Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 8 May 2025 at 09.00 to 12.00

Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

DRAFT AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1.	**Chair's welcome and introduction**	Information		09.00
2.	**Apologies for absence**	Information		
3.	**Declarations of interest (pertaining to agenda)**	Approval		
4.	**Minutes of previous meeting** *13 March 2025*	Approval	Yes	09.05
5.	**Matters arising**	Assurance		
6.	**Questions from the public**	Information		09.10
7.	**Patient story: Use of Virtual Reality Headsets** (also available for demonstration during break)	Information		09.15
8.	**Chair's report** *Deborah Evans, Chair*	Information	Yes	09.25
9.	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	09.35
GOVERNANCE				
10.	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Yes	09.45
11.	**Health & Safety** **Item 11a: Health & Safety Annual Report** **Item 11b: Health &Safety Management Framework** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	09.55
12.	**Modern Slavery Statement and Bribery and Corruption Statement** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	10.10
13.	**Gloucestershire Managed Services: Reserved matters (Articles of Association)** *Kerry Rogers, Director of Integrated Governance and Kaye Law-Fox, Chair (Gloucestershire Managed Services*	Assurance	Yes	10.15
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
14.	**People and Organisational Development Committee Report** *Marie-Annick Gournet, Non-Executive Director*	Assurance	Yes	10.25
15.	**Gender Pay Gap Report** *Claire Radley, Director for People & Organisational Development*	Assurance	Yes	10.35
16.	**Freedom to Speak Up Annual Report** *Louisa Hopkins, Freedom to Speak Up Guardian*	Assurance	Yes	10.45

BREAK (11.00 to 11.10)				
QUALITY AND PERFORMANCE				
17.	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Yes	11.10
18.	**Integrated Performance Report** *Al Sheward, Chief Operating Officer and Executive Director colleagues, Karen Johnson, Director of Finance*	Assurance	Yes	11.20
MATERNITY SERVICES				
19.	**Maternity Services Regulatory Compliance Report (section 31 Notice Response)** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Yes	11.40
20.	**Perinatal Quality Surveillance, Q3 2024** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Yes	11.50
FINANCE				
21.	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director/Karen Johnson, Director of Finance*	Assurance	Yes	12.00
22.	**Annual Plan 2025/2026 submission and Board Assurance Statement Report** *Karen Johnson, Director of Finance*	Assurance	Yes	12.10
STANDING ITEMS				
23.	**Any other business**	Information		12.20
24.	**Governor observations**	Information		
25.	**Date and time of next meeting:** 10 July 2025 at 09.00 Lecture Hall, Sandford Education Centre, Cheltenham General Hospital	Information		
Close by 12.30				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 13 March 2025, 09:00, Redwood Education Centre, Gloucester Royal Hospital		
Chair	Deborah Evans	Chair
Present	Vareta Bryan	Non-Executive Director
	John Cappock	Non-Executive Director
	Sam Foster	Non-Executive Director
	Marie-Annick Gournet	Non-Executive Director
	Balvinder Heran	Non-Executive Director
	Jaki Meekings-Davis	Non-Executive Director
	Mike Napier	Non-Executive Director
	Kaye Law-Fox	Gloucestershire Managed Services Chair/Associate Non-Executive Director
	Sally Moyle	Associate Non-Executive Director
	Will Cleary-Gray	Director of Improvement and Delivery
	Matt Holdaway	Chief Nurse and Director of Quality
	Karen Johnson	Director of Finance
	Lee Pester*	Chief Digital Information Officer
	Mark Pietroni	Medical Director and Director of Safety/Deputy Chief Executive Officer
	Kerry Rogers*	Director of Integrated Governance
	Al Sheward	Chief Operating Officer
Attending	James Brown	Director of Engagement, Involvement and Communications
	Debbie Tunnell	Deputy Director for People and Organisational Development
	Sarah Favell	Trust Secretary
	Ramonique Banga	Corporate Governance Officer
Apologies	Kevin McNamara	Chief Executive Officer
	Claire Radley	Director for People and Organisational Development
Observers		
Governors	Douglas Butler, Mike Ellis, Emma Mawby and Peter Mitchener	
Public	Four	

Ref	Item
1	**Chair's welcome and introduction**
	Deborah Evans, Chair opened the meeting, welcoming all members of the public and governors in attendance. It was confirmed that the meeting was quorate.
2	**Apologies for absence**
	Apologies had been received from both Kevin McNamara, Chief Executive Officer, and Claire Radley, Director for People and Organisational Development. Mark Pietroni, Medical Director and Deputy Chief Executive Officer would be deputising on behalf of Kevin McNamara who, alongside all NHS Trust Chief Executives, had been requested at short notice to attend a NHS England meeting at which a number of significant announcements as to the future structure of the NHS had been made.
3	**Declarations of interest**
	There were no declarations of interest in respect of agenda items.
4	**Minutes of previous meeting**

	It was noted that Jaki Meekings-Davis had been omitted from the attendees list for the meeting on 16 January 2025. This would be corrected. It was noted that the Action Log entry was incomplete for item 13/25. It was correct within the body of the minute. *Chief Operating Officer and Medical Director to provide an update report on histology performance to the Quality and Performance Committee and Board*. Mark Pietroni, Medical Director, confirmed this item would be before the Committee in April and reported, via the KIAR report, to Board during the May meeting. **RESOLVED:** The Board APPROVED the minutes of the meeting held on 16 January 2025.
5	**Matters arising**
	There were no matters arising.
6	**Questions from the public**
	Two questions had been submitted by Mr McInerney. Written responses to be provided to all questions and also shared with all Board members. The first question related to the assurance available to the Board that correspondence with patients is provided in a timely and respectful manner and the evidence that is available to support the assurance provided. The second question related to the assurance available to the Board as to its Equality, Diversity and Inclusion data, particularly with regard to issues of race discrimination.
7	**Staff Story**
	Unfortunately, the staff member was unwell and unable to attend the Board meeting. The Board extended their well wishes and asked that the staff member be invited to attend a future meeting, if they so wish, once they were feeling better.
8	**Chair's Report** *Deborah Evans, Trust Chair*
	Deborah Evans, Chair, expressed her thanks, on behalf of the Board and the wider Trust, to Mike Napier, Non-Executive Director, at what was his last public Board meeting. Having fulfilled two terms, serving over seven years and most recently as Vice-Chair, Mike's contribution would be very much missed. It was noted that Balvinder Heran, Non-Executive Director, would also be reaching the end of her term in May and although delayed to the meeting, her contribution to the work of the Board was noted in her absence. Deborah Evans, Chair, was pleased to announce that, following a rigorous selection process four further appointments were to be made to the Board. The Chair expressed her thanks to the governors who had significantly contributed to the selection process through their involvement with both shortlisting and candidate interviews. Conditional offers of appointment have been made to four candidates; two Non-Executive Directors and two Associate Non-Executive Directors It is envisaged that these appointments will take effect from 1 May 2025, subject to completion of the necessary recruitment processes, including Fit & Proper Person requirements. The pool of candidates for these roles had been significant and the Chair was confident the successful candidates would bring much to the Board.

	The news that had been released overnight in the media, impacting colleagues within NHS England and all Integrated Care Boards, was noted by the Chair, indicating that additional news was expected following the national meeting taking place that morning which Kevin McNamara, Chief Executive, was attending. Deborah Evans, Chair, spoke of the recent Council of Governors meeting where a refreshed structure to the meeting had facilitated a focus on both patient outcomes and staff experience. This had well received by all those attending. As part of her continued focus on the work of staff governors she had been 'shadowing' or meeting with Staff Governors individually and had recently met with Olly Warner, who had facilitated her meeting with the Cancer Support Workers team, of which he was the manager. She had also met with Sam Bostock, radiographer who has been so instrumental in providing support to patients suffering late effects of radiotherapy and she would be spending time with Russell Peek, neonatal consultant during April. Deborah Evans praised the work of the Trust's staff governors and confirm that, with support from Matt Holdaway (Chief Nurse) and Mark Pietroni (Medical Director) she would be looking for ways to amplify the voice of our Staff Governors. **RESOLVED:** The Board NOTED the report for information
9	**Chief Executive's Report** Mark Pietroni, Deputy Chief Executive
	Mark Pietroni, Deputy Chief Executive and Medical Director, presented this report on behalf of Kevin McNamara. In the context of the national announcements two key appointments within the Gloucestershire system were highlighted; Sarah Truelove would be joining NHS Gloucestershire Integrated Care Board as Chief Executive in the summer, and Jo Walker would take up the role of Chief Executive at Gloucestershire County Council. Those are two vital appointments within the Gloucestershire system, particularly as the discussions regarding the Government's devolution white paper continue. Also highlighted within this report was the Trust's excellent record in encouraging the use of apprentices in a wide range of roles, with 290 apprentices currently in post. Throughout National Apprentice Week the team had been raising awareness of all the apprentice opportunities and also the excellent work of those apprentices already working within the Trust. Whilst reviewing performance since the start of the year, Mark Pietroni expressed the thanks of the Board to both staff and the public in heeding the advice only to attend hospital if necessary. This had been a significant help in the management of the recent rise in Norovirus cases. Overall, there had been improvements in Urgent & Emergency Care, with improved performance against the 4-hour standard (61% to 63%) but the challenge remained for all Integrated Care System partners of achieving effective discharge of patients who no longer require hospital-based care. It was noted that there has been continued positive progress with elective recovery, particularly in relation to the 52-week target, with a 50 % reduction in patients waiting in excess of this period and with no patients waiting over 68 weeks, unless by their choice.

