on the day cancellations versus booking of long waiters continues but a focus on this element has shown an improvement in September dropping to 36 from 54 in August.

Neave, Lesley
30/10/2025 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

The 100-day challenge for stabilisation of theatres and supporting improving the "Start well project" that under pins increasing theatre productivity, commenced on the 1st September. It has concentrated so far on the concept of the golden patient and is showing improving the start time of theatre 1 to 9. The aim being stopping there being insufficient time to complete all on the list.

St Austell Surgical Hub (SASH) already uses the concept of the golden patient and is now drilling down into the detail of why on certain days the theatres do start late, for example this may be due to arrival time of surgeon, and we need to understand what is causing this.

Cancellation reasons are now being shared daily so that themes can be collocated and fed back to the group leading the 100-day challenge for learning and actions as required.

Risks to delivery and mitigations

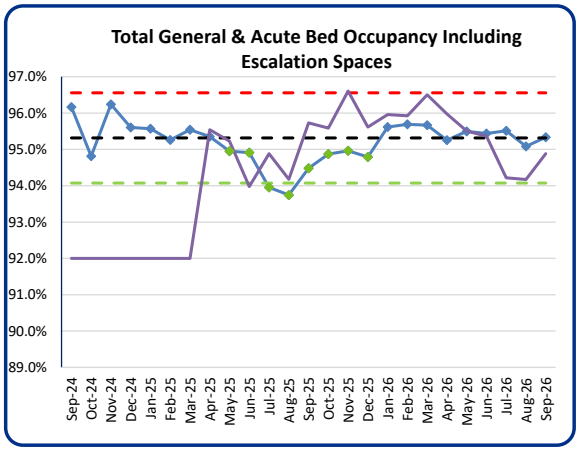
Sickness within theatre staffing continues to impact theatres having to be cancelled on the day. Continued HR support for managing sickness is in place.

Patients not engaging in pre-assessment instructions causing the need to cancel on the day. Ringing patients prior to surgery helps reduce this risk.

Ensuring that all lists are fully booked means it is a challange to get patients cancelled on the day back in within 28 days. Monitoring the position via the weekly scheduling meeting helps to reduce this risk.

Quality Assurance - Corridor Care

Lead Division - Medicine



Sep-26

95.34%

Lead Executives - Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer and Bernadette George, Acting Chief Nursing Officer

Corridor Care

Daily Highlights	Value
ED peak day	21
ED lowest day	4
Hospital peak snapshot	18
Hospital lowest snapshot	5

Background, what the data is telling us, and underlying issues

Corridor Care is broadly defined as a patient spending more than 45 minutes in a space without bedhead services, including a call bell, oxygen and suction, dimmable lighting, or fixed curtains to protect dignity; this definition applies across all Trust areas.

NHS England 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 came out 19th overall, averaging 47 per day.

Corridor care is an NHS Oversight Framework contextual metric for 2026/2027.

Corridor care remained a major challenge through September, with just a small reduction in the average number of inpatients in corridors to 14 per day. The average number of patients receiveing care in the ED corridor fell from 17 to 12. The number of escalation beds in use also fell from average 33 to 29.

Neave, Lynsey
30/10/2025 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

The Divisions continue to maintain a strong focus on optimising patient flow across the entire patient pathway. The Trust ceased the practice of inpatient corridor care in early October, including the routine use of the 2 majors esclation spaces. Corridor Care in the rest of the Emergency Deparment however continues. with continued focus to errradicate before the end of October. Authorisation of ward corridor care spaces is now via the COO/ CNO/CMO only as part of the total commitmentto end the practice of using corridor care spaces. Daily operational efforts remain centred on proactive discharge planning and ensuring timely progression of patients through their care journey.

Whilst progress has been made on corridor care spaces on wards the Trust acknowledges the continued use of spaces in ED which is the next area of focus

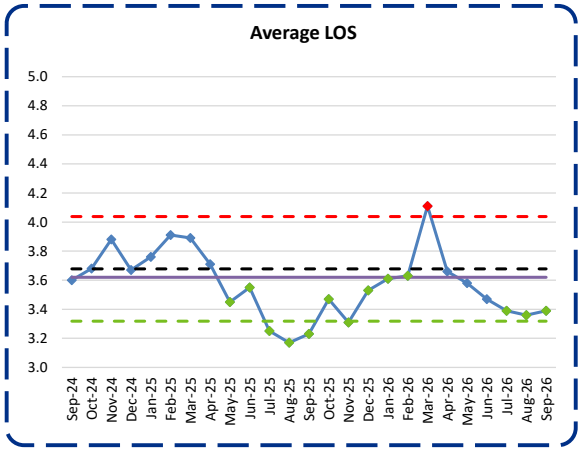
Risks to delivery and mitigations

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.

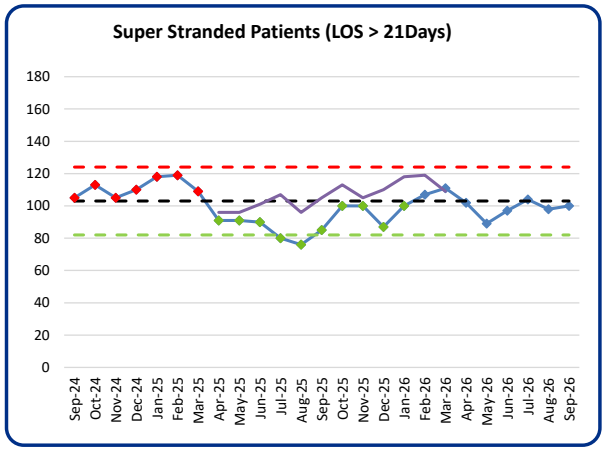
Quality Assurance - Length of Stay

Lead Division - Medicine

Lead Executives - Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer



Sep-26
3.39



Sep-26
100

Background, what the data is telling us, and underlying issues

Average length of stay increased incrementally in September but at 3.39 days remained below the 3.6 day target. The average number of stranded patients increased from 98 to 100.

Right patient - right place: The advent of the Discharge Ready Unit supports both metrics - cohorting of complex discharge patients with focused multi disciplinary team (MDT) support drives earlier discharge and releases specialty base ward capacity.

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.

Neave, Lisa
30/10/2025 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

The Whole Hospital Review and long length of stay review processes are embedded as business as usual (BAU).

The Discharge Ready Unit supports specialty bed availability and focus on delayed pathway 1-3 patients. The Trust continues to push system colleagues to reduce the number of medically fit for discharge patients in acute hospital beds.

A review of the tools used across the whole system has been scheduled to make better use of the capability of the tools as part of ongoing work to deliver the intended maximum waits from medically fit for discahrge to discharge

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.

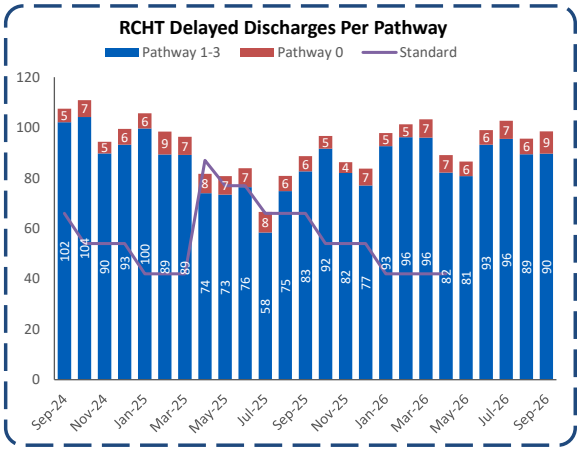
Non-Medically Optimised Patients. There is an unknown risk until an agreed process is worked up for review of these patients systematically.

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.

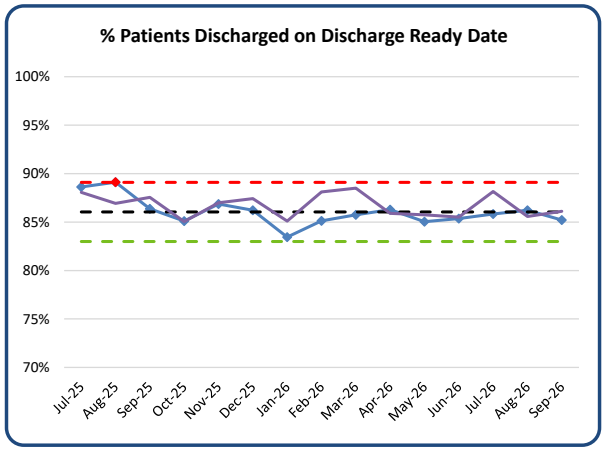
Quality Assurance - Length of Stay

Lead Division - Medicine

Lead Executives - Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer



Sep-26	
Pathway 0	9
Pathway 1-3	90
Total	99



Sep-26
85.21%

Background, what the data is telling us, and underlying issues

The number of delayed discharges increased across all pathways in September - the largest increase in pathway 0s. The Division is leading a push on Criteria Led Discharge (CLD) to acelerate discharge - this will reduce delays and benefit early flow out of the Emergency Department into the hospital.

Improvement actions planned, timescales, and when improvements will be seen

Criteria Led Discharge is being overseen by the Trust's Clinical Vision of Flow group.

The Medicine Division continue to work with wards to ensure accuracy of Planned Date of Discharge recording and planning for next day discharge.

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.

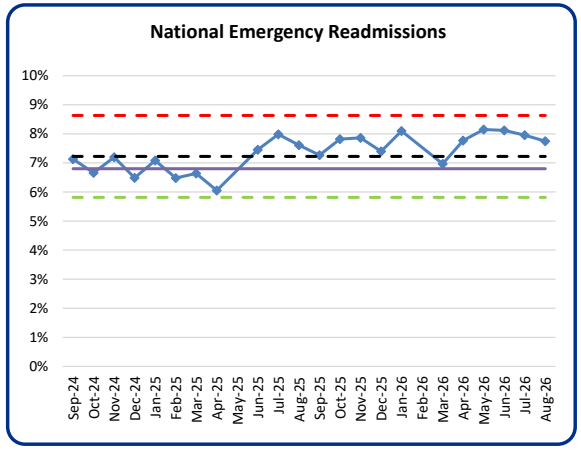
This has been highlighted at the two away days as a key topic.

Neave,Lynsey
30/10/2026 09:31:09

Quality Assurance - Readmissions

Lead Division - Medicine

Lead Executives - Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer



Aug-26

7.74%

Background, what the data is telling us, and underlying issues

The emergency re-admission rate continued to reduce in September towards the target of 6.8%.

The average time between index admission and re-admission was 10 days with re-admission length of stay (LOS) greater than the index LOS (average 6 days re-admission v. 4 days index admission).

76% of re-admitted patients intially presented on emergency pathways whilst 24% re-presented as emergencies having initially undergone elective care.

Neave,Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

This metric will continue to be subject to close scrutiny including any emerging trends. Correlation will be made with LOS and mortality measures.

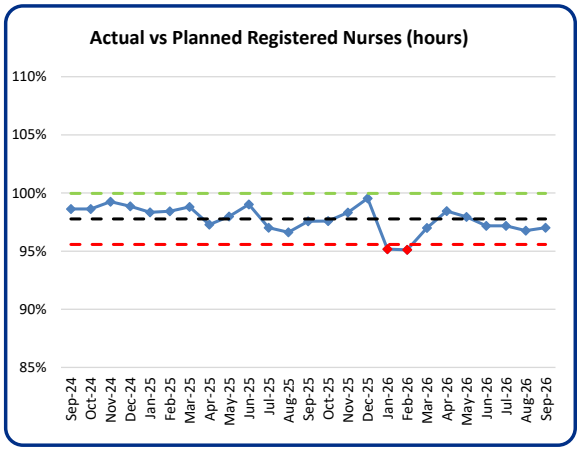
Risks to delivery and mitigations

The spike from April is being investigated due to the areas highlighted. The results of this will be discussed in the Divisions Governance forums.

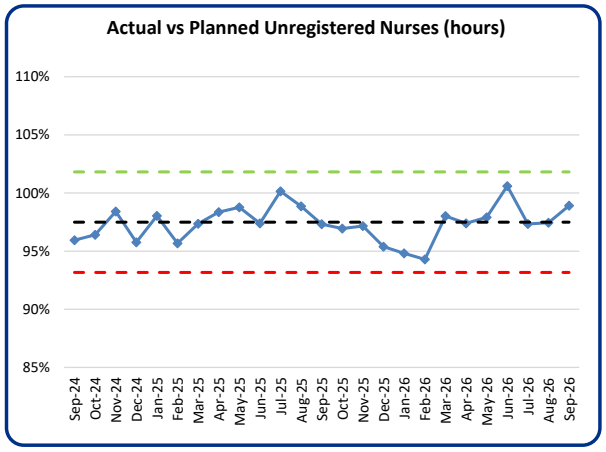
Further risks include workforce pressures, delayed discharge planning, poor multi disciplinary team (MDT) communication and limited community capacity. These will contribute to unsafe or delayed discharges which increase length of stay and admissions rates.

Quality Assurance - Nurse Staffing

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
97.02%



Sep-26
98.91%

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

Priority is to maintain current position with continued focus on ongoing recruitment position.

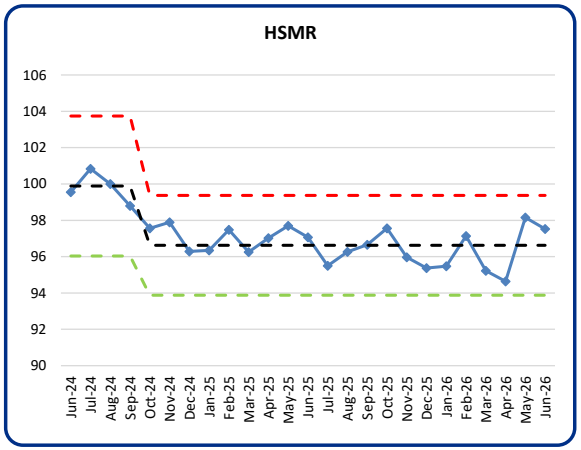
Risks to delivery and mitigations

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.

Neave,Lynsey
30/10/2026 09:31:09

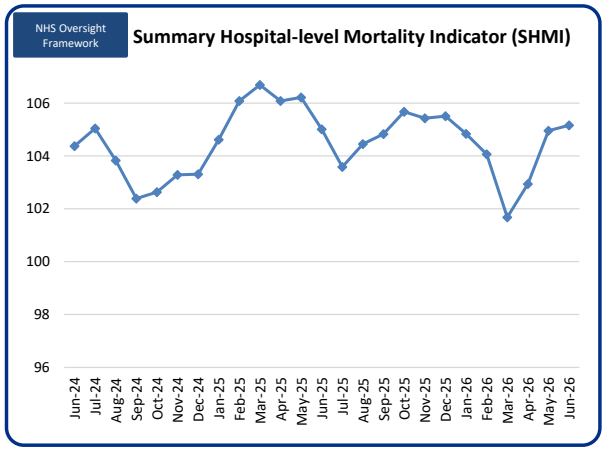
Quality Assurance - Mortality

Lead Executive - Meridith Kane, Chief Medical Officer



Jun-26

97.53



Jun-26

105.16

(Expected range)

Background, what the data is telling us, and underlying issues

HSMR for the rolling 12-month period July 25 to June 2026 is 97.53 (was 98.16). HSMR remains well within confidence limits.