	Finally, Mark Pietroni, Deputy Chief Executive, confirmed the opening of the third Catheter Laboratory within the Trust's Image Guided Interventional Surgery (IGIS) hub at Gloucestershire Royal Hospital at the beginning of February, with further reductions in patient waiting lists as a consequence. In addition, the Hyper-Acute Stroke Unit at Cheltenham General Hospital had been successfully moved to Hatherley Ward. This represented the final part of the Stroke Service reconfiguration bringing together specialists and state-of-the-art equipment to provide first class stroke treatment with significantly reduced 'door to needle' treatment times, to the benefit of this cohort of patients. **RESOLVED**: The Board NOTED the report for information.
10	**Board Assurance Framework** Kerry Rogers, Director of Integrated Governance
	Kerry Rogers, Director of Integrated Governance presented this summary report providing an update on the alignment of the Board Assurance Framework with the Trust's strategy 2025-2030, highlighting that the majority of this work will be undertaken during Quarter 2, following the launch and implementation of the new Trust Strategy in summer 2025. It was noted that there had been considerable time spent, both in Board development sessions and with the Council of Governors, to inform the development of the Trust's future Strategy and strategic objectives. It was intended that, once the Strategy was finalised the Board Assurance Framework would be refreshed to ensure effective alignment of the Trust's strategic risks to the achievement of those objectives. In the meantime, the Corporate Governance team continued to undertake a review of the process governing the Executive review of strategic risks with meetings planned with all Executive Directors during March/April to review risks and the effectiveness of controls in place with a planned subsequent refresh of the Committee approach to the review of strategic risks. This was in readiness for implementing an improved process of strategic risk management and utilisation of the Board Assurance Framework by October 2025. Sam Foster, Non-Executive Director, noted the positive evolution of the risk management process but was keen to understand the synergy between Trust risks and those of the Integrated Care Board as there was a degree of overlap, particularly with issues affecting the flow of patients into and out of the acute hospital environment. It was agreed by Deborah Evans, Chair, that it would be useful for the Trust to engage in a dialogue with system partners, recognising the difference in the risks carried by the respective organisations but providing a forum in which to explore collaborative controls and also the significantly different assessments of risks by partner organisation in respect of risk issues impacting across healthcare services within Gloucestershire. Kaye Law-Fox, Associate Non-Executive Director, highlighted the need to focus on effective controls and a consistent assessment and scoring of strategic risks across the Board Assurance Framework, particularly when considering estate related risks. Kerry Rogers, Director of Integrated Governance, acknowledged that executive directors would be primarily focused on the operational and strategic risks within their individual portfolio and that the developing risk management process would include increased collective board review of the strategic risks and their interaction. Discussions turned to the need for a review of the Trust's Risk Appetite during the first six months of the new financial year. This work would be undertaken in conjunction with the implementation of the new

	Trust strategy, with opportunity to not only refresh but redesign or realign risks to the strategic objectives. It was noted by Mike Napier, Non-Executive Director, that this would be an opportunity to take a blank sheet approach to the management of risks, recognising both existing and newly emerging risks to the Trust's strategic objectives. The Board were reminded that it would be receiving a paper regarding the Health and Safety Management Framework later in the course of this Board agenda but it was highlighted that the need for a Health & Safety strategy was imperative, with a strategic risk being developed for the Board Assurance Framework, through consultation with key stakeholders across the Trust. **RESOLVED:** 1.1. The Board NOTED the content of this report and continue to support the plan to align the refresh with the next phase of the strategic direction of the Trust as determined by the impending Strategy approval. 1.2. The Board APPROVED adoption on the Framework and the continued development of the new risk concerning Health and Safety regulatory compliance. Broader description of the improvement journey is outlined in the separate Health & Safety Report on the Board agenda. **1.3.** The Board SUPPORTED Board Committee involvement in ongoing developments in scrutiny and oversight of the effectiveness of controls in order to be assured of the management of risk.
11	**Audit and Assurance Committee Report** John Cappock, Non-Executive Director and Committee Chair
	John Cappock, Chair of Audit and Assurance Committee, presented the Key Issues and Assurance Report for the period December 2024 to February 2025 with the report being taken as read. It was confirmed that the Internal Audit plan for 2025/2026 had been approved subject to resolving the inclusion of an audit of national cleaning standards compliance. The positive engagement with the design of the annual audit plan had been very welcome, particularly in light of last year's limited assurance within the annual Head of Internal Audit opinion. It was felt by the Committee that there had been a marked improvement this year, assisted by improved escalation routes between the Internal Audit team and both Kerry Rogers, Director of Integrated Governance, and Karen Johnson, Director of Finance, to facilitate the 'unblocking' of any obstacles to audit compliance and it was hoped this would be reflected in the annual Head of Internal Audit opinion. **RESOLVED:** The Board NOTED the report for assurance.
12	**Health and Safety Management Framework Report** Kerry Rogers, Director of Integrated Governance
	Kerry Rogers, Director of Integrated Governance, presented a draft first version of the proposed Health and Safety Management Framework, setting out the intended structures required to implement the Framework. It was acknowledged that this draft was a 'work in progress' to facilitate meaningful consultation with key stakeholders, both within the Trust and Gloucestershire Managed Services. Kerry Rogers acknowledged the contribution to date from both Gloucestershire Managed Services colleagues and union representatives. Topic specialist groups had been

providing input into the Framework design. The focus remained on reporting structure but also the embedding of the Framework post design as it is recognised that current practices have led to some unacceptable approaches being normalised. This would be a change in focus for the Health and Safety Committee, with the committee not solely focused on receiving assurance but actively seeking out problems to ensure genuine assurance and evidence of the same.

This approach was endorsed by Deborah Evans, Chair and by Mike Napier, Non-Executive Director, who commented positively on the draft Framework and the direction of travel being undertaken. He commented that this piece of work would require an evolution of the Trust's health and safety culture towards a position where all staff recognising and owning their individual part to play in ensuring a positive health and safety culture of appropriate challenge.

The need for adequate resource, both capacity and expertise, within the Health & Safety team to ensure the embedding of the culture was recognised during the discussions. This had continued to be a challenge for the team with qualified health & safety staff attracting a premium in the private sector, consequently making it challenging to both recruit and retain skilled staff.

It was noted by several Non-Executive Directors that the work would provide a useful tool in discussions with system partners regarding the resourcing required to address dilapidated estate within the Trust. It was also a useful tool to inform the development/strengthening of estate and regulatory compliance strategic risks within the Board Assurance Framework. This would include identification of the controls needed, including the culture piece regarding accountability and also the Trust wide training requirement and communication plan.

John Cappock, Non-Executive Director, raised a question as to how the Board would continue to receive assurance on this issue and whether there was a role for an annual or more frequent report to Audit and Assurance Committee. This was agreed and would continue to be the subject of discussions with the Director of Integrated Governance as the Framework was progressed.

The report and draft framework were received positively by the Board, whilst recognising the continued need for progress.

RESOLVED: The Board:

1. APPROVED the recommendation to create a Group Health and Safety Committee effective from April 2025.
2. APPROVE the recommendation that the Group Health & Safety Committee report directly to the Trust Leadership Team forum as set out within the draft Framework and on the system/process of Health & Safety management, to report to the Audit and Assurance Committee from April 2025. It was NOTED that the People and Organisational Development Committee would continue to receive Health and Safety Reports only with direct relevance to workforce health, safety and well-being and against approved performance indicators.
3. SUPPORT the ongoing development of the Health & Safety Framework and the Board's role in its effective implementation.

13	**People and Organisational Development Committee Report**
	Balvinder Heran, Non-Executive Director and Committee Chair, was delayed due to traffic issues in the Gloucester area. To avoid delay to the agenda timetable it was agreed that the Key Issues and Assurance Report would be taken as read but considered alongside the reports for March and April at the Board meeting in May 2025. **RESOLVED**: The Board NOTED the report for assurance.
14	**Staff Survey 2024/Results** Deborah Tunnell, Deputy Director for People and Organisational Development
	Deborah Tunnell presented a high-level summary of the NHS Staff Survey results for 2024, released that morning. The focus of the report was on key outcomes and identified areas for continued improvement. It was recognised that, whilst overall the results were encouraging, the Trust's results remain below the median and there was more work to be done. With a 65% response rate (2023-68%) this remained a strong result, ranking 5th nationally and an indicator of good staff engagement. Also of note were a number of significantly improved scores in each of the seven People Promise themes and the overall score, with the Trust ranked 49th out of 58 Trusts (Trusts using Picker as their survey partner), an improvement from 59th out of 60 Trusts in 2023. When looking at the historic positive score data it was noted that the Trust had moved from 64th(out of 65) in 2022, to 12th most improved in 2023 and this year, to 5th most improved positive score. Nevertheless, it was recognised by the Board that the Trust continues to score below the national averages for both the People Promise and staff engagement metrics so there was a need to continue the work already being undertaken and no room for complacency. The survey results were being distributed to the Divisions for detailed analysis and to inform necessary action plans for improvement. Vareta Bryan, Non-Executive Director, commented on the quality of the intelligence/data now available to the Trust to inform its people priorities and that this must be used to identify effective actions to achieve positive change. Sam Foster, Non-Executive Director, commented that it would be a useful exercise to carry out a deep-dive into the areas where the Trust remains significantly below the national average. These less positive results need to be recognised and action plans developed in respect of the same. It was recognised that a lot of information will come from the narrative free text commentary received from staff members. This was to be worked through by the Divisions supported by the Human Resources teams but the emerging themes were (i) the impact of the physical environment (estate) both on the morale of staff directly and their concerns about their ability to provide excellent care (ii) workload and (iii) lack of clear career progression. Deborah Evans, Chair, requested a report to a future Board (July) following the analysis of the Staff Survey results, focusing on the negatives to be improved and the prioritisation of those areas. Marie-Annick Gournet, Non-Executive Director, endorse the need for an additional piece of work as outlined and emphasised the role of the Divisions in taking forward the action plans and being directly accountable for their performance in respect of staff related matters. Al Sheward, Chief Operating Officer, highlighted the work being done with divisional senior management teams with the focus moving from 'business as usual' service delivery to increased curiosity as to the individual drivers within services, including a

	focus on staff. Karen Johnson, Director of Finance, commented that whilst divisional focus was important any analysis should include the corporate areas with data indicating a disconnect between the organisation and employees within the corporate services areas. This would be a focus of the corporate divisional board. **ACTION:** Director for People and Organisational Development to provide a report to the Board (July meeting) following the analysis of the detailed Staff Survey results. Kaye Law-Fox, Associate Non-Executive Director, commented on the value of triangulating the survey results data in the context of other available data including vacancies, disciplinary and staff turnover to provide a rounded and accurate picture of the issues affecting workforce within the organisation. Sally Moyle, Associate Non-Executive Director, spoke of the importance of effective communication with staff detailing improvements, even when small and ensuring staff are aware of the value of their feedback and the actions taken as a consequence. **RESOLVED**: The Board NOTED the report for assurance. **ACTION**: Director for People and Organisational Development to provide a report to Board (July meeting) focusing on the areas within the Staff Survey results which are negative, with low satisfaction rates and providing an action plan for how these areas of concern will be addressed, both Trust-wide and divisionally (including corporate).
15	**Quality and Performance Committee Report** Mike Napier, Non-Executive Director, and Sam Foster, Non-Executive Director.
	Mike Napier, Non-Executive Director, presented this report indicating that he was taking the content as read but intending to highlight areas of particular focus. Maternity services remained a focus for the Committee with a 'deep-dive' on a maternity related issue tabled for the March committee meeting. Two reviews were underway into (i) Maternal death and (ii)Stillbirths with completion anticipated shortly. It was noted that these areas have been the subject of significant positive focus recently. The Committee had also received a briefing from the Chief Nursing Officer on the ongoing work being undertaken in respect of Child Protection Medical Assessments (neglect not abuse) to align shared understanding of both the issues and associated risks between the Trust and its Integrated Care Board colleagues. It was recognised that there have been differing professional opinions as to appropriate process standards and there have been a number of actions to align the approaches including Chief Executive Officer led discussions. Those discussions continue but it was emphasised by Mark Pietroni, Medical Director, that there was no risk to children as it was primarily a discussion as to process and adequate safeguards were in place to ensure children received assessments required, with multi-disciplinary team reviews taking place and access to alternative medical advice if there was a lack of consensus as to the approach to be taken in respect of individual assessments. **RESOLVED**: The Board NOTED the report for assurance.
16	**Integrated Performance Report** Al Sheward, (Chief Operating Officer), Matt Holdaway (Chief Nurse & Director of Quality), Mark Pietroni (Medical Director), Karen Johnson (Director of Finance) and Deborah Tunnell (Deputy Director for People and Organisational Development)

Al Sheward, Chief Operating Officer, presented the Integrated Performance report for the period December 2024 to January 2025 inclusive. It was noted that this meeting's report would be the last report in the current format with the new planning guidance providing new metrics for monitoring and assessment. Whilst the report was taken as read the following items were highlighted:

Performance

Urgent and Emergency Care

It was recognised that this period had been particularly challenging, especially for Urgent and Emergency Care, including the declaration of a system wide Critical Incident on the 8th January with a consequent impact on performance. The publicity regarding the Critical Incident appeared to have impacted Emergency Department attendance levels with 1,414 fewer patients attending in January, compared to December 2024. This led to an improved 4-hour wait position and a reduction in 12-hour breaches, despite the challenges with patient flow which was impacted by infection, prevention and control measures for Flu, Norovirus and Covid. Ambulance handover times remained an area of significant challenge during this period, particularly in early January (relevant to the Critical Incident) with some Emergency Department corridors being used to assist with the Critical Incident, albeit for the shortest time possible.

Elective care

January saw a reduction in the number of patients waiting in excess of 52 weeks from referral to treatment, reducing from 1256 patient (December) to 946 patients (January). This represented a significant effort by a number of teams with divisional leadership providing targeted focus on areas of challenge. It was noted that there would be a new metrics indicator 'time to first appointment' and this would require work to be done to ensure the accuracy of data regarding appointments cancelled or rearranged by patient request.

A significant reduction in the waiting list for Angiogram was reported for this period with Catheter Laboratories 1 & 2 operational with reduced downtime for servicing requirements. It was noted that Catheter Laboratory 3 is expected to be operational from mid-February. Additional weekend activity continued to further reduce the waiting lists during the relevant period.

Histopathology remains a noted concern for the Board with the achieved turnaround times performance marker only achieved in approximately 40 % of cases (standard: 70% turnaround times). It was recognised that there is a national shortage of Histopathologists at a time of a 30% increase in requests. With three consultant vacancies and older unreliable equipment there is an ongoing reliance on outsourcing, with specimens relevant to a cancer diagnosis prioritised. Remedial actions include increased use of digital scanning and a robust training programme to improve productivity. Further updates would be provided to the Quality and Performance Committee.

Patient flow through our hospitals

During the relevant period flow was impacted with a significant increase in the numbers of patients with 'no criteria to reside' (discharge ready) with a rise from 92 to 192 patients during a short period (January). The Trust has raised concerns with system partners as to

the resilience of the system and its ability to meet surges in demand. It was acknowledged that the system is endeavouring to achieve a reduction to fewer than 100 patients by the end of the financial year but there was reduced confidence this would be achieved.

Cancer

Cancer performance was noted to have plateaued with the 62-day reportable backlog at 185 patients, as at 3rd February 2025. The majority related to urology where delays were experienced in receiving timely diagnostic results. Dermatology was another pressure area.

The Trust did not achieve any of the three cancer operational standards and this will be the subject of a deep dive review to better understand the drivers of this position and identify further necessary actions.

Before considering the remaining metrics, the Board discussed the impact of the Integrated Performance Report as the format will have been in place for twelve months. Broadly the Board considered the format helpful and informative, enabling it to focus on the areas requiring additional attention. For the Non-Executive Director members of the Board those areas of focus included histopathology and data relating to delay related harm. It was noted with concern that there had been a significant number of patients previously identified as 'no criteria to reside' (medically fit for discharge) becoming unwell during their extended admission and consequently being recatorgorised as meeting the 'criteria to reside'. Whilst it was acknowledged that it was difficult to quantify the level of harm the Board identified this development as an area of concern. This issue was being examined through the Winter Debrief process but the Board considered it necessary that this risk to patients be raised in focused discussions with system partners.

Quality and Safety metrics

Patient Experience

This period saw a noted improvement in the Friends and Family Test scores, with satisfaction rates increasing from 92.2% (December) to 93.5%(January) with the most significant improvement being seen in the Emergency Department and In-patient & Day Cases.

The Patient Advice and Liaison Service (PALS) and the Complaints team saw an improved position during this period with higher levels of resolution within agreed response times. This improved position was attributed to the use of a red-amber-green (RAG) system pilot and a quality improvement programme focused on the complaints backlog within specific clinical services.

Venous Thromboembolism (VTE)

Mark Pietroni advised that this continued to be a focus with risk assessment and management compliance now recorded on the VTE dashboard across the Trust (save for maternity which is recorded separately via Bagernet). Overall compliance with national standards was high (96%) but further work was required in areas where the patient's length of stay was less than 36 hours (day cases). The primary issue was the carrying out of an assessment within 14 hours of admission, where the patient was a short-stay surgical patient and therefore likely to be discharged within the assessment window. The Division has assigned senior leads to target this area of non-compliance and it was believed the

implementation of the electronic patient record (EPR) would resolve this issue before end of March 2025.

Use of Resources/Finance metrics

Karen Johnson referred the Board to slides 43 to 61 within the Integrated Performance Report. In summary, at the end of Month 10 the Group financial position is a year-to-date deficit of c£2.2m against a planned deficit of c£2.4m, this included Gloucestershire Managed Services.

The Board was advised that the Trust remained in a challenging position, with considerable challenges to achieving the planned breakeven positions. All areas of focus are being reviewed to better understand the drivers of costs, with pay controls, particularly on locum and agency pay, beginning to demonstrate benefits. Non-pay continued to be an area of concern, with one division receiving mandated support. It was recognised that increased service delivery had a consequent negative impact on non-pay costs.