SHMI for the rolling 12-month period July 25 to June 2026 is 105.16 (was 104.96). SHMI remains elevated but within confidence limits.

Elective SHMI remains elevated at 133 (was 132).

Fractured Neck of Femur 95% Lower Confidence level remains elevated at 129.93 this has increased from 124.91

Other Fractures is no longer alerting. The 95% lower confidence level is 89.67 (102.95). There are 25 patients within this alert. A review of the patient will be presented at November MROG.

Skin and subcutaneous tissue infections has alerted with a 95% lower confidence level of 101.82 with 17 patients in the alert. An initial clinical coding review has been requested.

No other alerts identified.

Neave,Lynsay
30/10/2025 09:01:09

Improvement actions planned, timescales, and when improvements will be seen

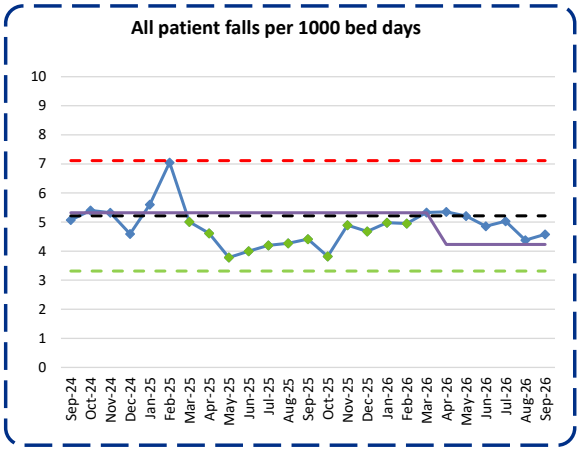
Elective SHMI actions:- Guidance on correct admission method coding remains in place across Same Day Medical Assessment (SDMA) and Medical Rapid Assessment and Triage (MRATS), supported by training and a standard operating procedure. The Clinical Effectiveness Team continues weekly mortality reviews and works with CITS to identify and correct coding inaccuracies, providing ongoing assurance of data quality. No improvement is yet evident in the available SHMI data; however, due to the reporting lag, the impact of these actions may not be reflected for several months. Monitoring will continue.

Risks to delivery and mitigations

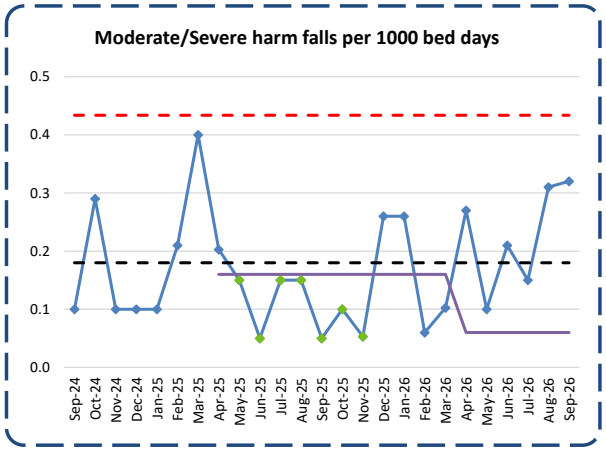
Risk 9081 - Clinical Coding Resource
Risk description: There is a risk that the mortality information will not be accurate due to the current issues with the clinical coding capacity. The trust are currently reporting data 1 month in arrears in order to mitigate this.

Quality Assurance - Patient Falls

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
4.58



Sep-26
0.32

Background, what the data is telling us, and underlying issues

In September, 86 inpatient falls were reported across the organisation, with a falls rate of 4.57 per 1,000 bed days against a target of 4.23. Six falls resulted in serious harm, giving a harm falls rate of 0.32 compared with the target of 0.06. Injuries included fractures and intracranial haemorrhage, contributing to increased morbidity, longer hospital stays and greater rehabilitation needs. A further three harm falls occurred in non-bedded areas and are reported separately from the inpatient harm metric.

Falls activity remains above Trust targets despite stable overall numbers. Delirium continues to be a significant contributory factor and is associated with increased risk of falls, harm and prolonged admission. Overdue nursing assessments have also been identified as a risk, potentially delaying recognition, escalation and intervention for vulnerable patients.

Neave,Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

Progress against the Falls Quality Summit action plan has been reviewed. Work is underway to develop resources supporting the recognition, assessment, and management of delirium, including guidance for nursing staff, delirium education, and ACVPU (alert, confusion, voice, pain, unresponsive) learning materials. In addition, assurance audits on overdue nursing assessments have been introduced, with clinical teams asked to review and escalate overdue assessments through handovers.

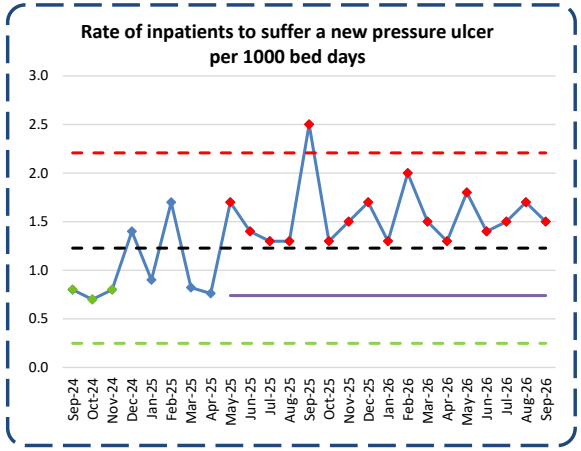
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Risks to delivery and mitigations

Delirium Identification and Management remains a high-risk issue on the Trust-Wide Risk Register (ID 10192) and is being escalated to Clinical Effectiveness Group (CEG) due to concerns regarding governance, accountability, and compliance with Trust standards.

Quality Assurance - Incidents

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26

1.50

Background, what the data is telling us, and underlying issues

The rate of inpatients to suffer a new pressure ulcer remains unchanged and static / stable at around 1.5 per 1000 bed days.

6 moderate harm incidents were reported this month, a slight decrease from the 7 in August, with investigations ongoing. Initial themes from incidents remain the same as previous incidents and investigations.

The incidence of pressure ulcers and breakdown of site, and location will be published in the Quarter 2 quality report for Hospital Acquired Pressure Ulcers for further learning and targeted work in specific inpatient areas and also the admission departments which all outside of this metric.

Improvement actions planned, timescales, and when improvements will be seen

The new Trust-Wide improvement plan for reducing hospital acquired pressure ulcers is ongoing with regular updates with senior leadership. Ward leaders updates are pending at upcoming Divisional Ward Leaders Meetings.

Work remains ongoing within admitting areas, as well an inpatient wards where high incident rates have been reported.

Heads of Nursing are starting a target piece of peer review and check and challenge.

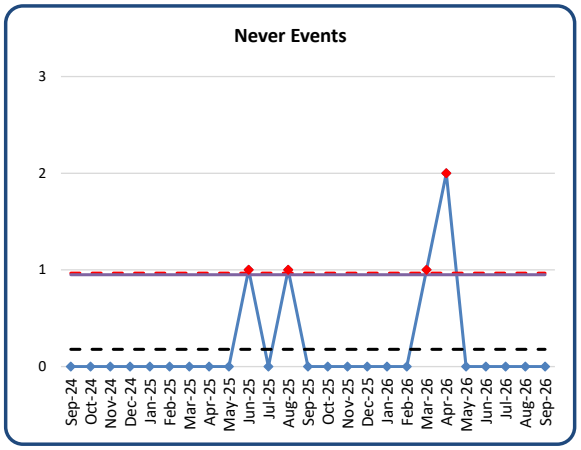
Risks to delivery and mitigations

There is an ongoing risk that due to lack of staff engagement and understanding of the expectations upon them in relation to 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 particular issues have been identified with documentation on the SSKIN and pressure ulcer risk assessment. Individual action plans have been developed for areas with high numbers of incidents.

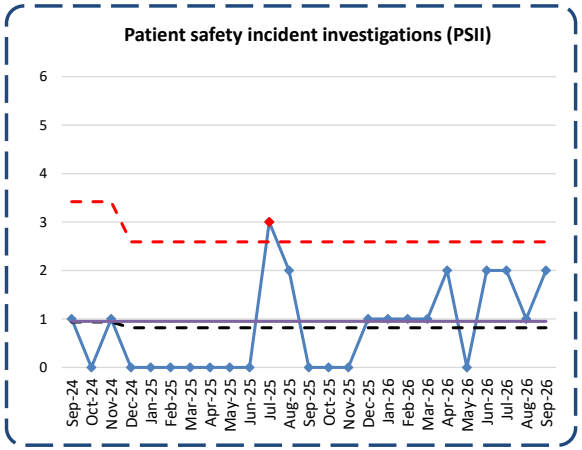
Neave,Lynsey
30/10/2026 09:31:09

Quality Assurance - Incidents

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
0



Sep-26
2

Background, what the data is telling us, and underlying issues

In September there were 2 new Patient Safety Incidents commissioned:

One - reported in August, comissioned in September was an intrauterine death of a baby followed by the death of the mother. This incident was originally referred to Maternity and Newborn Safety Investigation (MNSI) for review but is currently on hold awaiting family consent. The initial internal review of these cases are reported in the Perinatal Report to Trust Board.

The second incident is being reviewed under the Patient Safety Incident Review Plan to improve the recognition of the deteriorating patient on the surgical pathway.

The number of overdue incidents for review and awaiting final approval continue to be high and this is esclated via Patient Safety Incident Review and Oversight Group (PSIROG).

Neave, Lynsey
30/10/2025 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

One MNSI report was approved approved through the Patient Safety Incident Review and Oversight Group:

MNSI review (neonatal hypoxic ischaemic injury): A multidisciplinary "Stop and Share" learning proforma has been completed and disseminated to support immediate learning from the review, with a focus on CTG interpretation, escalation, transfer processes and newborn assessment. Progress against wider recommendations will continue to be monitored through maternity governance arrangements.

Targeted support to manage incidents has been offered and a quality assurance of awaiting final approval incidents is in progress to support management and closure of incidents.

Risks to delivery and mitigations

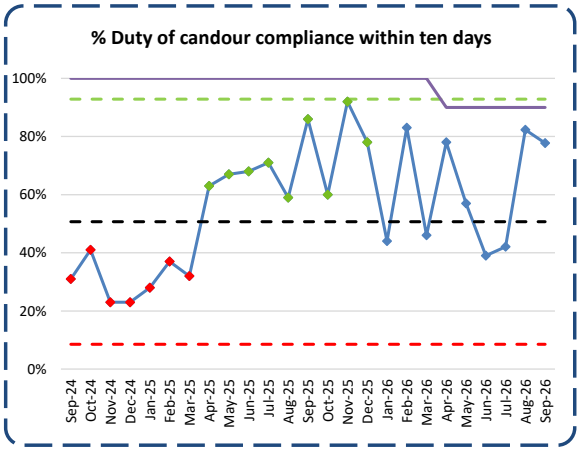
No risks to delivery identified at this time, all reports are within the 6 month timeframe.

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.

On going work with the Divisions to manage overdue incidents and actions.

Quality Assurance - Incidents

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
77.77%

Duty of Candour (All Incidents)	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Incident Graded Moderate or Above	18	14	23	19	17	27
Duty of Candour Complete	14	8	9	8	14	21
% Compliance with Duty of Candour	**78%**	**57%**	**39%**	**42%**	**82%**	**78%**

Background, what the data is telling us, and underlying issues

Duty of Candour (DoC) is the legal and professional duty for healthcare organisations and staff to be open, honest, and transparent with patients and families when something goes wrong in care that causes, or could cause, significant harm. It requires a timely apology, an explanation of what happened, and keeping those affected informed about any investigation and learning. The aim is to support patients and families, maintain trust, and ensure lessons are learned to improve safety and prevent recurrence.

The 10 day timeframe for DoC was 78 % in September (expectation of 95%), for this month we have sustained our performance around the 80% position whilst we work on further improvements.

Neave,Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

We have adopted the approach of linking with divisional leadership teams and divisional governance managers each week, with a review of the position twice weekly to offer intevention. Divisional performance is also shared each week. There are always circumstances were a considered and compassionate response outweighs a timeframe and we ensure those circumstances are clear.

Risks to delivery and mitigations

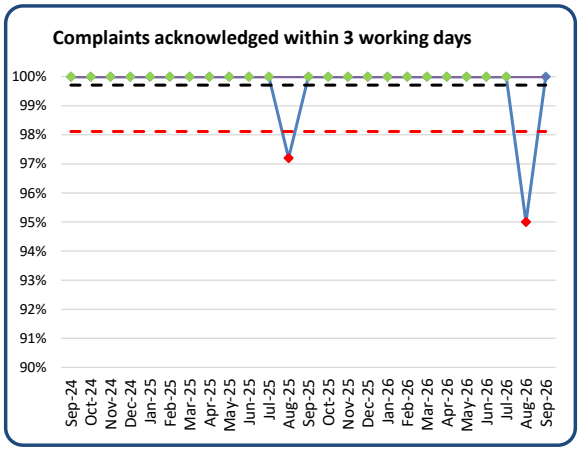
Risk
There is a risk of not upholding the requirements of the Patient Safety Incident Response Framework (PSIRF), being open and compassionate when adverse events occur, and a risk to regulatory compliance for Duty of Candour (Reg 20) of the Health and Social Care Act.

Risk to Delivery
Where operational pressure or gaps in workforce reduce timely incident review and duty of candour conversations.

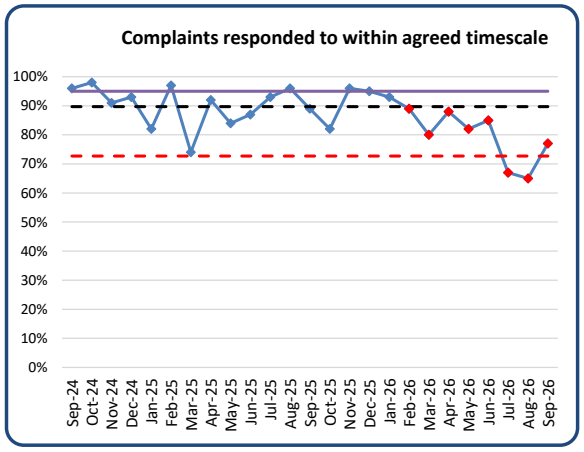
Mitigations
Prompt review of incidents meeting moderate harm threshold
Early escalation to senior leaders
Design of duty of candour in Radar healthcare (datix replacement)
Using Radar Healthcare training programme as an opportunity to provide further training on duty of candour.

Quality Assurance - Patient Feedback

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
100.00%



Sep-26
77.00%

Background, what the data is telling us, and underlying issues

100% of complaints were acknowledged within three working days. Acknowledgement performance remains strong and demonstrates a continued commitment to timely initial communication with complainants by Patient Expereince Team.

For Formal Complaints, 31 complaints were closed during the month, with 7 breaches recorded. This resulted in an overall response rate of 77%, an improvement from 65% in the previous month. However, performance remains below the Trust's KPI target of 95% and has not met the target for eight consecutive months since January.

For Informal Complaints, 161 complaints were closed, achieving an overall response rate of 52%. This represents a decrease from 56% in the previous month and remains below the Trust's KPI target of 95%.

Neave, Linsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

This suggests underlying pressures related to increasing workload, delays in obtaining responses from clinical teams, and variability in service-level performance.