Year to date delivery of financial sustainability schemes remained positive with anticipated delivery of target at year end. Overall, the cash position remained reasonable but it was noted that the NHS practice for capital schemes not to be offered on a recurrent cash-backed basis would impact this position longer-term and this would be factored in to decisions as to which schemes to progress. Capital spend continued at pace as the Trust approached financial year end but it was recognised that there was an underspend linked to scheme revision and the application of lease costs associated with IFRS 16 with plans in place to address the slippage.

Deborah Evans, Chair, noted the incredible amount of work undertaken to secure the Trust's financial position through the increased workforce controls and intense focus on the financial sustainability programme but it was recognised by all that the approaching financial year will be challenging for the Trust, and across the wider NHS. Matt Holdaway, Chief Nurse, commended the work of the Divisions in reducing reliance on nursing and medical locum and agency staff but also recognised that this area of efficiency would not be available in the next financial year.

People

Deborah Tunnell, Deputy Director for People and Organisational Development, provided a commentary on the section of the report relating to workforce. The improvement of the Trust's position in relation to the equality, diversity and inclusion agenda remained a priority but it was recognised that there had been slow progress in achieving higher levels of representation of BME staff in senior leadership roles. Whilst there was increased representation in Bands 8a and 8c, Band 8d and VSM (Very Senior Manager) grades had little to no BME representation. The Board was reminded of the action priorities in place to address this issue and these will continue to be monitored.

The Board was taken to slide 57/61 which indicated compliance levels against a number of workforce performance indicator targets. Identified as behind target were appraisals, essential training and use of bank staff. Appraisal compliance was 8% below target and this mirrors commentary within the recent Staff Survey results, particularly for corporate areas. A

	remedial plan was in place with a new appraisal process and paperwork launch planned for April 2025. **RESOLVED**; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
17	**Learning from Deaths** Mark Pietroni, Medical Director and Director of Safety
	Mark Pietroni, Medical Director, presented this report providing context as to the age of the data used. It was explained that the national data used to report to Board was six months old (April/June 2024) and the Trust did have more contemporaneous data available but was required to use the national data in its reporting of compliance with National Guidance on Learning from Deaths. The report was taken as read but the Board's attention was directed to page 8/29 (pack 173). It was recognised that the Trust was 'higher than expected' (as per national data) in terms of deaths within 30 days post discharge but with signs of improvement evident with a reduction in the SHMI (Summary High-level Mortality Indicator) for three consecutive months. The Hospital Mortality Group was meeting monthly to monitor actions (excluding neck of femur) and had not identified any care issues. Mark Pietroni, Medical Director, indicated that the primary issue was correct coding. He was clear that it had taken a considerable length of time and an extensive review of the data to reach that conclusion and this outcome had been a source of reassurance. It was recognised that the mortality figures for Cheltenham General Hospital were higher than Gloucester Royal Hospital (which had the trauma departments located there) and consequently this had been extensively reviewed with an audit of stroke, oncology and frail patient deaths being undertaken. All were identified as expected deaths which had not been accurately coded. The Board were taken to page 19/29 (pack 184) to consider the analysis of feedback from bereaved families for the period April to June 2024 which, overall (83%) was positive with areas of improvement identified as effective communication and inadequate explanation of end-of-life care to patients and family. Mike Napier, Non-Executive Director, commented on the use of relatively old data (over eight months) and whether this could be a useful source of assurance. It was acknowledged that there was a requirement to rely on the national data but he asked whether, within the report coversheet, more contemporaneous data could be provided. Mark Pietroni, Medical Director, agreed this had merit and would look to include within the Integrated Performance Report **RESOLVED:** The Board NOTED the Learning from Deaths quarterly report. **ACTION:** Medical Director to consider provision of more contemporaneous data to the Board, alongside the national Summary High-level Mortality Indicator (SHMI), either within the Integrated Performance Report or an addendum/coversheet for the Learning from deaths report).
18	**Maternity Services Regulatory Compliance Report (Section 31)** Matt Holdaway, Chief Nurse and Director of Quality
	Matt Holdaway, Chief Nurse, presented the Compliance Report which detailed ongoing progress against the improvement programme in place since May 2024. This report was in

	addition to monthly reports provided to the Care Quality Commission and the Trust's Maternity Delivery Group, which are available to Board members. Five improvement workstreams were initially identified with two having been stood down from Quality Improvement Group review as a result of progress made. These were now included within the Trust's usual governance processes. Three workstream areas remain the subject of enhanced scrutiny: • Postpartum haemorrhage risk assessment and monitoring • Venous Thromboembolism (VTE) risk assessments • Foetal monitoring peer reviews, accurate assessment and timely escalation of concerns. All areas were identified as progressing well against action plans however, one area of concern had been identified - the management of thromboprophylaxis, in particular the accuracy of the data relating to patient receipt. Compliance levels were below target. This was being reviewed by Dr Edwards, with the Maternity Delivery Group and an update would be provided within a future Board report. Vareta Bryan, Non-Executive Director (non-executive maternity safety champion), noted the progress made but highlighted an ongoing concern about the availability of consultants to support the quality improvement work. This would remain under review and the current recruitment efforts were noted. **RESOLVED:** The Board NOTED the report for assurance.
19	**Finance and Resources Committee Report** Jaki Meekings-Davis, Non-Executive Director and Committee Chair
	Jaki Meekings-Davis provided the Key Issues and Assurance Report on behalf of the Finance and Resource Committee, highlighting areas of necessary focus, in particular the position as regards achievement of the capital programme by the close of the financial year with spend as at month 9 at £21.7m against a plan of £34m. As in previous years, the weighting of expenditure towards the end of the financial year end puts inordinate pressure on staff and contractors. Levelling the profile of capital expenditure throughout the financial year would be considered an objective for the Committee during 2025/2026. Also noted was the work on the Financial Sustainability Plan and the need to make key necessary decisions as to the Annual Plan as soon as possible. There had been a commitment made at the recent Integrated Care Board Resource meeting that this would be a priority but the Board were conscious that the recent national announcements, impacting both NHS England and Integrated Care Boards generally, would be relevant to whether this could be achieved. **RESOLVED:** The Board NOTED the report for assurance.
	Any other business
	There were no items of business to note.
21	**Governor observations**
	Dr Ellis provided his observations on the meeting, with particular focus on the information provided regarding the Hyper-Acute Stroke Unit at Cheltenham General Hospital, commenting on his own positive experiences of Stroke services. He was supportive of the renewed focus on health & safety and acknowledged the positive trajectory of the Staff Survey results, whilst recognising the need for continued focus.

Close: 12:00
Date and time of next meeting: 8 May 2025, 09:00, Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

ACTIONS/DECISIONS			
Item	**Action**	**Lead / Due Date**	**Update**
14	Provide a report to Board focusing on the areas within the Staff Survey results which are negative, with low satisfaction rates and providing an action plan for how these areas of concern will be addressed, both Trust-wide and divisionally (including corporate).	July Board meeting Director for People and Organisational Development	
17	Provision of more contemporaneous data to the Board, alongside the national Summary High-level Mortality Indicator (SHMI), either within the Integrated Performance Report or an addendum to the Learning from Deaths report.	Medical Director Next scheduled report on Learning from Deaths	

Chair's Report to Board of Directors

April 2025

1. Purpose

This report describes some of my activities as Chair of the Trust since the March 2025 Board meeting and highlights the work of my fellow non-executive directors and our Governors. It is intended to increase visibility of our work rather than be a comprehensive account.

2. New Non-Executive Directors and Associate Non-Executive Directors

Our newly appointed Non-Executive Directors and Associate Non-Executive Directors started their appointments with the Trust on 1st May 2025. Sally Moyle has moved from being an Associate Non-Executive Director to a ful Non-Executive Director and will serve on Finance and Resources Committee in the first instance. She will also chair the Charitable Funds Committee as Marie-Annick Gournet is taking over the chair of the People and OD Committee. Our charity team were keen to record their thanks to Marie Annick and their welcome to Sally. John Noble will join Finance and Resources Committee and Audit and Assurance Committee. John will also be the veterans network link Non-Executive Director. Our two Associate Non-Executive Directors will each have a "home " committee which is People and OD for Raj Kakar Clayton and Audit and Assurance for Andy Champness. After their first six months they will also rotate to other committees to gain insight into the full range of Trust governance. Individual induction programmes are being developed for each of our new colleagues.

3. Quality, safety, patient and colleague experience

- Research and Innovation – our research lead, Noel Peter has submitted two ambitious research applications with a sustainability theme for national funding. The first will test a new one stop shop pathway for the many people who develop Carpal Tunnel Syndrome. The second is a multi-partner bid across Gloucestershire looking at new approaches to limiting and reversing frailty. Both proposals have involved patients as well as partners in their design and cognisant of the challenges of a large, urban and rural geography.

- Chair and Lead Governor conversations with Gloucestershire Health and Care - Andrea Holder our lead governor and myself had a joint meeting with Graham Russell chair of GHC and their lead governor Chris Witham. We were keen to learn about how they are developing the Governor role and to look for opportunities for dialogue and closer working

- Sikh faith knowledge share – our Equalities lead, Coral Boston organised an online education event, which was well attended by colleagues across the organisation and partners in other agencies in Gloucestershire. Apart from describing the faith and its main values and practices we had some very

practical conversations about how to support patients needs. Kaye Law- Fox our GMS chair was in attendance.

4. Governance and Assurance

The Trust Executive and Board are working hard to develop a stronger focus and greater assurance around health and safety. In this context I visited the Emergency Department with Kaye Law Fox and GMS colleagues to look at the first phase development of a security presence there which is part of a multi-year plan to address violence and aggression across both our hospital sites.

I am grateful to John Cappock for becoming our NED security champion and for supporting Kerry Rogers, our Director of Integrated Governance in hosting the governance aspects of health and safety with the Audit and Assurance Committee. The Trust Leadership Team is taking responsibility for operational aspects of health and safety, whilst People and OD committee will retain its interest in health and safety as concerns our people.

5. Visits and ambassadorial roles

Since the March Board meeting my visits and ambassadorial commitments have included

- Visiting our neonatal unit, hosted by Russell Peek, our medical staff governor and learning about his work, which also includes leadership of the postgraduate medical students programme at Worcester University
- Joining the 8 Days of Spring improvement event.
- A meeting with Diane Savory, chair of the Big Space Cancer Appeal and our chief executive, Kevin McNamara to review progress.
- I joined the People Promise Visit where we demonstrated our work against the elements of the People Promise to a visiting team from NHS England. This correlates directly with our responses to our staff survey. It was a very impressive round up of work from the HR and OD team.
- South West Faculty of Public Health event – I am a member of the Faculty of Public Health and joined a local event in Bristol about the history of slavery in the City and the toppling of the Colston statue.
- Meeting with Louisa Hopkins our Freedom to Speak Up Guardian – I meet with Louisa only occasionally as she is well supported by Claire Radley her manager and has regular meetings with Kevin McNamara our CEO and Marie Annick Gournet who is our Freedom to Speak Up Non-Executive champion.

6. Contributing to our One Gloucestershire Integrated Care system

We are in a time a rapid change across the intermediate tiers of the NHS, with NHS England being folded into the Department of Health and Social Care and the significant reductions in role and funding of ICBs.

My recent involvement has been:

- Meeting Jane Cummings the vice chair of the ICB to discuss how we work together

- A meeting of the ICS Non-Executive Directors network which many of our Non Executives attended
- A meeting of the Integrated Care Board
- A development session of the Integrated Care Board which included a presentation about the primary/secondary care interface work
- A joint meeting between the chair of the ICS, Gill Morgan with Graham Russell, GHC chair and myself

Chief Executive Report to the Board of Directors – May 2025

1. People and Culture

1.1 NHS Changes

In March 2025, the Government announced significant NHS changes and cost-reduction measures. These changes aim to streamline organisations, reduce duplication and spending and improve patient care.

The changes will fundamentally reshape how the NHS operates at a national and local level.

The Government announced plans that NHS England would be abolished and absorbed into the Department of Health & Social Care within two years NHS. The aim is to reduce duplication and running costs, ensuring more funds are directed towards patient care.

It was also confirmed that Integrated Care Boards (ICBs) will be required to cut their running costs by 50% by December 2025 as part of a drive to reduce costs and simplify the roles and responsibilities of the different parts of the NHS.

All trusts and systems will be required to reduce their financial deficits as no new national money is being made available to plug the gaps. There is also a target for all Trusts to reduce the growth in workforce that has taken place across the NHS since the pandemic in 'corporate and non- patient supporting roles' by 50% by the end of the year.

We knew this coming financial year would be a very challenging one, and it has been made even more so by national and international events.

There has been a series of well-attended staff briefings and published frequently asked questions, and we will continue to engage and involve colleagues across the organisation as more clarity is received.

1.2 Supreme Court ruling -Equality Act 2010

In April the UK Supreme Court made a ruling regarding the legal definition of a woman under the Equality Act 2010. This judgement will understandably have caused uncertainty and worry for members of our Trans community, including our colleagues and patients.

We anticipate some updated national NHS guidance to help ensure a consistent approach across the NHS and we will work in partnership with our Inclusion Network to review what aspects of our own practice we may be required to adapt following this legal ruling.

This judgement will understandably have caused uncertainty and worry for members of our Trans community, particularly our colleagues and patients.

Over the coming days and weeks, we will continue to review how the ruling will impact UK law and other national guidelines and best practices and we will respond appropriately.

1.3 Phlebotomy Industrial Action

The Trust wrote to UNISON on 11 April asking for an updated job description detailing the additional responsibilities that would require the role to be a band 3 and then offering to meet with them and calling on them to pause the action.

UNISON began industrial action of Gloucestershire hospitals phlebotomy services in March 2025, which has caused disruption for patients and staff and is presently continuing until at least 18 May 2025.

UNISON has argued that Phlebotomists at our hospitals are on the wrong banding, which affects their pay. Other local health services in Gloucestershire and the majority of other Trusts across the country pay the same as we do for phlebotomist roles.

This is a national, not local issue, and we have encouraged the union to raise it for review, rather than take industrial action that directly impacts patients.

All NHS Agenda for Change roles are matched to national role profiles, which have been developed with unions, and are regularly reviewed. This ensures consistency of pay and banding across the country. As a Trust, we pay in accordance with the Phlebotomists Band 2 National Profile.

The Trust has put in place staffing to cover the industrial action and ensure blood can be taken for our patients including general outpatient clinics and the Edward Jenner clinic.

1.4 OFSTED report for Little Oaks Nursery

The Trust delivers nursery and early years support for staff at our Little Oaks Day Nursery, and in March 2025 they received an OFSTED "Good" rating across all areas, including overall effectiveness, quality of education, behaviour and attitudes, personal development, and leadership and management.

The inspection report noted that the nursery offers a nurturing and welcoming environment where children are happy, engaged, and supported in their developmental needs.

The team were recognised for how they deliver a broad curriculum, fosters strong relationships with parents and professionals, and focus on the physical, emotional, and social development of the children.

Congratulations to all the team on their hard work.

1.5 HSJ Award - Community Ophthalmic Link project

Our Ophthalmic Imaging Team won a joint award at the recent HSJ Partnership Awards with a number of partners for 'Most Impactful Use of Technology' for the Community Ophthalmic Link (COL) project. The project, the first of its kind in the country when it was launched three years ago, enables secure data sharing between secondary and primary eye care, and has had a real impact—reducing referrals, cutting hospital waiting times, and saving £226,896. It is a great example of how technology and partnership working can benefit patient experience.

The system, OphthalSuite Community Ophthalmic Link, developed by BlueWorks OIMS alongside NHS Gloucestershire, Gloucestershire Hospitals NHS Foundation Trust, and Gloucestershire Local Optical Committee, enables community optometrists to access patient's eye health records quickly and securely.

Launched across Gloucestershire in 2022, it enables community optometrists to access secondary care (hospital) eye examination results in real-time, and search information and statistics, including comparing all exams and ophthalmic imaging taken over different periods. Clinicians also have secure access to view patient's ophthalmology data including photos, scans, videos, metadata, GP letters and care plans.

The success of the project means Gloucestershire is the first area in the country to provide complete digital records to optometrists working in the community, which has a direct impact on improving referrals and quality of care across the county.

1.6 Anaesthesia Clinical Services Accreditation (ACSA)

The Trust's Anaesthetist Department have achieved the prestigious Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (ACSA), for its anaesthetics and allied peri-operative services, becoming the 55th UK department to do so.

This achievement reflects years of hard work, including significant changes to practices and policies and also demonstrates the continued high standards of care. The department has had to manage the Covid pandemic, a significant increase in demand, as well as the wider challenges the NHS has experienced since they started out on the ACAS pathway in 2021.

There will be a ceremony in Cheltenham on 8 July 2025 where the Royal College will formally present five plaques for each of the service teams based in Cheltenham, Cirencester, Gloucester, Stroud and Tewkesbury.

1.7 Young Influencers

The Trust's Young Influencers organised a sponsored relay in April to raise money for the 'Lions at Large' Big Space Appeal. Despite some bad weather on the day, 11 Young Influencers were on site at Gloucestershire Royal and supported staff and the public in taking part in the relay.

The lion sculpture was also an important attraction and the Young Influencers supported over 50 staff and over 100 patients and community members to put their fingerprints on the mane and to also suggest a name.

The team raised £862.64, exceeding their £750 target which is a phenomenal achievement.

The Young Influencers will be organising at least one more event, where they plan to wheel the lion to different waiting rooms and departments and invite more people to add their fingerprints to the sculpture and get involved in the Big Space Appeal.

2 Performance

2.1 Urgent and Emergency Care

Following a difficult Quarter 4 (January to March 2025), the Trust was able to recover on most of our performance areas. The daily attendance to our Urgent and Emergency Care services increased slightly with an average of 444 per day in February compared to last year (an increase of around 25 per day) and Monday 31st March saw the highest number of patients in the last 12 months with 504 attendances.

Over the last financial year 2023-2024 the Trust was not able to consistently meet its performance against the 4-hour standard, and we know that patients in some parts of our community often had limited access to Ambulance services. This was particularly evident in the response times for Category Two emergency calls (ie stroke patients) which should be responded to within 18 minutes, but the average time was at times over 100 minutes making Gloucestershire an outlier nationally.