To address these challenges, the Medicine Division has implemented a weekly Complaint Scrutiny Group, involving Heads of Nursing, Service Managers and Governance Leads, with a focus on early escalation, identifying barriers to completion, and improving the timeliness and quality of complaint responses.

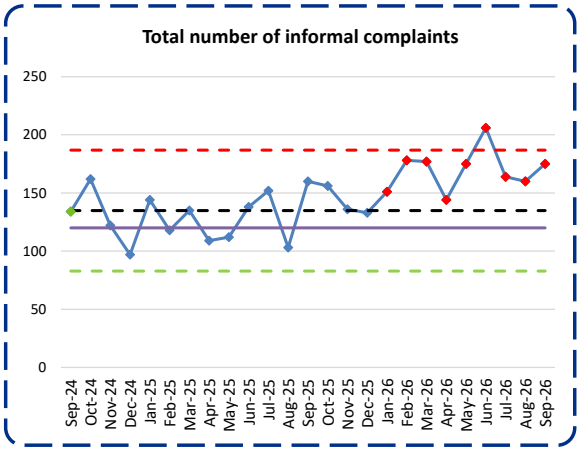
In addition, Divisions presented at the July Patient Performance Meeting, outlining the key actions being taken to improve complaint performance and compliance. These actions are already in place and are expected to deliver measurable improvements in informal complaint response compliance and overall performance over the next three months.

Risks to delivery and mitigations

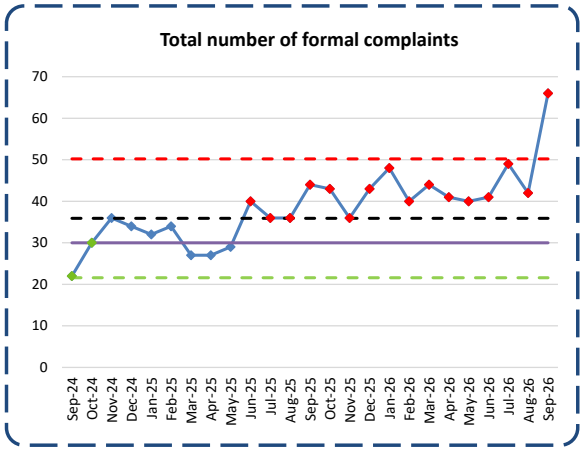
Key risks to delivery include sustained high complaint volumes, delays in divisional responses, and variable engagement across divisional teams; these are being mitigated through strengthened oversight, increased senior accountability, and continued emphasis on balancing response quality with timeliness.

Quality Assurance - Patient Feedback

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
175



Sep-26
66

Background, what the data is telling us, and underlying issues

September recorded the highest monthly total of formal complaints received since the introduction of the formal and informal complaints framework, with 66 formal complaints received. These figures exclude concerns resolved within 24 hours or directly at ward level. The highest number of formal complaints were received within Medicine (30), followed by Surgery (13), Women & Children (8) and Clinical Support & Cancer Services (3).
The increase was largely driven by the Emergency Department (10 complaints), with Neurology (4), Clinical Reception - Cardiology (4) and Orthopaedics (4) also recording higher complaint volumes. Communication with patients and families remained the most frequently reported theme.

163 informal complaints were received during the month. The majority were received within Medicine (84; 54%), followed by Surgery (40; 25%), Clinical Support & Cancer Services (26; 17%) and Women & Children (7; 4%).
The top five areas for informal complaints were Emergency Department (16), Clinical Reception - Cardiology (13), OPD Ophthalmology (7), Oral and Facial Surgery Unit (7) and Orthopaedics (6). Communication, appointment management, waiting times and access to services remained the key themes.

Improvement actions planned, timescales, and when improvements will be seen

Please see previous page which also applies to these metrics.

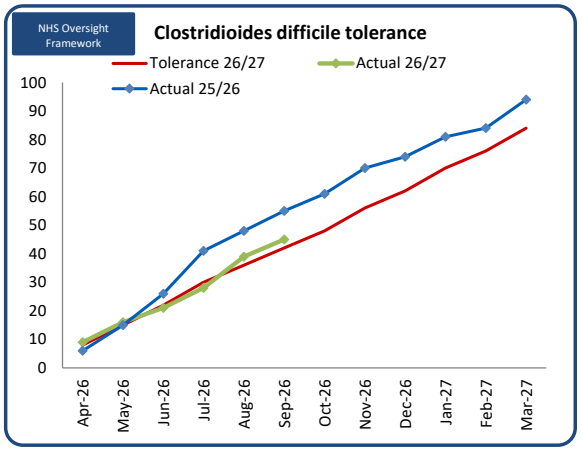
Risks to delivery and mitigations

Please see previous page which also applies to these metrics.

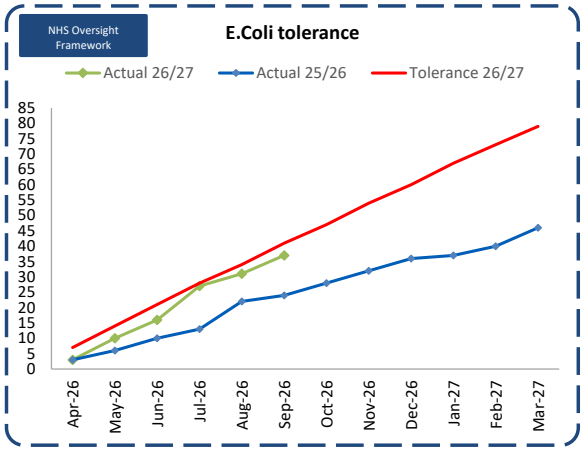
Neath Port Talbot 30/10/2025 Item 10

Quality Assurance - Infection Prevention and Control (IPAC)

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26	
Cdiff cumulative	45
Tolerance	42



Sep-26	
E. Coli cumulative	37
Tolerance	41

Background, what the data is telling us, and underlying issues

Clostridioides difficile (C.diff) 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 2025/2026 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. The E.coli chart shows a cumulative total month on month for the year vs last year and this year's tolerance. 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.

Neave, Lynsey
30/10/2026 09:31:09

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 Trust is not currently planning to change C.*diff* first line treatment at this time. The infection control team review all *C.diff* cases on a weekly basis with the MDT. A hospital associated infection (HAI) point prevalence survey was completed in May 2026, the data has identified that pneumonia, lower respiratory tract infections, and urinary tract infections, are the leading causes of HAI's. The survey also highlights a significant increase in HAI risk for patients whose stay exceeds 14 days. There is ongoing work within the Trauma care group to improve enhanced recovery procedures (e.g. ensuring patients are sat up, dressed, invasive devices removed at earliest opportunity etc). Initiatives like this are important in reducing length of stay, risk of pneumonia, and infections linked to invasive devices such as skin infections and urinary tract infections.

Infection prevention team have adapted mandatory training to include commode cleaning.

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.

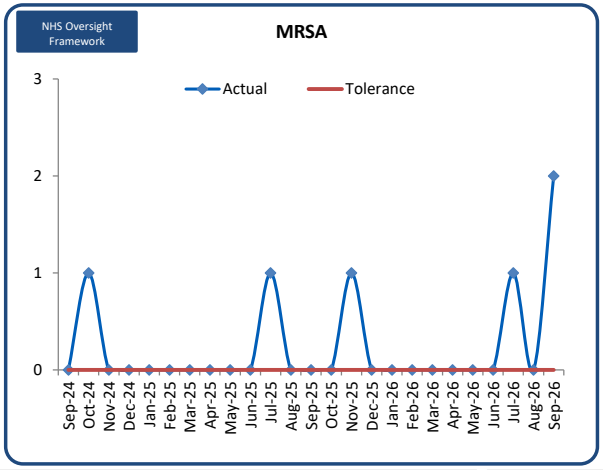
Prescribing of antimicrobials outside of Trust guidelines, using 'watch' and 'reserve' antimicrobials which are held back due to growing resistances. Mitigated by an extensive Trust guideline and routine monitoring with feedback provided to medical leads regularly.
Regular antimicrobial stewardship / prescribing meetings.

Delays in medical optimisation and discharge of those with no criteria to reside leading to extended lengths of stay and increased risk of HAI. Data fedback to multiple groups and divisions at study events, committee, steering group, patient safety and oversight.

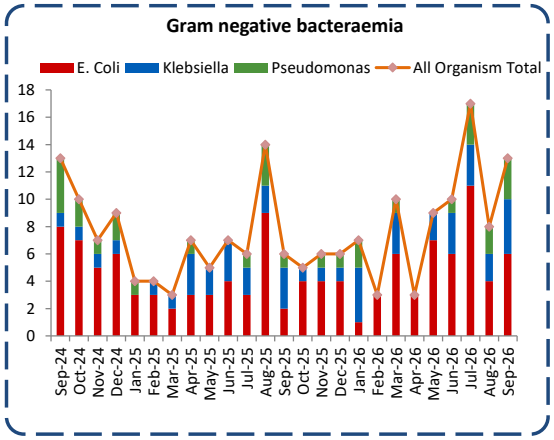
Delay in collecting relevant microbiological specimens, particularly blood cultures when a person triggers the Sepsis 6 protocol. IPAC lead has presented at the World Sepsis day study event in September.

Quality Assurance - Infection Prevention and Control (IPAC)

Lead Executive - Bernadette George, Acting Chief Nursing Officer



Sep-26
2



Sep-26	
E.coli	6
Klebsiella	4
Pseudomonas	3
All Organism Total	13

Background, what the data is telling us, and underlying issues

Blood stream infections (or bacteraemia) 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 gram-negative total chart shows number of cases per month, per organism. 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.

One MRSA bacteraemia case was Hospital reported in July and a further Hospital attributed case in September. The second reported case for September in the graph above was community onset - Healthcare associated.

Neave,Lynsey
30/10/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

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.

Infection prevention and control are directing attention to community services in regard to gram-negative reduction / hospital avoidance work. The focus will be on the early identification and treatment of those with urinary catheter complications in the community. The IPAC team is engaging in a re-design of the urinary catheter passport and a stakeholders day in October.

The Infection Prevention team have been working with the Haemodialysis service to reduce MSSA bacteraemia's. This work has resulted in a marked reduction in bacteraemia's in this patient group. The intervention of using antimicrobial wash and wipes also reduces the overall MRSA colonisation and potential MRSA bacteraemia risk.

The MRSA hospital acquired case in July had a PSR1 review undertaken. The patient was admitted with a urinary tract infection and with an acute kidney injury. All appropriate care was delivered in line with trust policy and therefore the outcome of the review was no harm was caused. The findings were the MRSA hospital acquired case in September was MRSA positive on screening undertaken on admission and when reviewed by the IPC team there was no evidence anything further could have been done to prevent the bacteraemia in a critically ill patient. However, to note is that cases of MRSA bacteraemia are rising nationally.

Risks to delivery and mitigations

The IPC team have completed the audit programme over the summer months to prepare for the increase in Winter related illnesses. However, the numbers of both Norovirus and Respiratory infection rates is unpredictable and an increase above season norms would impact the ability of the IPC team to undertake this work.

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. Sepsis Modern Service Framework expects this mechanism.

Improper use of invasive devices. Education and monitoring use is a key part of the infection control annual programme of work.

Working with partners across the system; commissioning, roles and responsibilities can make community care more challenging.

Working with community partners to understand and develop the roles of integrated neighbourhood teams.

The operational Cornwall ICB IPAC team no longer exists, this will impact relations within primary care, currently there are no known mitigations and there is no capacity within RCHT IPAC to support this area. The removal of this service has the potential to increase the number of community cases with Winter illnesses presenting at RCHT.

People and Culture Committee Section



Outstanding Care for One+All

Neave,Lynsey
30/10/2026 09:31:09

People and Culture Committee Specific - Executive Review

Executive Director Summary, key issues to highlight

Alison Thorne-Henderson, Dual Chief People Officer

September's people metrics show stronger recruitment and retention, but staff experience and core workforce compliance remain material risks. Staff feedback is unchanged: 30.62% would recommend the Trust as a place to work, 41.52% as a place to receive care and 47.01% feel secure raising concerns or speaking up. This is because this is the last quater's staff pulse survey and we are currently completing the Annual staff survey. These remain priority NHS Oversight Framework concerns and require visible leadership action and evidence that staff feedback is leading to change.This also applies to the staff standards within the pack.

Wellbeing is mixed. Sickness absence increased from 5.25% to 5.43%, while stress-related sickness improved from 31.7% to 28.9%. The reduction in stress-related absence is welcome, but the rise in overall absence means divisional prevention, early intervention and attendance support should remain tightly monitored. The plan to bring in the Organisational Development (OD) Hub to train managers on how to have difficult conversations when approved. Equally the plan to train managers on attendance management should start when the 2 Strategic Workforce Leads start in January.

Development indicators also moved in different directions. Appraisal completion recovered from 57.9% to 59.6% and health and safety statutory training improved from 91.34% to 91.84%. Statutory and mandatory training, however, eased from 77.39% to 77.17% and remains the clearest compliance gap; divisions have a recovery plan and need to plan protected time for staff for overdue training and appraisals.

Recruitment and retention improved across the principal measures. Total vacancies reduced from 10.07% to 9.25%, turnover from 7.27% to 7.08%, registered nurse vacancies from 8.03% to 6.75%, and medical vacancies from 4.34% to 3.97%. The next priority is to sustain these gains and translate lower vacancies into safer, more stable staffing, less use of bank and higher cost premuim workforce such as agency and additonal duty hours (ADH) spend.

Diversity remains an area for improvement. Ethnic-minority representation in the workforce rose from 14.47% to 14.66%, while representation at band 8c and above fell slightly from 2.06% to 2.04%, leaving a 12.62 percentage-point gap. When the Strategic Buiness Partners start work on Inclusive Recruitment training will also need to b e prioritised. In the meantime from a culture perspective Inclusive Companies will be supporting Divsions with training up to the new Calendar year.

Priorities for the next quarter are therefore to improve speaking-up confidence and staff advocacy ,start to reverse the rise in sickness absence, recover mandatory training and appraisals, sustain vacancy and turnover reductions, and accelerate progression into senior leadership before the launch of Ecare.

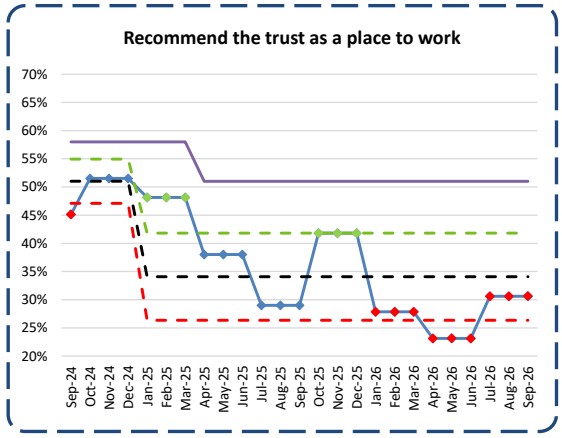
Ella Stracey, Chief Strategy Officer

The We Are RCHT Culture Transformation Programme continues to develop at pace, with governance arrangements established, dedi cated resources appointed to some roles, with recruitment processes ongoing for the remaining posts, and key initiatives delivered across leadership development, quality improvement, inclusion, wellbei ng, communications and staff recognition. Staff survey actions are being fully integrated into a single culture improvement framework to strengthen accountability and reduce duplication. The programme is being aligned with new national NHS Staff Standards and Leadership Framework requirements and will be monitored through staff survey and pulse survey measures, with an ambitious aim of achieving upper -quartile staff experience performance by 2030/31. In September, the Trust launched a new 'Fundamentals of Management' two day development programme, which is a key milestone in ensuring our managers have the right skills and support in place. Feedback from the sessions have been very postive. Work is underway to strengthen reporting of programme actions against expected impact, to ensure we contin ue to focus in the right areas.