Our two hospitals receive on average 3000 ambulances per month and this has impacted on handover delays. Following a difficult summer in 2024, where ambulance delays peaked at 183 hours lost in a single day the Trust has reduced these delays to a total 53 hours per day (for an average delay of 46 minutes). This is slightly above the new national maximum of 45 minutes per ambulance. A greater proportion of ambulances are being offloaded by the 15-minute standard and improvements have been demonstrated in all other offload indicators showing a real improvement

in all areas. By comparison, in April 2024 220 patients had a delay of over 4 hours waiting to be offloaded, and in March 2025 this was down to 14, with the aim of reducing this again. When flow out of the hospital is compromised, for example by poor discharges, infection outbreaks or high numbers of patients without meeting the criteria to stay in an acute bed (nCTR), our ability to offload into an already crowded department is compromised.

In October working with colleagues from the Ambulance Trust, we commenced the THP90 programme and have consistently (with one or two challenging periods) been able to deliver better offload times whilst seeing higher numbers of ambulance conveyances month on month. By the end of April 2025 we hit our 60-minute maximum offload time, and by the end of May we aim to be at 45 minutes. Our teams are now being approached by other Trusts in England to learn how we have sustained improvement and deal with those challenging days, which will happen but are far less impactful on our communities and patients than they were previously.

We have not boarded patients on our ward corridors since July 2024. However, it is recognised however that we have had to deliver some elements of care in our assessment and emergency care settings at time of extreme demand, but the use of Temporary Escalation Spaces (TES) is measured in minutes and not hours and days as it would have been previously.

However, there remains a significant challenge for the Gloucestershire System with an increase in Non-criteria to reside (NcTR) patients waiting to be discharged to another care setting, which is above our target and sits at around 140 currently. We continue to discharge over 100 patients home every day and require our colleagues in the system to help us discharge a further 20 patients each day. Compared to December when none of the 15 improvement measures showed deterioration against the November position, 11/15 measures showed improvements. Those indicators showing deterioration relate to increases in activity measures.

2.2 Elective (Planned) Care

There is continued progress with elective recovery. The Referral to Treatment (RTT) percentage improved, moving from 66.91% in January to 68.68% in February, although improvements continued to be made in reducing the number of patients waiting 52 weeks or more.

The Trusts performance against the rest of the South West region remains favourable, particularly in relation to RTT performance and 52-weeks as a percentage of incompletes. Many Trusts have remained relatively static on 52-week waits, where GHT has made reductions. The unsubmitted March month-end position suggests the Trust will finish the year with 125 reportable 52-week breaches, compared to 588 submitted in February – we were at c2,800 at the start of 2024/25.

In conjunction with reducing the risk of 65-week breaches, considerable focus has been placed on reducing those patients waiting 52 weeks or more. At January month-end the validated position was 946 patients breaching this standard, compared to 1,256 in December and 1,479 in November.

3. Quality & Safety

3.1 Clinical Vision of Flow (CVOF)

During the 8 Days of Spring 2025, the Clinical Vision of Flow (CVOF) programme continued to actively test and implement new ways of working to improve hospital flow. This seasonal initiative brought together teams across the hospital to trial new ideas, strengthen collaboration and identify ways to improve patient flow and overall experience.

Key highlights included the relaunch of ED huddles with a renewed focus on safety and team communication and the pilot of the Renal Assessment Procedure Unit (RAPU) to fast-track

assessments and support same-day discharges, in addition to a renewed emphasis on timely TTOs (To Take Out medications) to help patient discharges run more smoothly.

A significant focus of this event was to embed our Patient Pact with clinical teams. Developed through CVOF workshops and refined with input from multiple staff groups, the Pact serves as a guide that supports our teams to deliver the exceptional care we aspire to offer every patient.

3.2 Pharmacy Manufacturing Unit

Following a routine inspection of our sterile production facilities on Wednesday 16 April 2025, the Trust temporarily paused the production of Systemic Anti-Cancer Therapy (SACT) at our Pharmacy Manufacturing Unit (PMU) at Cheltenham General Hospital as a precautionary step.

This does not affect the safety or effectiveness of any SACT treatments already given or those due to be given in the coming days.

We are sourcing SACT medicines from our external partners to ensure continuity of care for patients. A small number of patients had their appointments rescheduled and additional appointments were made available on Avening Ward over the weekend of 26–27 April 2025.

We are working to restart the in-house production as soon as possible, although it may take time and our approach was a precaution to ensure the highest standards of patient safety.

3.3 New Movements Matter campaign launched

The Gloucestershire Local Maternity and Neonatal System has launched a new campaign, #MovementsMatter, to emphasise the importance of monitoring baby movements during pregnancy. This campaign aims to encourage pregnant individuals, along with their family and friends, to contact Maternity Triage if they have any concerns about the baby's movements.

The campaign's primary goal is to ensure that parents-to-be are vigilant about their baby's movements from around 16 to 24 weeks of pregnancy and addresses common hesitations from people who may feel reluctant to contact healthcare providers about changes in baby movements.

The work by LMNS is to raise awareness and ensure, if there are any concerns, to encourage people to call and get checked rather than risk the baby's health. The campaign also aims to correct outdated and incorrect advice, such as the misconception that baby movements slow down towards the end of pregnancy due to lack of space. Additionally, it advises against using home Dopplers as a means of reassurance, as hearing the baby's heartbeat does not necessarily indicate that everything is well.

Information and advice on monitoring baby movements has been published online at www.gloshospitals.nhs.uk/movements-matter.

4. Strategy

4.1 Cancer Care on the Move: mobile cancer care unit

A new mobile cancer care unit officially launched in Gloucestershire on 15 April, continuing to bring life-saving cancer care closer to cancer patients across the county. The unit, provided by the cancer care charity Hope for Tomorrow in partnership with the Trust, will offer patients a more convenient, accessible, and comfortable way to receive vital treatment in their local community.

Originally launched in 2007 as the world’s first mobile cancer care unit, the unit has played a crucial role in supporting NHS oncology and cancer services in Gloucestershire for over 17 years.

Following fundraising by Hope for Tomorrow, the previous vehicle has been replaced and continues to provide state-of-the-art access, supporting an average of 20 patients per day. Over the past year alone, more than 1,820 patient visits have taken place on board, reducing pressure on hospital oncology departments and helping patients avoid unnecessary travel and the associated time and costs.

4.2 New MRI scanner at Cheltenham General Hospital

The Trust has secured a new state-of-the-art MRI scanner, marking a major upgrade in the hospital's diagnostic imaging capabilities at Cheltenham General Hospital.

The new GE Signa Voyager MRI system replaces the previous scanner, which had served CGH for over 12 years and was at the end of its life. Expertly craned into place following meticulous coordination by the Capital team, the scanner installation included vital chiller system updates to ensure optimal performance.

Staff training is set to begin on 4 May and the new scanner is expected to be fully operational and open for patient use from 21 May 2025 and will restore Cheltenham's MRI capacity to two scanners, significantly enhancing diagnostic precision and supporting high-quality patient care. The new MRI not only offers improved image quality and faster scan times but also enhances MRI capacity across the county.

5. Regulatory

5.1 Care Quality Commission

The Trust is expecting the delayed CQC Inspection report into Medical Services at Cheltenham General Hospital to be published before the summer.

Kevin McNamara
Chief Executive

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – APRIL 2025

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting will be available shortly.

The Committee was reminded of the limited assurance in the annual head of internal audit opinion for the previous financial year. The reasons for these have been well rehearsed and delivering sustainable improvements against these remains a high priority for the work of the Committee to do better in our responsiveness, remaining on top of recommendations and agreed time scales. Pleasingly, the agenda featured the draft Head of Internal Audit opinion for 2024/25 and at this stage, the Trust is on track to get back to a moderate level of assurance. This will remain provisional pending the completion of some final work relating to 2024/25 but it is an excellent outcome and the Committee wishes to record its thanks to the Executive team and to all who have contributed to this improvement in the overall governance position. The Committee received positive messaging on the various improvement themes from the internal audit representatives and we need to ensure that we remain consistent in our delivery against management actions and show similar vigilance against follow up actions. There is still much to do to build on this work but it is a very solid platform on which to further develop this work.

The Committee received three final internal audit reports, all of which were rated as moderate for design and operational effectiveness. These included Data Quality Cancer Waits, Data Quality Provider Workforce return and Workforce controls. All reports provided helpful challenge and effective responses to the findings.

The Committee also received a thought piece from BDO in respect of Green Plans and the questions that Audit Committees should be asking. It was agreed that a report responding to these questions would be provided to a future meeting of the Committee.

In respect of follow up work, good progress was reported with further work required around GMS assurance mapping and Freedom to Speak Up. Both items are expected to be completed by end of May, failing which the relevant Executive lead will be requested to attend Audit and Assurance Committe to explain the reasons for non-compliance.

The finalised Internal Audit Plan for 2025/26 was endorsed by the Committee following executive refinement of some elements following the February meeting. The plan has been the product of extensive executive engagement and provides broad and effective coverage across the key functional areas of the Trust with good coverage of patient facing and focussed services.

The last KIAR referenced the Committee dealing with a confidential matter. This has been incorporated into the work plan for 25/26 and 26/27

Items rated Red

Item	Rationale for rating	Actions/Outcome
	There were NO items rated as RED	

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit	**Three final reports**, Data Quality Cancer Waits, Data quality Provider Workforce Return and Workforce control all rated moderate for design and operational	Ensure delivery against agreed outcomes in the management responses.

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

	effectiveness. Rated amber pending delivery of management actions	
	Follow up report – Generally looking much better and clearly a lot of work has gone in to get us to this point. There are four long standing management actions outstanding, Follow up work is taking place prior to the next meeting of the Committee to address and close off these items. If not closed, given extent of slippage, lead Execs will be invited to attend the next AAC meeting to explain why.	Good sustained progress and delivery of the annual plan. This needs to be sustained into the future to avoid any possibility of a further limited assurance. Corporate governance and Finance will follow up on these matters
Board Assurance Framework (BAF) and Risk Register	**Board Assurance Framework and Risk Register** Currently under review and the Committee had an update on progress to date. No movement in risks position. Several Committee members commented on the dissonance between some current risk scores and target scores.	Committee will receive an update on proposed revised ways of working at its next meeting.
Modern Slavery and Bribery and Corruption statements	Modern Slavery Statement and Bribery and Corruption statement were both endorsed by the Committee for approval by the full Board	Pending approval by the full Board
Annual report update	This item focussed on the first draft of the Annual Governance Statement. The Committee provided extensive feedback on the draft and clearly conveyed that the AGS should be positive in tone and should reflect and give credit for the progress that has been made since 2023/24.	Revised draft to be circulated and will be endorsed for approval at the June meeting.
Review of ToRs and effectiveness	Both will be progressed between meetings.	Committee members to comment and submit responses
Unaudited A/Cs	Update from the Director of Finance on the positive outturn for the Trust and system in respect of capital and revenue	Audited A/Cs will be scrutinised by the Committee and endorsed for approval by the Board
Items Rated Green		
Item	**Rationale for rating**	**Actions/outcomes**
Head of Internal Audit Opinion. **Rated as green** given the significance of this achievement. The annual opinion is moderate as opposed to substantial and under normal circumstances this would probably warrant amber. However, it is very important to formally recognise the substantial progress that has been made over the past 12 months compared with the position at the end of 23/24 and the significance of this achievement. It is very pleasing that BDO have provided this independent validation of the progress that has been made and this outcome should rightly be celebrated. Congratulations and thanks to the entire Executive team and to all who have contributed to this significant step in the right direction.		
High quality papers – as usual, circulated well in advance of the meeting which made prep easier.		

Follow up actions between meetings – Very good progress in year. Focus needed on historic 2023/24 actions
Good focus on non-traditional audit Committee areas, with focus on patient added value
Matters arising. No outstanding matters on this occasion
External Audit brief time table was received which detailed the approach for the forthcoming external audit and time line to deliver end June approval by Board. The external auditor confirmed that at this stage there are no concerns to share and that she and her team are getting good cooperation from the finance team and communications between both parties are working effectively.
Counter Fraud report – Excellent, clear digestible report. Good progress reported against various ongoing cases. Evidence of added value particularly around input to raising fraud awareness across a range of staff groups. Currently on track for a good year end counter fraud annual outcome
Single tender actions report – a slight uptick in the volume of single action waivers reported, all with accompanying justifications. However, the Committee felt that it would be appropriate to undertake more of a deep dive into the rationale for the uptick at a forthcoming meeting
GMS - There was no business specifically related to GMS on this occasion
Losses and compensations – low levels of losses and compensations were approved

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to the Board of Directors			
Date	8 May 2025		
Title	Health and Safety Compliance - Annual Health and Safety Report - Health & Safety Management Framework		
Author / Sponsoring Director/ Presenter	Lee Troake, Head of Risk and Safety Kerry Rogers, Director of Integrated Governance		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	
Regulatory requirement	✓	To highlight an emerging risk or issue	✓
To canvas opinion		For information	✓
To provide advice		To highlight patient or staff experience	✓

Summary of Report

The Board has ultimate accountability for health and safety and must exercise proper oversight of the system as a whole. The Annual Health and Safety Report for 2024/25 is presented to the Board to assist it in discharging its duties. It evaluates our alignment to health and safety regulatory requirements and internal governance. The components of the report collectively provide a picture of the Trust's compliance status, areas of risk, and forward-moving strategies and provides analysis of standards of health and safety management throughout the Trust during the reporting period.

Board members have a crucial role in overseeing health and safety performance and the Board should ensure it is confident in the integrity of the report. Members should acknowledge the range of challenges highlighted in the report and satisfy itself of the ability to improve in relation to the on-going activities to strengthen compliance and good governance.

H&S Annual Report 24/25
The report has been presented to the Group Health and Safety Committee (Group H&SC) in April, where all elements of the report were acknowledged and accepted with the exception of the RAG rating given to water safety. Representations were considered as to whether the status reflected the improvements made in this area over the past 18 months. The report was presented and was discussed further at TLT, including the request to review the water safety RAG. Risk, Health and Safety confirmed their rationale to include recognition of a water audit that was also underway to establish the overall compliance of the water management system. It was agreed by TLT that the RAG should remain amber.

The Board is invited to approve the assurance rating and compliance status as reported and recommended by TLT which is summarised below. The Board is asked to acknowledge areas RAG-rated red within the report which include resources, control of hazardous substances, health surveillance, fire, asbestos management and surveys. High-risk incidents also include abuse, aggressions and violence, blood borne viruses through sharps injuries and splashes, and falls from height in the Tower.

Topic / area	Assurance rating
H&S Policies – up to date	
H&S Governance	
H&S Resources	

Risk Assessments	
Control of Hazardous Substances Assessments	
Control of Hazardous Substances - Ventilation	
Health Surveillance	
Fire Safety	
Water Safety	
Asbestos Management	
Surveys	
V&A	
Sexual safety	
DSE	
Workplace Inspections	
Consultation	
Work-related Stress	
Training for employees	

Given the number of high-risk areas that require attention, TLT agreed that the current Health and Safety Plan 2024-2026 would be suspended to ensure Trust resources are able focus on, and oversee, actions around asbestos management, fire and water which are currently managed by the subsidiary, as well as other high-risk areas. An interim 12 months jointly agreed Plan will be presented to TLT in June 2025.

H&S Management Framework
The Board is also required to note that the new health and safety governance structure came into effect from 1 April 2025. The revitalised and re-branded Group H&SC will report to the TLT and provide assurances to the Audit and Assurance Committee (A&AC) with regard to the effectiveness of the system of control to manage H&S compliance. This governance road map should help to achieve group-wide optimisation in health and safety decision-making and an agile environment in which to execute improvements.

The success of the framework relies on achieving improvements as highlighted in the Annual Report which includes a clear contractual agreement between the Trust and its subsidiary which outlines in greater detail than at present the role and responsibilities of each. The current SLAs do not provide this clarity and it is important that the contractual terms are revised, with priority and urgency given to the areas of fire safety, water management, asbestos management and ventilation.

The March Board meeting approved the direction of travel as part of consultation on the Management Framework, which was subsequently approved by the Trust Leadership Team for adoption. The final Framework document is included for reference in the attachments to this report.

Risks or Concerns

As outlined in the Annual Health and Safety Report 2024-25

Financial Implications

Any costs to improving compliant status will be considered as part of normal financial governance and scrutiny.

	Date:

Recommendation

The Board is invited on the Trust Leadership Team's recommendation to:

i. Review the annual health and safety report and confirm commitment to ensuring a safe and healthy workplace for all employees and visitors by supporting the improvement activity highlighted.

ii. Confirm it is assured that the key areas of improvement activity will address any shortcomings identified in the report.

iii. Confirm it is assured that implementation of the new Health and Safety Management Framework will support the Trust and its subsidiary to address the specific risks identified in the report, and

iv. Support urgent revision to the contract with GMS in relation to fire safety, water management, asbestos management and ventilation to ensure roles and responsibilities and expectations are clear

v. Recommend and / or take any additional actions as it sees fit, to address issues highlighted.

Enclosures

Annual Health and Safety Report 2024-25
Appendix 1 – Progress Against Year 1 Objectives and Targets 2024-25
Appendix 2 – Survey List
Health and Safety Management Framework and appendices 1-4

Annual Health and Safety Report

April 2025

TROAKE, Lee (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST)

1. Introduction from the Chief Executive

It can be the case in NHS organisations that when we talk about safety, we often only view it through the lens of clinical safety. However, the broader Health and Safety agenda has a critical role to play in ensuring that both patients, staff and visitors can access our services in a way that is as safe as possible.

Since joining the Trust in January 2024 one of the key areas of focus has been to get a good line of sight on health and safety issues and to set out clear governance and a plan for how we will address issues and shortcomings in our approach to Health and Safety. In a Trust that has a significant backlog maintenance challenge and an ageing estate, some of which dates back to 1848, health and safety is both a bigger priority and a bigger challenge.

This report therefore provides an overview of some of those challenges that we have been managing during the course of 2024/25. It also provides clarity on the Health & Safety priorities for this new financial year so that for those areas where further work is required to meet relevant standards, we can demonstrate progress to our colleagues and the wider public.

Whilst the challenges are significant, unfortunately they are not unlike many parts of the NHS, and we are committed as a Trust Board to prioritising many of the issues contained in this report to improve safety for everyone that uses our services and our buildings.

Kevin McNamara

Chief Executive Officer

2. Purpose

This report is presented to advise the Board of the health and safety performance of the Trust for 2024/25 and outlines adherence to health and safety regulatory requirements and internal governance. The components of the report collectively provide a snapshot of the Trust's compliance status, areas of risk, and forward-moving strategies and provides analysis of standards of Health and Safety management throughout the Trust during the reporting period. The report highlights the essential policies, procedures, and controls implemented to manage compliance and contains essential data, performance metrics, and trend analyses to provide valuable insights into the Trust's compliance trajectory.