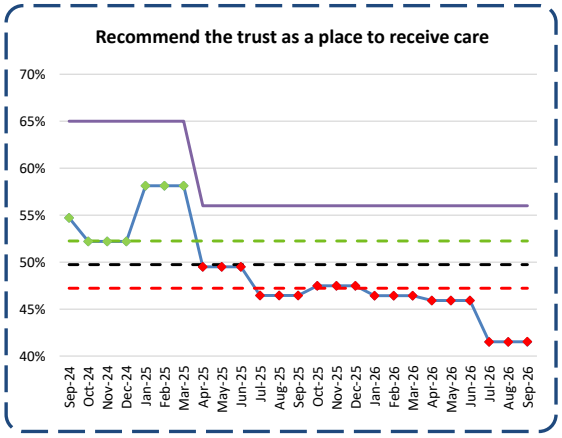
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People and Culture - Staff Feedback

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



Sep-26
30.62%



Sep-26
41.52%

Background, what the data is telling us, and underlying issues

Recommend the Trust as a place to work – 30.6% for Q2

Recommend the Trust as a place to receive care – 41.5% for Q2

Our people reported an improved position in recommending the organisation as a place to work, though there was further decline in recommending the organisation as a place to receive care.

Positively, Staff generally report strong attachment to their immediate teams. Relationships with line managers are significantly more positive than views of the wider organisation. Many respondents feel their work makes a difference and remain committed to patient care.

The staff survey launched at the end of September and results will be available in early January.

Key Concerns

Confidence in senior leadership and organisational decision-making is low. Staff do not believe concerns raised are consistently acted upon. Recognition and appreciation remain weak. High levels of emotional exhaustion and burnout are evident. Significant concerns about:

Bullying and harassment, staffing levels, patient flow pressures, ongoing organisational restructures, visibility and behaviour of senior leaders.

Matthew Inson 30/12/2025 08:31:09

Improvement actions planned, timescales, and when improvements will be seen

In August 2025, Trust Board endorsed the 'Culture Programme and in April 2026 "We Are RCHT' Culture Transformation programme, which sets out how we will make RCHT a better place to work.

Actions so far include:

Enhanced communication and engagement approach (tone review, humanising and senior leadership visibility, branding); Establishment of 'One and All'; Relaunch of the Values Champions awards with enhanced communications programme; Establishment of a senior leadership forum; Establishment of oversight and working group for the culture programme including workstream leads; Redesign and re-establishment of onboarding and exit questionnaires complete; Culture Practitioner completing team building sessions and agreement for another 2 posts; Bystander training for Executive Development Team; High Potential Leadership scheme launched across the system; We are RCHT training day 22nd of July; Launch of a more junior leadership forum in November; Long service awards; Updated recognition and reward SharePoint intranet page; Integrating reward and recognition channels into leadership training offers; Coming We Are RCHT training 17th 18th and 19th of November at WCH, SMH and RCH respectively; Recruitment underway for two additional culture practitioner roles.

Risks to delivery and mitigations

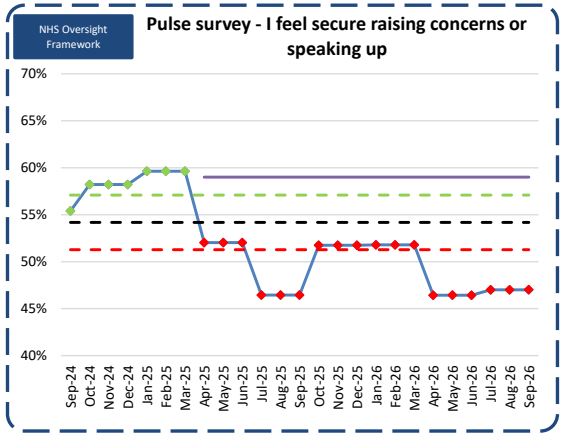
The organisational financial position and focus needed on this.

Operational release of staff to training leadership programmes.

Clinical admin review and staff still at risk of redundancy in People and Organisational Development (POD).

People and Culture - Staff Feedback

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



Sep-26
47.01%

Background, what the data is telling us, and underlying issues

The Freedom to Speak Up (FTSU) Guardians and champions continue to be a popular route for staff to raise concerns, but feedback continues to inform us that some staff state they come to the Guardians with concerns as they do not feel safe and confident that concerns will be addressed at a more local level. The most recent pulse survey results indicate a stabilising position in feeling secure to raise concerns. Psychological safety is mixed across the organisation, often staff feel unsafe raising concerns and fear detriment following or during the raising concerns. We are receiving more anonymous concerns which may indicate fear around raising concerns .

Improvement actions planned, timescales, and when improvements will be seen

The lead Guardian continues to work with each division to support FTSU work going forward, this will include sharing information about current themes, and supporting cultural improvement work, with the aim of increased promotion of speak up escalation routes, and a deeper understanding of themes across the organisation. The FTSU champion network now has over 112 members (83 at RCHT), including nursing staff, doctors, and health care support workers. The champions meet monthly and promote FTSU work across the organisation, providing a diverse range of colleagues to raise concerns with. Colleagues are already raising concerns with some of our newly trained champions, so in terms of promoting FTSU the champion role is successful. The Guardians and champions will be out and about for Freedom to Speak up week (12-16th October) visiting teams across our hospitals to promote speaking up .

Risks to delivery and mitigations

Low confidence in speaking 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 that concerns will be addressed appropriately, we may not see improvements in cultural change, and staff and patient safety could be impacted.

Mitigations include:

Divisional support (Guardian and Organisational Development practitioner)

Management support – new leadership programme commenced September 2026.

Enhanced communication (CEO leading one and all sessions) Executive and Guardian walk about's in progress.

Guardians both spending one day a month at St Micheals and West Cornwall hospital.

Continue to triangulate data (Triangulation group with key colleagues ongoing.)

Ongoing development of the FTSU champion network.

Neave,Lynsey
30/10/2026 09:31:09

People and Culture - Staff Feedback

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

NHS Staff Standards

NHS Oversight Framework	RCHT 2025 Staff Survey score	RCHT position in National Benchmarking
Overall Score	**7.27**	**Lower quartile**
Line Management	6.55	Lower quartile
Health and Wellbeing	5.14	Lower quartile
Violence Prevention and Reduction	8.95	Interquartiles range
Championing Sexual Safety	9.51	Lower quartile
Tackling Racism	7.52	Lower quartile
Promoting Flexible Working	5.96	Lower quartile

Background, what the data is telling us, and underlying issues

The 2025 NHS Staff Survey shows RCHT below the national average across most NHS Staff Standards, with five out of six in the lower quartile, and in the lower quartile overall.

Key challenges include line management, wellbeing, flexible working, sexual safety and racism. This reflects wider staff feedback, Freedom to Speak Up intelligence, pulse surveys and workforce data, including pressure, change and lower confidence in the wider organisation and senior leadership.

The **We Are RCHT Culture Transformation Programme** is the organisation's main improvement approach to the NHS Staff Standards. Staff survey priorities are integrated into its workstreams, with the aim that everyone feels cared for, listened to and able to make a difference.

Meeting of the Board of Directors (Public) - 30/04/2026 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

The six workstreams provide the delivery framework:

Culture Development Infrastructure: deliver Fundamentals of Leadership and Management from September 2026; review appraisal processes and training; implement NHS leadership and management expectations; expand leadership networks and culture champions.

Quality Improvement (QI): embed QI in induction and leadership development; support staff-led improvement in frontline teams; relaunch Innovation at RCHT and use survey feedback to target support.

Inclusion and Equality: relaunch Inclusive Recruitment and reverse mentoring; deliver active bystander training; introduce the Disability and Inclusion Passport; strengthen engagement with staff networks; include Security in the Culture Transformation Oversight Group to help address violence and aggression; and link the Organisational Development Practitioner with the Enhanced Domestic Abuse and Sexual Violence Coordinator to embed action on sexual harassment.

Wellbeing: improve staff rest areas and access to food; promote occupational health and wellbeing support; launch the staff benefits offer; use workforce and survey data to target action on sickness and burnout.

Communication and Engagement: continue One and All sessions, executive visits and staff listening; launch the manager's brief and refreshed induction content; deliver the Staff Survey campaign; publish "You said, together we did".

Reward and Recognition: develop the RCHT framework and manager guidance; expand Values Champions, thank-you cards and long-service recognition; deliver the annual staff awards; gather staff feedback on recognition preferences.

Delivery is underway in 2026/27. Progress will be measured through the NHS Staff Survey, pulse surveys, Freedom to Speak Up intelligence, workforce indicators and programme benefits. New priorities will be absorbed into the programme rather than creating separate plans.

Risks to delivery and mitigations

Operational pressure, organisational change and limited resources may slow delivery.

Survey measures may take time to improve.

Use the culture programme as the single framework, with clear ownership and oversight.

Targeting practical action where data shows the greatest need.

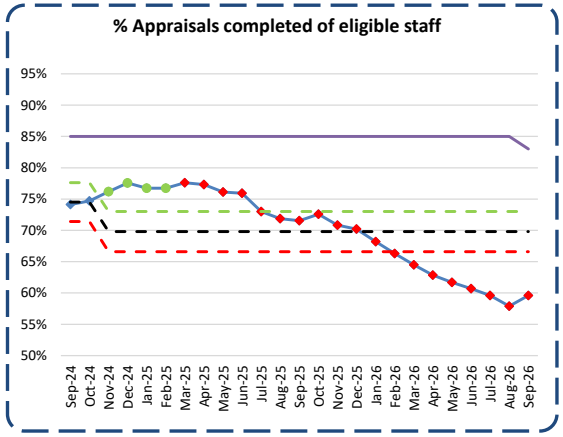
Monitor impact through the Culture Transformation Oversight Group and People and Culture Committee.

Co-design with divisions, Staff Side and staff networks.

Show progress through clear "You said, together we did" updates.

People and Culture - Staff Development

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



Sep-26
59.6%

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, continues to impact on the completion of appraisals, this month there has been no decline.

For the remainder of the year, and until the eCare rollout has been completed, the appraisal compliance target has been revised to 83%. The target is expected to return to 90% once the eCare rollout is complete. Current compliance is 59.6%, which remains below the revised target.

Divisional Directors have presented their data and the concerns of this impacting sickness and well-being, and they recognise the importance of appraisal, and are working on action plans to increase compliance. The PPPP People meetings have discussed this in 2 meetings as well as reinforcing this through Quarterly Performance Reviews.

Improving both the completion and quality of appraisals will support earlier identification of concerns, clearer objectives, timely feedback and intervention before issues escalate into formal processes.

Neave Ward
30/10/2025 09:31:09

Improvement actions planned, timescales, and when improvements will be seen

Divisions will implement local recovery plans and monitor appraisal compliance monthly from September 2026, with progress reviewed through People meetings and Quarterly Performance Reviews.

The People Experience team will continue to provide monthly data so that areas of low compliance or recording gaps can be targeted.

National and regional developments relating to appraisal arrangements will also be monitored, and relevant staff standards and the new management and leadership framework will be incorporated into manager development activity.

Improvement should be evidenced through sustained month-on-month increases in recorded appraisal completion.

Risks to delivery and mitigations

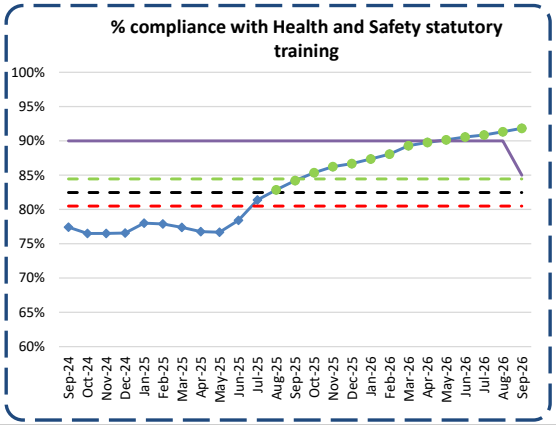
Continuing operational pressures may limit managers' capacity to complete meaningful appraisals and release staff to participate.

There is also a risk that completed appraisals are not recorded promptly, reducing confidence in the reported compliance position. These risks will be mitigated through divisional plans, monthly exception reporting, escalation through Quarterly Performance Reviews and clear reminders on recording requirements.

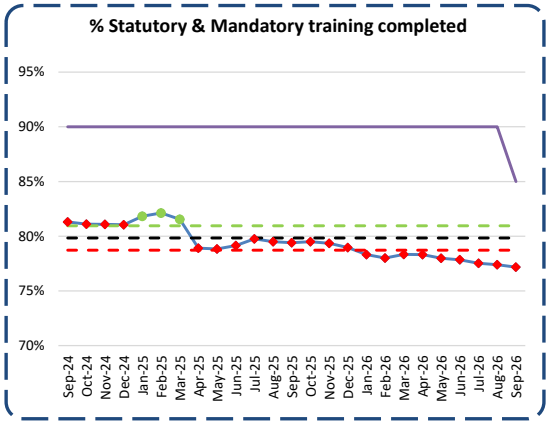
Any additional organisational development or appraisal training resource will be considered through the established governance route.

People and Culture - Staff Development

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



Sep-26
91.8%



Sep-26
77.2%

Background, what the data is telling us, and underlying issues

Statutory and mandatory training compliance has remained at approximately 77-78% since May 2026, indicating a persistent plateau rather than short-term fluctuation.

For the remainder of the year, and until the eCare rollout has been completed, the statutory and mandatory training compliance target has been revised to 85%. The target is expected to return to 90% once the eCare rollout is complete.

The data suggests the following underlying issues:

Reduced face-to-face delivery capacity in April and May due to the planned eCare 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.

Attendance on training is often reduced in August due to the summer holidays.

101 available spaces were unused on both Manual handling level 1 and level 2 and Basic Life Support (BLS) in August 2026.

148 DNAs across Manual Handling level 1 and 2 and Basic Life Support in September 2026.

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Improvement actions planned, timescales, and when improvements will be seen

Learning & Development have implemented several actions to increase throughput:

Paper to Executive Leadership Team (ELT) – encouraging Divisional leaders to utilise time now before new ECARE launch in April 2027.

Increased classroom availability and expanded scheduling of statutory and mandatory sessions – new dates released for 2026/27 at the end of July.

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:

October 2026: Stabilisation if capacity remains consistent and staff release improves.

Expected national launch of new statutory and mandatory training in early 2027.

Development of new HR system has begun nationally – RCHT HR system experts identified.

Transforming People Services (TPS) Programme launched – 17 workstreams – POD staff contributing to.

Risks to delivery and mitigations

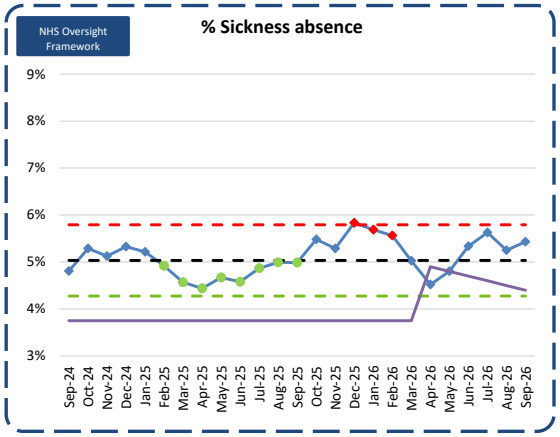
Future eCare rollout phases will again pause face-to-face mandatory training in April 2027, reducing delivery capacity; A full time trainer is leaving the team in September which will reduce the teams capacity to deliver training; Staff release challenges continue to limit attendance, particularly in 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

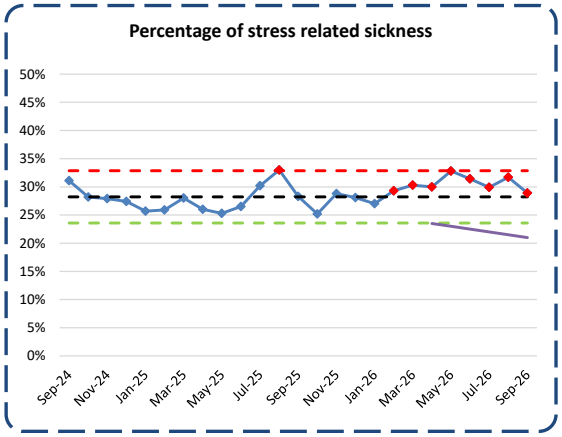
Continued expansion of classroom availability to maximise delivery before future eCare phases; Resident Doctors Induction days to target this group of staff - between 80 and 90 attendees each day; Consultants mandatory training sessions planned from August, to target poor compliance; Proactive advertising of unfilled spaces, including regular posts on the staff Facebook page; Requesting to recruit into vacant post in October 2026; Close working with Trust educators to encourage attendance and support local compliance improvement. Increase delivery of our learning forum to maintain this relationship; Encouragement of protected learning time to support staff release for mandatory training.

People and Culture - Absence

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



Sep-26
5.43%



Sep-26
28.90%

Background, what the data is telling us, and underlying issues
Overall sickness absence has increased slightly to 5.43%, indicating continued workforce pressure. The effect of the organisational change and reduction in headcounts will also be having an impact on people resilience, but the hope is once the new structures settle, we will see some improvements. Stress-related absence accounts for 28.9% of absences, which is a slight decrease from the previous 31.7%.

Professional standards data indicates that sickness absence can also contribute to delays in progressing employee-relations matters. In turn, workplace conflict, prolonged formal processes and unresolved concerns may adversely affect staff wellbeing, engagement and psychological safety. This reinforces the need for consistent early intervention, effective return-to-work conversations, timely access to support and confident local management of absence and wellbeing concerns.

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
Health and wellbeing strategic intent document to support culture programme written Inclusive Wellbeing Group.

Targeted wellbeing interventions posted on wellbeing channel. Reviewing current programme to ensure that it is inclusive.

Educating divisional directors to ensure effective management of the Return-to-Work (RTW) Interviews and reviewing the RTW forms.

Risks to delivery and mitigations
Risks
Strategic Workforce Partners not in place – second round of recruitment.

Further reductions to the Assistant People Partner and People Partner roles in December.

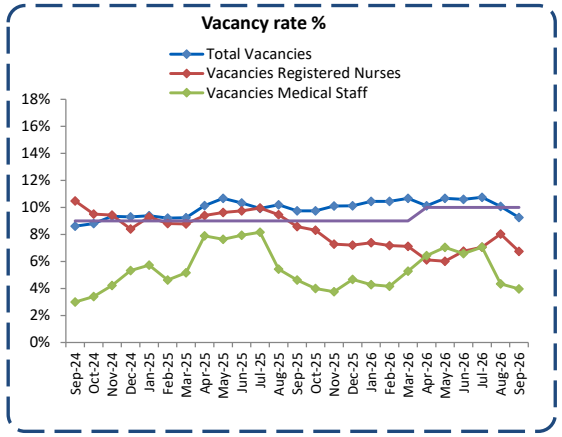
Operational pressure - Divisions due to conflicting demands impacting on attendance and engagement.

Mitigations
Recruitment Campaign underway for recruitment into key roles.
Plan being reviewed on reduction of the People Experience team.
Engaging with Divisions through PPPP meetings and other committees.

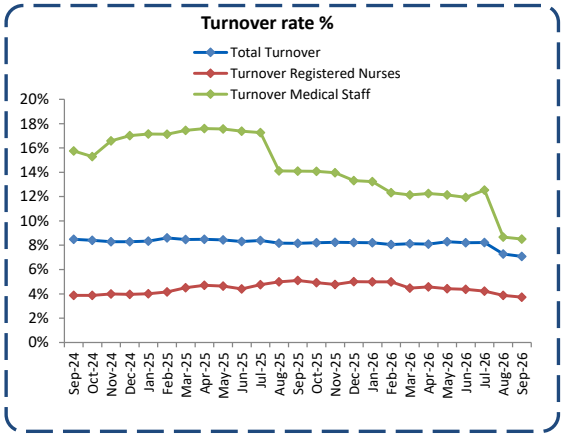
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People and Culture - Vacancy

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



Sep-26	
Total vacancies	9.3%
Vacancies registered nurses	6.8%
Vacancies medical staff	4.0%



Sep-26	
Total turnover	7.1%
Turnover registered nurses	3.7%
Turnover medical staff	8.5%

Background, what the data is telling us, and underlying issues

There has been a focus on closing the vacancy gap for band 3 Health Care Assistants (HCA) and band 5 nurses with monthly targeted recruitment events since March 2026, the figures above show a dramatic reduction in vacancies for those two roles.

Turnover rate - dropped slightly to 7.1%

The overall turnover continues to fall for the second month from 7.30% to 7.1% with the turnover of nurses and medics by 0.2% each.

Improvement actions planned, timescales, and when improvements will be seen

As the recruitment events have seen the reduction in vacancies for HCA's and registered nurses, we hope to scale these back but would be happy to hold events in the west of the county to attract candidates to West Cornwall Hospital and St Michael's Hospital.

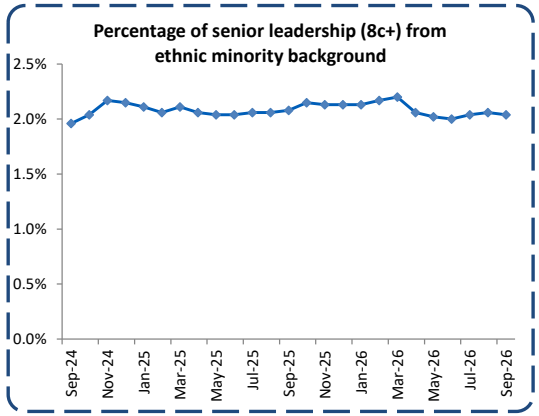
Risks to delivery and mitigations

As the need for monthly recruitment events diminishes, the preferred focus would be on local engagement for non-registered roles and more targeted campaigns for registered vacancies. The recruitment events have been useful, and the figures show that they have been effective. However, they have resulted in hundreds of applications primarily from candidates from out of county and those seeking sponsorship. This has resulted in an additional workload for clinical staff to shortlist and interview and for the recruitment team to manage.

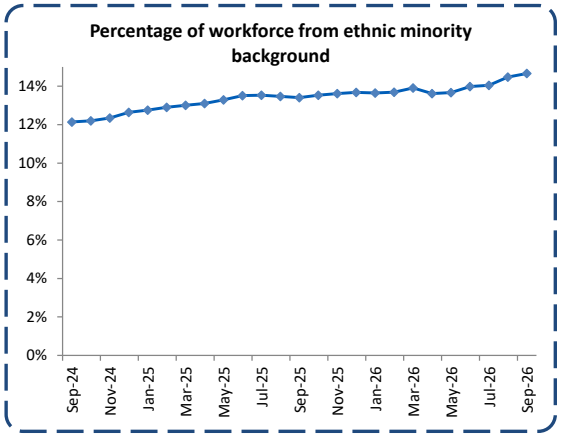
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People and Culture - Diversity

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



Sep-26
2.04%



Sep-26
14.7%

Background, what the data is telling us, and underlying issues

Ethnic minority staff represent 14.7% of the Trust's workforce, demonstrating a diverse employee population that exceeds local community demographics. However, this diversity is not yet reflected at senior leadership level, where only 2.04% of Band 8c and above roles are held by staff from ethnic minority backgrounds. This is a very slight reduction from last month's figure of 2.06% and highlights a significant gap in progression and representation within senior leadership.

Improvement actions planned, timescales, and when improvements will be seen

To address this, the Trust is delivering a range of actions through its Workforce Race Equality Standard (WRES) and Ethnicity Pay Gap programmes. These include targeted talent management and leadership development initiatives, mentoring and sponsorship opportunities, strengthened succession planning, and the rollout of inclusive recruitment training for appointing managers. Improvements are expected over the medium to long term as these interventions begin to take effect.

Risks to delivery and mitigations

A key challenge is that many ethnic minority staff are internationally recruited nurses who enter the organisation at Band 5, meaning progression to senior leadership roles can take several years. To mitigate this, the Trust will focus on improving retention, developing structured career pathways, expanding mentoring support, and creating targeted talent pipelines to increase readiness for senior roles.

Whilst improvements in leadership representation are expected to take time, these actions are designed to build a sustainable pipeline of diverse talent and support a more representative leadership workforce in the medium to long term.

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Our values

Respect

Compassion

Honesty

Teamwork



Outstanding
Care for **One+All**

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board In Public

Date of Meeting: 05 November 2026

Item Number: 20

Title of Report: Corporate Risk Register Report

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 report provides assurance on executive oversight and accountability for the Trust's significant risks, summarising new Corporate Risk Register entries and their alignment with the Board Assurance Framework.

Consultation:

The information in this report was discussed at the Executive Risk Group on the 27th August and the 24th September and endorsed by the Audit and Risk Committee 13th October 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	
Quality Impact Assessment completed?			X	

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
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 CRR supports health and wellbeing by ensuring robust governance and risk management for significant risks, safeguarding public funds and quality standards in healthcare organizations.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The CRR identifies risk areas and inefficiencies, enabling improved productivity, reduced waste, and ensuring accountability, which supports service quality and equitable benefits.
Sustainable and efficient use of NHS resources by RCHT	The CRR supports the sustainable and efficient use of NHS resources by providing objective, risk-based assurance and advisory services that evaluate and improve governance, risk management, and control processes, ensuring the safeguarding of public funds and quality standards.

Recommendation(s):

The Committee **is recommended to:**

- **Receive for assurance** the new entries to the Corporate Risk Register
- **Receive for assurance** the changes in scores and the impact on the Trust's strategic priorities which have been endorsed by the Audit and Risk Assurance Committee

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Corporate Risk Register Update

1. Situation / Executive Summary

The Corporate Risk Register report, **endorsed by the Audit and Risk Assurance Committee on 13 October 2026**, provides oversight of the Trust's significant risks and their implications for strategic delivery.

The register comprises **52 risks: 42 extreme and 10 high**, reflecting continuing exposure across patient safety, workforce capacity, digital transformation, estates infrastructure and financial sustainability.

No Corporate Risk Register risks were formally closed during August or September 2026. T6 water ingress (10027) and T1 recovery water ingress (9663) were recorded as reduced in score and replaced by the consolidated Roof Leaks – all three sites risk (9994). These changes represent consolidation rather than closure; the underlying roof-leak risk remains on the register at a score of 20.

Key developments concern electronic patient record readiness, capital programme affordability and delivery, infrastructure resilience and workforce shortages. Four risks decreased in score, including neonatal nurse staffing; no risks were closed. The risk associated with accommodating acutely unwell patients in the SDSA corridor increased from high to extreme following identified control deficiencies.

The controls review highlights reliance on administrative monitoring and escalation, which support oversight but do not consistently address underlying risk.

Sustainable improvement requires stronger preventive controls, workforce solutions and infrastructure investment, supported by the proposed controls library and Radar Healthcare implementation.

The Board is asked to **receive the report for assurance**, note the Committee's endorsement and consider the implications of continuing risk exposure for the Trust's strategic priorities.

2. Background

The Corporate Risk Register consists of all open and finally approved risks rated between 12 (high) and 25 (extreme) that are considered significant risks to the Trust. All CRR risks are reviewed by the executive with regular updates against actions and risk progression heard at the Executive Risk Group.

The ERG also receives updates on the broader risk profile and reports against key quality indicators for risk.

3. Assessment

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There are currently 52 risks on the CRR. The full list is in appendix 1.

Changes in August:

Ten risks were presented for approval to the CRR register in August 2026:

Risk ID	Risk title	Risk description	Score/ Movement
10373	0006_PGM-RIS_PR02 Capital Affordability Gap Impacts Business Case Approval	If capital costs exceed the funding envelope, the OBC/ FBC may not demonstrate affordability. Scope reduction, value engineering, redesign, delayed approvals, reputational impact or requirement for additional funding will be required.	16 NEW
10261	NBPR 002 0006_PGM-RIS_PR03 Revenue Affordability Constraints Impact Deliverability	There is a risk that the building is not affordable from a revenue perspective due to staffing and operational costs. This is caused by: The design does not provide the benefits to outweigh the cost of the project. The design does not take into account the revenue affordability challenges and is not designed to be efficient from a clinical perspective, therefore resulting in additional staff needed. There is also confusion in relation staff being needed from a quality perspective which becomes part of the operational model for the business case. Opportunities to reduce costs, or increase benefits This could lead to delay to business case	16 NEW
10374	0006_PGM-RIS_PR04 Delay or Uncertainty in National Capital Funding Approval and Release	If capital funding approval or release is delayed the programme may be unable to progress design, procurement or construction. Programme delay, demobilisation of teams, inflation exposure, re procurement risk, loss of market confidence	12 NEW
10365	DGR615 Productivity at and after Go-Live (ECPR)	There is a risk that productivity at and immediately post go-live will be impacted by the introduction of the new EPR. If agreement with NHSE is not in place prior to go-live then there is a risk that NHSE could withdraw their support for go-live. This is caused by changes to workflows, changes to clinical and administrative processes and procedures and an ongoing	20 NEW

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Risk ID	Risk title	Risk description	Score/ Movement
		learning curve, post adoption. This could lead to a degradation in organisational performance, a negative impact on patient experience and reductions in income.	
10366	DGR617 Reporting Delivery (ECPR)	There is a risk that the Trust will be unable to evidence the availability of 100% of statutory reports and P1 operational reports at go-live. This could be caused by a failure to complete the development of the reports prior to formal integration testing and then the failure to test and sign off the reports prior to go-live. This could result in NHS England being unable to support a go-live decision.	20 NEW
10367	DGR619 Funding (ECPR)	There is a risk that insufficient funding is made available to deliver the entirety of the Programme. This is caused by failure to accurately forecast costs and / or failure to secure adequate funding to meet those forecasts. This will likely result in adverse effects on quality, as alternative resourcing strategies may need to be employed and potentially failure to reach the go-live milestone, leaving the trust in an intolerable position where the new solution remains in a state of unreadiness and the legacy solution runs into a unsupported and unviable state.	20 NEW
10368	DGR616 CFT Readiness (ECPR)	There is a risk that CFT will not be ready to support a decision to go-live This could be caused by a lack of readiness in relation to CFT's adoption of eCare functionality or a failure to integrate the eCare solution with CFT's retained legacy systems and processes This could result in a no-go decision in the	16 NEW

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Risk ID	Risk title	Risk description	Score/ Movement
		lead up to eCare go-live or significant compromise in the RCHT / CFT solution at go-live	
10369	DGR614 NHSE agreement to Go Live (ECPR)	There is a risk that NHS England may not support the programme's go-live due to perceived lack of readiness. This could be caused by a failure to evidence an acceptable position against key criteria from the NHS England Stage 4.5 Readines Review. This audit takes place circa 2 months prior to go-live to confirm readiness for safe and effective clinical operation. This could result in an extension to the plan, with a major unplanned impact on resource availability, operational performance, availability of legacy systems, & commercial agreements, resulting in a significant budget overspend.	15 NEW
10370	DGR618 Training (ECPR)	There is a risk that end user training will reach insufficient numbers of staff prior to go-live. This is caused by the fact that training is scheduled to run from February to April, which overlaps with a period of winter pressures and also runs through a half term school holday period and the Easter holidays This will potentially result in an inability to release staff from operational roles to attend training, reducing the number of individuals trained prior to go-live. Aside from any operational impact, any extension of the training programme would drive an increase in programme costs.	12 NEW
10371	DGR620 Impact of Easter on staff availability (ECPR)	There is a risk that the impact of the Easter Holiday period on the go-live event may compromise the delivery of training, the availability of super users and floorwalkers, the availability of end users to attend access and favourite's fairs and	12 NEW

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Risk ID	Risk title	Risk description	Score/ Movement
		the availability of support staff to respond to related critical incidents This would be caused by high absence levels and the need to prioritise resources towards patient care. This could result in lower productivity levels at and beyond go-live, higher volumes of human error, an increased volume of suport calls to the service desk and ultimately impacts on patient care.	

No risks were closed in month

No risks changed in score in month.

Changes in September

Seven risks were presented for approval to the CRR in September 2026:

Risk ID	Risk title	Risk description	Score/ Movement
10358	Delivery of RCHT Green Plan	There is a risk that… The Trust will not comply with the NHS Net Zero Carbon Targets by 2040 and Green Plan. This is caused by… The age of the estate and the need for capital investment. This could lead to… failure to meet statutory NHS England Net Zero Strategy requirements, CQC requirements, increased operational and utility costs, reduced energy resilience, regulatory non-compliance, reduced access to future capital funding opportunities and reputational damage to the Trust.	15 ↑
10372	0006_PGM-RIS_PR01 Evolving NHP / H2.0 Requirements Drive Redesign and Cost Growth	If NHP/H2.0 requirements are unclear, evolving or inconsistently interrupted, the programme may need repeated redesign and reassurance Design rework, programme delays, increased capital and revenue costs with delayed OBC/FBC approval, loss of cost certainty.	20 ↔

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Risk ID	Risk title	Risk description	Score/ Movement
10375	0006_PGM-RIS_PR05 Programme Delays Due to Cumulative Dependencies	If dependencies are not aligned and managed through the master programme, cumulative delays may extend the programme This would lead to increased preliminaries and fees, inflation, delayed operational benefits, erosion of contingency	20 ↔
9994	Roof Leaks - all three sites	There is a risk of the failure of roofs across all 3 sites, caused by required repairs not being carried out. May result in leaks, damage to patient environment and loss of service.	20 NEW
9967	Internal Drainage & Waste Systems	There is a risk that sewerage could leak into hospitals, including clinical and non-clinical areas. This is caused by the ageing drainage system becoming blocked or failing with increased usage where there has been limited investment and lifecycle replacement. This could lead to the closure of bedspaces, clinics, theatres, and toilets, cancellation of appointments, increased risk of infection, impact on strategic projects, adverse media interest and increased cost.	16 NEW
10163	Clinical Administration Workforce Level	There is a risk that operational performance across the Trust will not meet performance targets, backlogs will continue to grow and patients will experience delays. This is caused by lack of clinical administration workforce. This could lead to a delay in the delivery of patient care which would result in poorer outcomes for patients and subsequent harm.	16 NEW
10093	Staff retention due to pay difference with industry standards	There is a risk that Estates Maintenance/Technical Staff (B3-B5) could leave the Trust. This is caused by pay for these staff not being commensurate with equivalent industry/trade rates of pay. This could lead to decrease in ability to	16 NEW

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Risk ID	Risk title	Risk description	Score/ Movement
		complete planned (statutory and mandatory) and reactive maintenance, poor environment, failure of key plant and equipment, impact on patient flow and outcome. intervention from statutory agents such as HSE etc.	

No risks were closed in month.

Four risks have decreased in score:

Risk ID	Risk title	Score/ Movement
9006	Neonatal Nurse Staffing Risk	12 ↓
9969	VoIP licence renewal	12 ↓
10027	T6 water Ingress (replaced by 9994)	12 ↓
9663	Risk to patient safety due to T1 recovery water ingress (replaced by 9994)	12 ↓

One risk has increased in score:

- **Risk ID 9397** has increased from 12 (high) to 15 (extreme) following identified insufficiencies in control. This risk is scheduled for review at the ERG in October.

Risk ID	Risk title	Score/ Movement
9397	SDSA corridor waiting area accommodating acutely unwell patients	

4. Risk

All new areas of risk are described in section 3 above.

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5. Accountability

Bernadette George, Acting Chief Nursing Officer is the Executive Director for the

6. Recommendations

- **Receive for assurance** the new entries to the Corporate Risk Register
- **Receive for assurance** the changes in scores and the impact on the Trust's strategic priorities which have been endorsed by the Audit and Risk Assurance Committee

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29/10/2026

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

Care Group	Risk reference	Risk title	Executive lead	current	Target rating	Date risk identified	Target date (review date?)	Strategic objective
Chief Operating	9742	(ECPR) (DGR002, DGR049) RCHT Capacity to Fully Engage	Mrs Johanna Susan Floyd	16	8	11/02/2025	31/05/2026	
Clinical Support	10163	Clinical Administration Workforce Level	Mrs Jemma Moore	16	4	04/03/2026	06/04/2026	
Clinical Support	8693	Blood Sciences Workforce and Training Capacity (EPRR)	Lisa Vipond	16	4	18/10/2022	28/09/2026	
Clinical Support	2382	Insufficient workforce and loss of key skills due to staff	Mr Iain Davidson	16	3	14/10/2009	30/10/2026	Quality: To provide
Corporate	10375	0006_PGM-RIS_PR05 Programme Delays Due to	Sue Harris	20	1	29/08/2025	18/09/2026	
Corporate	10372	0006_PGM-RIS_PR01 Evolving NHP / H2.0 Requirements Drive	Sue Harris	20	1		18/09/2026	
Corporate	10367	Funding DGR619 (ECPR)	Adam Wheeldon	20	1	17/08/2026	18/09/2026	
Corporate	10366	Reporting Delivery DGR617 (ECPR)		20	1	17/08/2026	18/09/2026	
Corporate	10365	Productivity at and after Go-Live DGR615 (ECPR)		20	1	17/08/2026	18/09/2026	
Corporate	9573	Failure to meet statutory timescales for disclosures made	Mark Scallan	20	9	22/10/2024	09/07/2026	
Corporate	8521	Capital Programme - funding and delivery	Adam Wheeldon	20	15	11/04/2022	30/10/2026	
Corporate	8303	Cyber-Attack EPRR	Mr Martin Price	20	20	26/07/2021	11/09/2026	
Corporate	10373	0006_PGM-RIS_PR02 Capital Affordability Gap Impacts	Sue Harris	16	1		18/09/2026	
Corporate	10368	DGR616 CFT Readiness (ECPR)		16	1	17/08/2026	18/09/2026	
Corporate	10261	NBPR - 002 - Affordability (Revenue / Operating Model)	Sue Harris	16	3	13/05/2026	31/03/2027	
Corporate	9752	(ECPR) (DGR058, DGR059, DGR060, DGR062, DGR063) -	Linzi Lancaster	16	12	14/11/2024	01/09/2026	Quality: To provide
Corporate	9751	(ECPR) (DGR109, DGR190) eCare Cash Releasing Benefits	Mrs Emily Cudmore	16	9	11/02/2025	30/11/2026	
Corporate	9384	(ECPR) End of IT System support an maintenance - eCare	Miss Liz Evans	16	4	11/07/2024	30/09/2026	
Corporate	8589	Financial Sustainability Programme (FSP) Delivery	Mr Doug Riley	16	12	30/06/2022	24/10/2026	
Corporate	10369	DGR614 NHSE agreement to Go Live (ECPR)		15	1	17/08/2026	18/09/2026	
Corporate	10358	Delivery of NHS Net Zero Carbon Targets & Green Plan	Miss Tanya Saker	15	10	03/08/2026	18/09/2026	
Corporate	9664	Safeguarding Maternity Provision	Suzie Williams	15	9	16/12/2024	10/12/2025	
Corporate	9081	Clinical Coding Resource	Linzi Lancaster	15	6	04/09/2023	01/09/2026	People: Attract develop and
Corporate	10374	0006_PGM-RIS_PR04 Delay or Uncertainty in National Capital	Sue Harris	12	6		18/09/2026	
Corporate	10371	DGR620 Impact of Easter on staff availability (ECPR)	Mr Matthew Overton	12	1	17/08/2026	18/09/2026	
Corporate	10370	DGR618 Training (ECPR)	Mrs Johanna Susan Floyd	12	1	17/08/2026	18/09/2026	
Corporate	9972	Lack of Immutable Backups (EPRR)	Robert Phillips	12	4	18/09/2025	24/10/2026	
Corporate	9743	(ECPR) (DGR053, DGR054, DGR071) - eCare impact on	Linzi Lancaster	12	8	01/01/2025	16/07/2026	Quality: To provide
Estates & Facilities	9994	Roof Leaks - all three sites	Leslie Rust	16	4	26/09/2025	30/09/2026	
Estates & Facilities	10093	Staff retention due to pay difference with industry standards	Mr Richard Parris	16	4	11/12/2025	01/04/2027	
Estates & Facilities	10034	Nurse Call System - Age	Robert Davies	16	4	27/10/2025	20/11/2026	
Estates & Facilities	10024	Risk of infection due to outdated/missing Ventilation Systems	Ryan Hill	16	8	22/10/2025	28/12/2026	
Estates & Facilities	9967	Internal Drainage & Waste Systems	Ryan Hill	16	8	09/09/2025	30/11/2026	
Estates & Facilities	9937	Insufficient electrical capacity at RCH to meet the growing demands of the Trust (NBPR)	Mr Richard Parris	16	4	17/12/2024	01/07/2026	
Estates & Facilities	8040	There are underlying unsafe conditions to the building infrastructure that have an	Mr Brian Johnson	16	8	13/10/2020	19/08/2026	
Estates & Facilities	7870	Capability and Resource of the Operational Estates Team	Mr Richard Parris	16	4	02/06/2020	03/10/2026	
Estates & Facilities	7302	Environment Agency/CQC/HSE Compliance re Radioactive Materials - Condition of	Philip Bond	16	8	24/04/2019	31/07/2026	Quality: To provide compassionate,
Estates & Facilities	8858	Failure of Sterile Services Department (Engineering Support & Infrastructure)	Mr Richard Parris	15	8	15/05/2023	01/07/2026	
Estates & Facilities	1250	Medical Gases not compliant with HTM02	Mr Richard Parris	12	4	01/04/2008	01/10/2026	
Medicine Division	9048	ED Overcrowding	Mr Dan Bawden	25	8	10/08/2023	26/10/2026	
Medicine Division	9839	Paediatric ED crowding risk (NBPR)	Emma Wise	15	12	23/04/2025	30/04/2026	
Medicine Division	8462	Use of ICE for blood tests in Rheumatology	Mr Andrew Pothecary	12	4	16/01/2022	16/11/2026	
Security Services	9469	SECSY_001 Access Control & ID Badge System - End of Life August 2025	Miss Natasha Quick	20	12	15/08/2024	27/08/2026	
Security Services	8922	SECSR_001 Lack of Security at the RCH to Support the Trust	Miss Natasha Quick	16	12	02/06/2023	27/08/2026	
Security Services	9719	BC002 Security Services - Training (Security Officers)	Miss Natasha Quick	15	6	13/11/2024	31/10/2026	
Security Services	9754	BC014 Security Services - Compliance with NHSE Violence Prevention and Reduction	Miss Natasha Quick	12	6	13/11/2024	31/08/2026	
Surgery Division	9397	SDSA corridor waiting area accommodating acutely unwell patients	Zoe Ainsworth	15	9	25/07/2024	29/01/2027	
Surgery Division	9551	(ECPR) E Care functionality (ACCT)	Rebecca Whittaker	12	8	10/06/2024	30/11/2026	
Surgery Division	8585	NOF mortality increases	Charlotte Chapman	12	9	29/06/2022	11/11/2026	
Women and Children	10080	Obstetric Medical Staffing	Miss Sophie Haynes	20	4	26/11/2025	28/09/2026	
Women and Children	9524	Maternity Triage	Mrs Sarah Harvey-Hurst	16	4	30/09/2024	31/10/2026	
Women and Children	9106	Delivery of the Children in Care service and related statutory duties	Alison Birch	16	2	02/10/2023	27/11/2026	

Corporate Risk Register		Risk Lead	Current	Date escalated to CRR	Date risk changed		Score when identified	Date risk Identified	BAF ref	Progression in month	Dates to achieve target risk score
Chief Operating Officer	9742	(ECPR) (DGR002, DGR049) RCHT Capacity to Fully Engage with eCare while Delivering Operational Activity Targets	Mrs Johanna Susan Floyd	16	Sep-24	Nov-25	↔	16	Feb-25	3	↔	Mar-26
Clinical Support and Cancer	10163	Clinical Administration Workforce Level	Mrs Jemma Moore	16	Aug-26	Aug-26	↔	16	Aug-26	2	NEW	Apr-27
Clinical Support and Cancer	8693	Blood Sciences Workforce and Training Capacity (EPRR)	Lisa Vipond	16	Mar-25	Dec-21	↑	12	Oct-22	2	↔	Sep-26
Clinical Support and Cancer	2382	Insufficient workforce and loss of key skills due to staff vacancies and recruitment.	Mr Iain Davidson	16	Mar-23	Jun-25	↑	6	Oct-09	2	↔	Mar-28
Corporate	10375	0006_PGM-RIS_PR05 Programme Delays Due to Cumulative Dependencies NBPR	Sue Harris	20	Sep-26	Aug-26	↔	20	Jul-26	4	NEW	Dec-27
Corporate	10372	0006_PGM-RIS_PR01 Evolving NHP / H2.0 Requirements Drive Redesign and Cost Growth NBPR	Sue Harris	20	Sep-26	Aug-26	↔	20	Aug-26	5	NEW	Jan-28
Corporate	10367	Funding DGR619 (ECPR)	Adam Wheeldon	20	Aug-26	Aug-26	↔	20	Jul-26	4	NEW	Dec-27
Corporate	10366	Reporting Delivery DGR617 (ECPR)	John Howarth	20	Aug-26	Aug-26	↔	20	Jul-26	5	NEW	Dec-27
Corporate	10365	Productivity at and after Go-Live DGR615 (ECPR)	John Howarth	20	Aug-26	Aug-26	↔	20	Jul-26	3	NEW	Dec-27
Corporate	9573	Failure to meet statutory timescales for disclosures made under Data Protection Act (Subject Access Requests) .	Mark Scallan	20	Jun-26	Mar-26	↔	20	Oct-24	6	↔	Sep-26
Corporate	8521	Capital Programme - funding and delivery	Adam Wheeldon	20	Jan-26	Feb-22	↑	27	Apr-22	4	↔	Oct-26
Corporate	8303	Cyber-Attack EPRR	Mr Martin Price	20	Jan-26	May-22	↓	30	Jul-21	5	↔	Sep-26
Corporate	10373	0006_PGM-RIS_PR02 Capital Affordability Gap Impacts Business Case Approval NBPR	Sue Harris	16	Aug-26	Aug-26	↔	16	Jul-26	4	NEW	Dec-27
Corporate	10368	DGR616 CFT Readiness (ECPR)	John Howarth	16	Aug-26	Aug-26	↔	16	Jul-26	3	NEW	Dec-27
Corporate	10261	NBPR - 002 - Affordability (Revenue / Operating Model)	Sue Harris	16	Aug-26	Aug-26	↔	16	Jul-26	4	NEW	Mar-27
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	↔	Jun-26
Corporate	9751	(ECPR) (DGR109, DGR190) eCare Cash Releasing Benefits	Mrs Emily Cudmore	16	Jun-23	Mar-25	↔	12	Feb-25	4	↔	Jan-27
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	8589	Financial Sustainability Programme (FSP) Delivery (ECPR)	Mr Doug Riley	16	Feb-25	Dec-21	↓	25	Jun-22	4	↔	Mar-27
Corporate	10369	DGR614 NHSE agreement to Go Live (ECPR)	John Howarth	15	Aug-26	Aug-26	↔	15	Jul-26	3	NEW	Dec-27
Corporate	10358	Delivery of NHS Net Zero Carbon Targets & Green Plan	Miss Tanya Saker	15	Sep-26	Aug-26	↔	15	Aug-26	4	NEW	Jan-40
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	10374	0006_PGM-RIS_PR04 Delay or Uncertainty in National Capital Funding Approval and Release NBPR	Sue Harris	12	Aug-26	Aug-26	↔	12	Jul-26	4	NEW	Dec-27
Corporate	10371	DGR620 Impact of Easter on staff availability (ECPR)	Mr Matthew Overton	12	Aug-26	Aug-26	↔	12	Jul-26	2	NEW	May-27
Corporate	10370	DGR618 Training (ECPR)	Mrs Johanna Susan Floyd	12	Aug-26	Aug-26	↔	12	Jul-26	2	NEW	Dec-27
Corporate	9972	Lack of Immutable Backups (EPRR)	Robert Phillips	12	Jul-22	Feb-25	↔	16	Sep-25	5	↔	Aug-26
Corporate	9743	(ECPR) (DGR053, DGR054, DGR071) - eCare impact on Trust wide Business Intelligence (RADAR) capability	Linzi Lancaster	12	Sep-24	Mar-25	↔	12	Jan-25	3 and 5	↔	Dec-26
Estates & Facilities	9994	Roof Leaks - all three sites	Leslie Rust	20	Aug-22	Feb-25	↔	20	Sep-25	6	NEW	Feb-35
Estates & Facilities	10093	Staff retention due to pay difference with industry standards	Mr Richard Parris	16	Sep-26	Dec-25	↔	16	Dec-25	6	NEW	Jan-27
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	9967	Internal Drainage & Waste Systems	Ryan Hill	16	Sep-26	Aug-26	↔	16	Sep-26	6	NEW	Sep-26
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	↔	Jul-27
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) (EPRR)	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	↔	Sep-26
Medicine Division	9048	ED Overcrowding	Mr Dan Bawden	25	Feb-24	Feb-23	↑	12	Aug-23	1	↔	Apr-26
Medicine Division	9839	Paediatric ED crowding risk (NBPR)	Emma Wise	15	Jul-26	Apr-25	↔	15	Apr-25	1 and 6	↔	Apr-27
Medicine Division	8462	Use of ICE for blood tests in Rheumatology	Mr Andrew Pothecary	12	Jan-26	Mar-22	↓	28	Jan-22	3	↔	Apr-26
Security Services	9469	SECSY_001 Access Control & ID Badge System - End of Life August 2025	Miss Natasha Quick	20	Jun-26	Mar-26	↔	20	Aug-24	6	↔	Apr-27
Security Services	8922	SECSR_001 Lack of Security at the RCH to Support the Trust	Miss Natasha Quick	16	Dec-25	Feb-26	↓	12	Jun-23	1	↔	Oct-26
Security Services	9719	BC002 Security Services - Training (Security Officers)	Miss Natasha Quick	15	Jun-26	Mar-26	↔	15	Nov-24	1 and 6	↔	Sep-26
Security Services	9754	BC014 Security Services - Compliance with NHSE Violence Prevention and Reduction Standard	Miss Natasha Quick	12	Jun-26	Jun-26	↔	12	Nov-24	1 and 6	↔	Mar-27
Surgery Division	9397	SDSA corridor waiting area accommodating acutely unwell patients	Zoe Ainsworth	15	Jul-23	Jul-23	↔	16	Jul-24	1	↑	Apr-26
Surgery Division	9551	(ECPR) E Care functionality (ACCT)	Rebecca Whittaker	12	Feb-23	Dec-23	↑	25	Jun-24	5	↔	Apr-27
Surgery Division	8585	NOF mortality increases	Charlotte Chapman	12	Jan-26	Dec-25	↑	26	Jun-22	1	↔	Feb-26
Women and Children Division	10080	Obstetric Medical Staffing	Miss Sophie Haynes	20	Mar-26	Mar-26	↑	16	Nov-25	2	↔	Aug-26
Women and Children Division	9524	Maternity Triage	Mrs Sarah Harvey-Hurst	16	Jul-23	Oct-24	↔	16	Sep-24	1 and 2	↔	Sep-26
Women and Children Division	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: 05 November 2026

Item Number: 21

Title of Report: Starred Item:* Use of Trust Seal Bi Annual Report 2026/27

Executive Director Lead: Company Secretary

Author and Job Title: Stephanie Creek, Deputy Company Secretary

Email Address: stephanie.creek@nhs.net

Purpose of the Report:

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

The purpose of this report is to inform the Committee of the number of times that the Trust Seal has been used in accordance with requirements under the Trusts Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved for Board.

Consultation:

The Committee is required to review the use of the Trust Seal bi-annually and this forms part of the Committee workplan. As per Standing Orders the register of sealing shall be made bi-annually to the Trust Board following review by the Committee.

The Company Secretary consults the requirements within Standing Orders each time use of the seal is requested and cross checks to decisions of Committees and the Board are undertaken where relevant.

Key Risks (please tick one or more):

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

Reputational ☐ **Legal / Regulatory** ☒

Impact:

Neave, Lynsey
30/10/2026 09:34:09

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 inequalities in benefits from those services	N/A
Sustainable and efficient use of NHS resources by RCHT	N/A

Recommendations:

The Board is recommended to:

- **Receive** and **note** the use of the Trust Seal Bi Annual Report for 1 April 2026 to 30 September 2026.

Neave,Lynsey
30/10/2026 09:31:09

Use of the Trust Seal Bi Annual Report 2026/27

1. Situation / Executive Summary

Documents, such as a deed or agreements, signed on behalf of the Trust are sealed under the direction of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation and Reservation – Part IV – Custody of seal and sealing of documents section 36 and 37, in the presence of the Company Secretary or the Deputy Company Secretary, who have custody to the Trust Seal.

2. Background

In the period 1 April 2026 to 30 September 2026 the Trust seal was applied to 12 documents. Where use of the seal was subject to commercially sensitive or legally privileged information, details have been redacted for publication.

3. Risk

There is a risk of non-compliance with Standing Orders, Standing Financial Instructions and Scheme of Delegation and Reservation. Measures are in place to ensure this risk is mitigated through limiting use of the seal with oversight by the Company Secretary or Deputy Company Secretary only, securing the seal in safe custody and through completion of a 'request to seal' report to accompany all requests. Requests are also mapped back to the originating Board decision where relevant.

4. Accountability

Per Standing Orders, the Company Secretary, on behalf of the Chief Executive, is responsible for holding the Trust seal and reporting bi-annually to the Trust Board.

5. Recommendations

The Committee is recommended to:

- **Receive** and **note** the use of Trust Seal Bi-annual Report for 1 April 2026 to 30 September 2026.

Neave,Lynsey
30/10/2026 09:31:09

Number	Date Seal Used	Affixed in the Presence of		Document Title	Purpose of Document
		Name	**Position**		
242	26.08.2026	Kim O'Keeffe / Dr Meredith Kane	Acting Chief Executive and Chief Medical Officer	Lease - Part Ground and Second floor, 28 Mount Wise	Agreement
241	13.08.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Parent Company Guarantee (certified copy)	Deed
240	13.08.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Parent Company Guarantee	Deed
239	30.07.2026	Dr Meredith Kane / Robin Jones	Chief Medical Officer / Chief Operations Officer	Women and Children's NHP Alliance Agreement	Agreement
238	27.07.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Form of agreement for women and children's hospital 2.0 Alliance contract for the NHP	Deed
237	10.07.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Minor works contract for planned care relocation	Deed
236	10.07.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Design & Buildings Contract for Tower Sewerage	Deed
235	10.07.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Minor Buildings Contract for EPOC & Phoenix Roof	Deed
234	10.07.2026	Kim O'Keeffe / Ian Dean	Acting Chief Executive and Chief Finance Officer	Deed of Agreement - RCHT Critical Infrastructure	Deed
233	07.04.2026	Ian Dean / Robin Jones	Chief Finance Officer / Chief Operating Officer	Women and Children's Hospital NHP Alliance Agreement	Agreement

Neave,Lynsey
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232	07.04.2026	Ian Dean / Robin Jones	Chief Finance Officer / Chief Operating Officer	Homeless Out of Hospital Care Service with Cornwall Council	Deed
231	07.04.2026	Ian Dean / Robin Jones	Chief Finance Officer / Chief Operating Officer	WH Smith's Lease	Lease

Neave,Lynsey
30/10/2026 09:31:09

Meeting: Trust Board in Public

Date of Meeting: 05 November 2026

Item Number: 22

Title of Report: Receipt and Management of Petitions Policy

Executive Director Lead: Chief Executive

Author and Job Title: Lynsey Neave, Company Secretary

Email Address: lynsey.neave@nhs.net

Purpose of the Report:

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

To consider the proposed amendments to the Receipt and Management of Petitions Policy following a comprehensive review and learning.

Consultation:

Consulted with the Senior Information Risk Owner (SIRO) and Chief Nursing Officer to ensure any associated learning has been achieved from the data breach in 2025.

Presented to Executive Leadership Team and Audit Risk Assurance Committee as the appropriate governance routes ahead of presentation to Trust Board as a matter reserved for Board.

The Policy was shared with the Joint Negotiating and Consultancy Committee (JCNC) to seek any comments; no comments, questions or concerns were raised.

Key Risks (please tick one or more):

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

Reputational ☒ **Legal / Regulatory** ☒

Impact:

Neave,Lynsey
30/10/2026 09:31:09

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 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:

- **Approve** the proposed amendments to the Receiving and Management of Petitions Policy as a matter reserved for Board

Neave,Lynsey
30/10/2026 09:31:09

Receiving and Management of Petitions Policy

1. Situation / Executive Summary

The report sets out the proposed changes to the Receiving and Management Petitions Policy, as a matter reserved for Board.

2. Background

A petition represents the expression of the views of the people who sign it. For RCHT, petitions are an important mechanism for local people to have a voice on local health matters.

The Trust introduced a new policy in 2023 which was determined as a matter reserved for Board. The policy was based on a review of HM Government guidance for public petitions and benchmarking from other Trusts and consideration of local authority guidance on e-petitions.

Outside of the very specific area of Parliamentary petitions (whereby petitions reaching a specific threshold will trigger a government response, and if a higher threshold is met, a parliamentary debate will take place on the issue), and local authority petitions, where there is also specific legislation regarding petitions for referendums on local constitutional changes, there is very little evidence of any legislation addressing the more informal type of petition of the nature encountered by the Trust.

This review is its (first three year) review of the policy and takes into account of associated learning achieved from an FOI data breach in 2025. The Policy was shared with the Joint Negotiating and Consultancy Committee (JCNC) to seek any comments; no comments, questions or concerns were raised.

3. Assessment

The Trust periodically receives petitions, and specific questions were raised in relation to two specific petitions submitted to the Trust Board by a trade union as part of enquiries made associated with an FOI Data breach in 2025 . The Trust engaged with legal advisers which identified the Trust has followed its policies, however to strengthen data minimisation this review of the policy takes into account the learning from this event.

The Trust has considered the following:

- what elements of a petition it considers are necessary to be published;
- requiring that any petition submitted includes the necessary transparency information given to signatories and;
- updating the petitions policy to include transparency information in the process for gathering signatories and how those presenting petitions should evidence this to the Trust to be regarded as a petition the Trust will accept.

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30/10/2026 09:44:06

Summary of changes

- The policy has been updated from Version 1.0 (September 2023) to Version 2.0 (June 2026).

- Revisions strengthen the policy's approach to data protection, transparency and lawful processing of petition information. New wording clarifies that petitions must comply with the UK GDPR, Data Protection Act 2018 and Data (Use and Access) Act 2025. The policy now identifies the likely lawful basis for processing petition data as Article 6(1)(e) public task, with Article 9 conditions to be identified where special category data is processed. It also introduces clearer expectations around transparency, data minimisation and proportionality when processing or publishing petition information.

- New wording clarifies the lawful basis for processing petition data, including where special category data may arise.

- Additional requirements have been introduced for petition organisers to ensure signatories are clearly informed how their personal data will be used and whether any information may be published. The policy now places greater responsibility on petition organisers to ensure signatories are properly informed about how their personal data will be used. Petition organisers are required to include a clear privacy or transparency statement at the point of signature collection, explaining how the Trust may use personal data, whether any information may be published, and how individuals can object to the use or publication of their data. The Trust may require assurance or evidence that these transparency requirements have been met, and failure to provide this information may result in the petition not being accepted for formal consideration.

- A new requirement has been added for petitions to include an appropriate privacy/transparency statement at the point of collection.

- The Trust's approach to publication of petitions has been revised to emphasise data minimisation and proportionality.

- The policy now makes clear that the Trust will not routinely publish full personal data, such as email addresses, signatures or full postcodes.

- Revised wording allows for publication, where appropriate, of either a redacted petition or a summary including the number of signatories.

- Additional safeguards have been included where petitions may reveal special category data, with a requirement for appropriate Article 9 conditions and protections.

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30/10/2026 09:11:09

- The policy also now states that, where a petition is rejected, the Company Secretary will write to the petition organiser to explain the grounds for rejection.

- Minor drafting amendments have also been made to improve clarity, consistency and governance wording, including references to the Chair's role and agenda handling.

4. Risk

There is an obligation under Article 5(1)(c) to limit the use of personal data to what is necessary. Risk of challenge the Trust has not complied with this requirement.

There is an obligation under Article 5(1)(a) to be transparent as to how personal data will be used. The policy sets out clearly how personal data will be used.

The handling of information within a petition will fall squarely within the Trust's public task and so the Trust will have a lawful basis for processing such data under Article 6(1)(e) of the UK GDPR – processing necessary for the performance of its public task. The policy sets out how the Trust will handle data.

5. Accountability

Company Secretary is responsible for the review of the Policy. The Audit and Risk Assurance Committee seek assurance ahead of requesting Board approval of the policy as a matter reserved for Board.

6. Recommendations

- **Approve** the proposed amendments to the Receiving and Management of Petitions Policy as a matter reserved for Board

Neave,Lynsey
30/10/2026 09:31:09

Royal Cornwall Hospitals
NHS Trust

Receipt and Management of Petitions Policy

V2.0

August 2026

Neave,Lynsey
30/10/2026 09:31:09

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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 are 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. As stipulated in the Trust's Standing Orders, the Chair shall include details of a petition on the agenda of the next Board of Directors meeting, pending consideration of the related Policy on the Receipt and Management of Petitions.

1.2. A petition represents the expression of the views of the people who sign it and petitions are an important mechanism for the expression of community views and the public voice. However, to avoid the danger of listening only to active, vocal groups, petitions should not be viewed in isolation but as one piece of evidence and information which contribute towards an overall picture.

1.3. This guidance outlines how the Royal Cornwall Hospitals NHS Trust (hereafter referred to as 'RCHT' or 'Trust') will handle any petitions from the local community. This guidance is relevant to the receipt and management of a petition received by the Trust physically or electronically.

1.4. Any issues regarding the policy may be discussed with the Company Secretary.

2. Purpose of this Policy/Procedure

2.1. The purpose of this policy is to set out how the Trust will receive and manage petitions in relation to the remit of the organisation, from members of the public, staff or union bodies.

2.2. The policy applies to the public, all staff, RCHT members, temporary staff, seconded staff, contractors and others undertaking work on behalf of the RCHT.

3. Scope

This policy applies to any member of public, union body or staff member wishing to submit a petition to the Trust Board of Directors. Responsibility for implementing and advising on the policy sits with the Company Secretary.

4. Definitions / Glossary

4.1. RCHT – Royal Cornwall Hospitals NHS Trust.

4.2. NHS – National Health Service.

4.3. Local community – communities within the geographic remit of the Trust's services.

5. Ownership and Responsibilities

5.1. Role of the Chair of the Board of Directors

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The Chair of the Trust is responsible for considering, on the advice of the Company Secretary, petitions submitted to the Trust Board of Directors, and determining whether to add details of the petition to the next available Board in Public agenda.

5.2. Role of the Company Secretary

The Company Secretary has responsibility for ensuring that the policy is adhered to and for advising on its application. The Company Secretary will receive submitted petitions and acknowledge their receipt to the petition organiser. The Company Secretary will liaise with other directors as required and the Chief Executive on the nature of the petition and any resulting next steps.

5.3. Role of the Board

The Board is responsible for formally receiving and noting the petition and providing a response to the petition organiser.

5.4. Role of all Trust Staff

All RCHT staff are responsible for forwarding any petition received by their team to the Company Secretary team for attention of the Chair.

5.5. Role of a petition organiser

The petition organiser should ensure that the criteria for a valid petition is met before submitting to the Company Secretary.

6. Standards and Practice

6.1. There is not currently any specific national statutory guidance governing the handling of petitions by NHS bodies. In developing this policy, the Trust has considered relevant legislation, NHS governance principles, published terms and conditions applicable to HM Government e-petitions, and practice adopted by other NHS organisations..

6.2. All petitions must comply with UK GDPR and Data Protection Act 2018 and Data (Use and Access) Act 2025 requirements. The Trust will process personal data under Article 6(1)(e) (public task) and, where applicable, Article 9(2)(h) (management of healthcare systems). The processing and publication of any petition data must also meet the principles of transparency, data minimisation and proportionality. Article 9 conditions will be identified where/when special category data is processed.

6.3. As a general principle, the Trust reserves the right to only publish summary information pertaining to any petition, including for example the nature of the petition and the number of signatories, unless there is clear justification for publishing additional detail.

6.4. Criteria of consideration of petitions outside of a formal consultation process

6.4.1. In order to be received for consideration, petitions relating to matters outside of a formal consultation process meet the criteria outlined below:

- Petitions should be sent to the Company Secretary either physically or electronically and must contain a minimum of 20 signatures, excluding the petition organiser. If the minimum number of signatures is not met, the petition will be rejected by the Company Secretary.

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- Petitions should include a ‘statement of petition’, which should comprise:
    - The organisation to which the petition is being addressed.
    - The proposition which is being promoted by the petition.
    - The timeframe over which the petition has been collected.
    - The following information about each petitioner should be included:
        - ❖ Name.
        - ❖ Postcode.
        - ❖ Signature (in the case of a written petition).
        - ❖ Confirmation that each signatory is willing for their information to be shared as part of the petition and has been clearly informed how their personal data will be used, including whether any information will be published in the public domain.
- The petition organiser must be resident within the area to which the petition relates, and their name should be printed on the first page of the petition.

6.4.2. Petition organisers must include within the petition a clear privacy/transparency statement to be provided to signatories at the point of signature collection, setting out:

- How their personal data will be used by the Trust;
- Whether the petition or any part of it (including names or other identifiers) may be published;
- How individuals may raise objections to the use or publication of their data.

Failure to provide this information may result in the petition not being accepted for formal consideration.

6.4.3. The Trust will require petition organisers to provide assurance, and where appropriate, evidence of how the above transparency requirements have been met. The Company Secretary will undertake proportionate due diligence to satisfy itself that signatories have been appropriately informed

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6.4.4. Petitions will not be considered if they are repeated, vexatious, contain unverifiable signaturesor if they concern issues which are outside of the Trust’s remit. A petition will be considered as a vexatious petition if it focuses on individual grievances.

6.4.5. A petition will be considered as a repeat petition if:

- It covers the same or substantially similar subject matter to another petition received within the previous six months, or,

- It is presented by the same or similar individuals or groups as another petition received within the previous six months on the same or similar matter.

6.4.6. Petitions will also not be considered if the information contained in the proposition is confidential, libelous, false, defamatory or offensive. The Chair of the Board will make the final decision, as advised by the Company Secretary, on whether a petition should be rejected on these groups. If rejected the Company Secretary will write to the petition organiser to advise on the grounds for the rejection.

6.4.7. A petition will be considered as confidential, libelous, false or defamatory if:

- It contains information which may be protected by an injunction or court order, or,

- It contains material which is confidential, for example legally privileged, potentially confidential, commercially sensitive, or which may cause personal distress or loss.

6.4.8. A petition will be considered as offensive if it contains language that may cause offence, is provocative or extreme in its views.

6.4.9. A petition will be considered as outside the Trust's remit if:

- It focuses on a matter relevant to another organisation, or,

- It requests information available via freedom of information legislation, or, its aim is to correspond on personal issue(s) with an individual(s).

6.4.10. Where a petition **does not** meet the requirement set out in the criteria above then the Company Secretary will respond in writing within 10 working days, or sooner if a Board in Public meeting is scheduled during that period, to confirm the petition has been received and that, as the petition does not meet the criteria, that a formal response to the petition will not be provided.

6.4.11. Where a petition **does** meet the requirements of the criteria above, the Company Secretary will liaise with the Chair of the Board and Chief Executive and provide advice on application of the policy. Subject to the Chair's agreement and the relevant deadlines, the petition would then be added to the agenda of the next available Board in Public meeting to be formally received and noted. A response will be made in writing. The following timelines will apply where a valid petition has been submitted:

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- Subject to the Chair's agreement, a petition will be included on the next available Board in public meeting if received by the Company Secretary at least ten working days before the meeting. The Chair of

the Board may consider including a petition received after that deadline but is under no obligation to do so.

- The Trust will take a proportionate approach to the publication of petitions in accordance with UK GDPR principles. A clear determination will be made in each case as to what information is necessary to publish to support transparency while protecting personal data.

- In applying the data minimisation principle, the Trust will not routinely publish full personal data contained in petitions. In particular, the Trust will not ordinarily publish:

  - Email addresses;

  - Signatures;

  - Full postcodes or other detailed identifiers;

- Where appropriate, the Trust reserves the right to:

  - Publish a redacted version of the petition; or

  - Publish a summary including the number of signatories

- Petitions may, in some cases, reveal special category data (for example, identifying an individual as a patient or a member of a trade union). Where this occurs, the Trust will ensure an appropriate lawful basis under Article 9 UK GDPR is identified and will apply additional safeguards to protect such data

- Once formally received and noted by the Board, a response will be made in writing within five working days on the meeting. The Company Secretary (and/or their approved Dputy in the case of absence) will draft this response on behalf of the Chair of the Board.

6.5. **Petitions received during a formal consultation period**

6.3.1 Where a petition concerns an issue currently out for formal consultation the petition will instead be considered as an item of correspondence, in the same way that any other response would be considered during a consultation period. Such a consultation may be run by the Trust itself or via the Cornwall and Isles of Scilly Integrated Care Board on a service provided by the Trust.

6.3.2 Petitions will be considered as valid for consideration as part of the consultation if they meet the requirements set out in the criteria outlined in this policy.

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6.3.3 All petitions received during a formal consultation period will be shared with Cornwall and Isles of Scilly Integrated Care Board, the relevant Healthwatch group(s), scrutiny committee(s) and council(s), as appropriate, as part of the report on views received during consultation and the overall results of the consultation.

6.3.4 When a report on the outcome of consultation is prepared, the following issues will be taken into account when considering a petition:

- Consultation is not a public vote. Influence will be afforded to the most cogent ideas and arguments, and not necessarily to the views of the most numerous stakeholders.

  The petition should be relevant to the subject of the consultation. It may not necessarily use the same words, but it should have a bearing on the proposal(s) within the consultation.

- The petition should reflect the latest proposals and policy statements being made and not relate to issues that are no longer under consideration. This is particularly relevant when considering the timescale during which signatures have been collected.

- The petition should provide an accurate reflection of the proposals in the consultation, rather than including misleading information or statements.

- The petition should relate to the consultation and to the proposed action of the Trust (and/or its stakeholders), rather than to broader policy agenda beyond the scope of the consultation.

- A petition's concerns will be assessed in relation to the aims being put forward in the consultation, and the rationale and constraints behind it. For example, a petition that proposes a realistic alternative option will normally be given greater weight than a petition that simply opposes an option that has been put forward for valid reasons.

- A petition's concerns will also be assessed in relation to the impact on other populations (local and national) if these demands were accepted. This assessment could take into account views expressed in other petitions (which may conflict) or in more direct responses to the consultation.

6.3.5 The organiser of the petition will receive correspondence from the body which has initiated the consultation, in the same manner as other respondents (such as acknowledgement, an outcome letter describing how the issues raised during consultation have influenced the decisions made following consultation).

6.3.6 Petitions will be formally acknowledged in the analysis of consultation responses, along with all the other responses. If what petitioners call for is accepted or rejected, the reasons for this should be given, set out against a transparent set of criteria.

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6.3.7 Any publication or sharing of petition data as part of consultation reporting will comply with the same transparency, data minimisation and

proportionality principles set out in this policy.

7 Dissemination and Implementation

7.1. The document is available on the document library. Significant updates will be communicated via Trust wide email.

7.2. Implementation of the policy will be via Trust wide communication and supported by appropriate training for the relevant members of staff.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	The Corporate Governance team will evaluate all petitions to ensure that the requirements of the policy are met.
Lead	Company Secretary
Tool	Excel spreadsheet to record petitions.
Frequency	Every three years
Reporting arrangements	Executive Leadership Team Audit and Risk Assurance Committee Trust Board of Directors
Acting on recommendations and Lead(s)	Company Secretary
Change in practice and lessons to be shared	Petitions deemed to be non-compliant will not be formally accepted by the Board. However, those petitions that are rejected, a formal note of this will be made on the appropriate committee agenda, if applicable. Compliant petitions that influence either a change in a decision previously made or a change in practice should be disseminated as appropriate to the relevant department or Trust-wide. Any suspicion of fraud or bribery should be reported at the earliest available opportunity by contacting the Trust's Counter Fraud Specialist.

9. Updating and Review

This policy will be reviewed in three years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation and/or guidance, as instructed by the senior manager responsible for this policy.

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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:	Receipt and Management of Petitions Policy V2.0
This document replaces (exact title of previous version):	New document
Date Issued / Approved:	tbc
Date Valid From:	tbc
Date Valid To:	tbc
Author / Owner:	Company Secretary
Contact details:	01872 256343
Brief summary of contents:	The Policy describes how the RCHT will handle any petitions received from the local community be they in paper or electronic format.
Suggested Keywords:	Petitions, receipt, management, policies.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Executive
Approval route for consultation and ratification:	Trust Board
Manager confirming approval processes:	Company Secretary
Name of Governance Lead confirming consultation and ratification:	Deputy Company Secretary
Links to key external standards:	None
Related Documents:	None
Training Need Identified:	None
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet

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Information Category	Detailed Information
Document Library Folder/Sub Folder:	Chief Executive / Corporate Governance

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2023	V1.0	Initial version – new document.	Sian Millard, Company Secretary
July 2026	V2.0	Updated draft	Lynsey Neave, Company Secretary

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:	Receipt and Management of Petitions Policy V2.0
Department and Service Area:	Corporate Governance Team.
Is this a new or existing document?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Lynsey Neave, Company Secretary
Contact details:	01872 256343

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 Policy describes how the RCHT will handle any petitions received from the local community be they in paper or electronic format.
2. **Policy Objectives**	Clarity regarding the receipt of petitions, actions required as well as the roles and responsibilities of key officers within the RCHT.
3. **Policy Intended Outcomes**	Clarity regarding the receipt of petitions, actions required as well as the roles and responsibilities of key officers within the RCHT.
4. **How will you measure each outcome?**	There is a risk in only listening to active, vocal groups and so any petitions received will not be viewed in isolation. They will be seen as one piece of evidence and information which contributes to an overall picture.
5. **Who is intended to benefit from the policy?**	The local community to ensure their views can be heard irrespective of whether this is part of a formal consultation process or not.

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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: Yes • 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:** Trust Secretary, Cornwall Partnership NHS Foundation Trust. Interim Strategic Governance Advisor, Cornwall, and Isles of Scilly Integrated Care Board.
6c. What was the outcome of the consultation?	Feedback on draft policy reflected within final version. Ensuring alignment across the three NHS bodies in Cornwall and the Isles of Scilly.
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	Positive – provides for consideration of views. No negative impact.
Sex (male or female)	No	Positive – provides for consideration of views. No negative impact.
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	Positive – provides for consideration of views. No negative impact.
Race	No	Positive – provides for consideration of views. No negative impact.
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Positive – provides for consideration of views. No negative impact.

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Protected Characteristic	(Yes or No)	Rationale
Religion or belief	No	Positive – provides for consideration of views. No negative impact.
Marriage and civil partnership	No	Positive – provides for consideration of views. No negative impact.
Pregnancy and maternity	No	Positive – provides for consideration of views. No negative impact.
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	Positive – provides for consideration of views. No negative impact.

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: Lynsey Neave Company Secretary.

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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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 24. The functionality to raise a question will not be available from item 19. 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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