It is important that members of the Board seek assurances that health and safety activities are supporting improvements in the management of health and safety and as such the report includes:

- The health and safety system, including areas of low/non-compliance as outlined below
- Effectiveness of existing management controls
- Regulatory compliance: adherence to legal and industry-specific standards
- Identification of employee training needs to create a safer working environment.

From 2025/26 the H&S Annual Report will be produced on a Group basis and will also incorporate H&S obligations concerning our PFI provider.

3. Compliance Obligations

The primary health and safety legislation is the Health and Safety at Work etc Act 1974, which places general duties on employers to ensure the health, safety, and welfare of their employees and others who may be affected by their work activities. The Management of Health and Safety at Work Regulations reinforce the provisions of the Act and specify what employers should do to protect the health and safety of people while at work. These include key employer responsibilities such as risk assessments, a safe workplace, training and information, consultation and welfare provisions. Other regulations that are applicable to the Trust include, but are not limited to:

- Workplace (Health, Safety and Welfare) Regulations 1992
- The Health and Safety (Display Screen Equipment) Regulations 1992
- The Manual Handling Operations Regulations 1992 amended 2002
- The Regulatory Reform (Fire Safety) Order 2005
- The Work at Height Regulations 2005
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)
- The Personal Protective Equipment at Work Regulations 1992
- COSHH (Control of Substances Hazardous to Health) 2002
- The Provision and Use of Work Equipment Regulations 1998 (PUWER)
- Lifting Operations and Lifting Equipment Regulations (LOLER)

- The Working Time Regulations 1998

Some areas of law are supported by healthcare technical memorandums (HTMs) which set out a route to compliance e.g., fire, water, ventilation.

A compliance RAG rating has been applied to relevant sections to provide a transparent evaluation. The definitions of Red, Amber and Green are shown below:

Red	Amber	Green
•Indicates significant issues requiring immediate attention	•While not critical yet, signals potential problems or deviations from requirements and warrants closer monitoring / action	•Compliance assured and proceeding as planned

4. Policies and procedures

The Trust's arrangements in relation to its Occupational H&S Management system are set out in its Health and Safety Policy (B0403). This includes a statement of intent, roles and responsibilities and a broad outline of our arrangements for risk assessment, inspections, COSHH assessments, safety information and training, consultation, PPE, and first aid provisions. The Policy is underpinned by a suite of 14 legislation-specific policies and procedures which provide more detailed guidance for the implementation of our arrangements. All polices are currently in date.

The Health and Safety Policy will be due for renewal in July 2025 and is already under review as part of a wider refresh of the governance structure supporting the introduction of the H&S Management Framework.

RAG: Green

5. Health & Safety Management & Governance

A recent refresh of health and safety governance stems from weaknesses relating to oversight of the Trust's subsidiary along with a renewed focus through a change of executive leadership. This has led to a welcome emphasis on 'Group' governance, accountability and responsibility. It has become clear that responsibilities within the Group required further clarification and that the current reporting structure did not fully support a transparent and open approach to identifying gaps, particularly in areas delegated to GMS, and seeking improvement.

The new Health and Safety Management Framework intends to provide the Trust Board with clear oversight of health and safety compliance and to promote a collaborative approach with synergy-generating measures to health and safety issues. This governance road map should help to achieve group-wide optimisation in health

and safety decision-making and an agile environment in which to execute improvements.

Whilst the Trust remains the duty-holder in law for the health and safety of its staff, patients and public, the framework sets out the roles and responsibilities of GMS operating as a controller of our premises with contractually delegated duties. As a separate legal entity, GMS also remains a duty-holder as employer of its own staff.

The Trust's Health and Safety Committee Chair changed in year, with the Director of Integrated Governance taking over the role from the Director for People and OD. As of April 2025, the Trust Health and Safety Committee, which has always been attended by GMS, will re-branded and re-established as the Group Health and Safety Committee (GH&SC). Upward reporting from the Committee will move from the People and OD Committee, which did not include GMS representatives, to the Trust Leadership Team (TLT) and twice yearly to the Audit and Assurance Committee (A&AC), which in turn report to the Trust Board. GMS compliance reporting will be transferred from the Contract Management Group to the GH&SC to give greater exposure to compliance issues affecting health and safety. The Trust Board and GMS Board will be expected to co-operate on health and safety matters. As a separate legal entity, however, GMS will retain its own internal health and safety reporting structure and is both responsible for, and in control of, the manner in which it implements safety within its organisation.

The clarification of roles and responsibilities has thrown a greater spotlight on the broad approach of the existing Service Level Agreements (SLAs) which form the contract with GMS. There is insufficient detail on the obligations, quality standards and commitments of each party to guarantee the standards to be upheld and provide a detailed framework of expectation. Suitable and sufficient SLAs act as both a tool for compliance checking and a barrier to unreasonable client demands, which would safeguard both the Trust and GMS. It is important that SLAs are reviewed and aligned to the requirements of any legislation, Healthcare Memorandums (HTMs), or other key guidance where the Trust has delegated duties to GMS and this work began in 2024/5 following the external review of the subsidiary arrangements.

Forward-focussing, the 2025-26 programme of work to continue activity to improve and enhance governance will include:

- Approval of recommendations of named lead executives and lead sub-board committees for each HTM and identification of individuals for the various roles under the HTMs
- Clarification of Responsible Persons (RPs), Deputy RPs, Appointed Persons and Authorised Engineers (AE) to be held centrally for each HTM
- Authorised Engineer (AE) annual audits to be considered at Group H&S Committee, TLT & Audit & Assurance Committee for greater transparency and oversight
- HTM Sub-groups to:
  - Review the relevant policy and procedures, roles & responsibilities to align with the HTM and legislation
  - Review its TOR in line with the HTM and legislation
  - Standardise reporting templates and confirm standing agenda items

- Confirm last annual AE audit

RAG: Amber

6. Health and Safety Resources

As an employer, the Trust must appoint a competent person or people to help meet its health and safety legal duties. The Risk, Health and Safety Team is responsible for the safety management system for approximately 8000 staff, all visitors and the environmental safety of all patients. Over a six-year period the team has consistently struggled to recruit and retain sufficient qualified and experienced health and safety advisors. This is in part due to the dual role of the team, which includes responsibility for the risk management system also.

There are some issues to resolve regarding resourcing of the team. Whilst there is confidence these matters are now close to resolution, until they are, the risk of being unable to deliver the improvements required, as well as ordinary business remain, only in part mitigated by the strengthened focus and developments achieved through the last 12 months.

RAG: Red

7. Risk Assessments

In order to manage health and safety across the organisation, we must control the risks in our workplace. To do this we need to consider what might cause harm and decide whether we are taking reasonable steps to prevent that harm.

The Management of Health and Safety at Work Regulations require the Trust to carry out risk assessments and make arrangements to implement necessary control measures. The Trust's arrangements for risk assessments are detailed in B0636 Risk Assessment which was reviewed in August 2024. Clinical and non-clinical departments are required to have a suite of essential risk assessments in place, plus any additional assessment pertaining to their local activities. These are stored online on a SharePoint site to allow 24/7 access. There are 3300 risk assessments on the site. However, the proactive management of these is significantly affected by the inadequate functionality of a basic SharePoint site.

The Health and Safety Strategy includes an objective to improve the quality of risk assessments. Two key areas audited in 2024-2025 included electrical safety and slips and trips. Findings from the audits is provided to the divisions to support local improvements. Common themes included not identifying localised hazards, inconsistent scoring, and lack of follow-up on actions. This has prompted a further push to ensure staff carrying out risk assessments in each department are trained.

The number of staff attending risk assessment training has increased, with a total of 237 staff now trained. Overall, 54% of departments have one or more individual trained to carry out risk assessments. D&S, Surgery and Medicine have achieved this in 65-69% of their departments, while W&C have reach only 29% and corporate 9%.

Year	2021	2022	2023	2024
Number trained	50	48	76	63

RAG: Amber

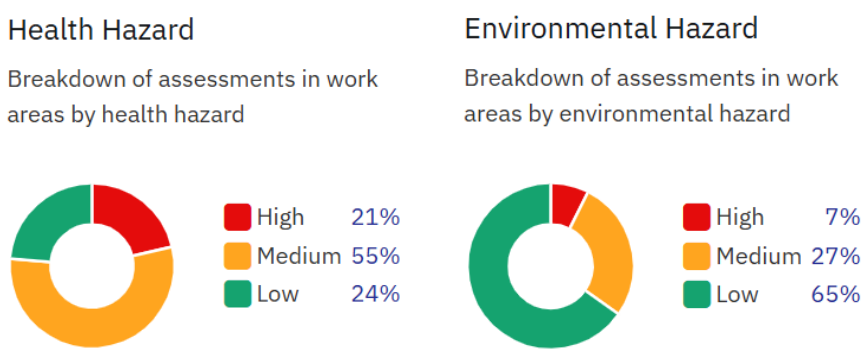
8. Control of Substances Hazardous to Health

The Control of Substances Hazardous to Health Regulations (COSHH) require the Trust to assess the hazards from substances we use or create (COSHH assessment) and adequately control them. Where controls include local exhaust ventilation (LEV), this must be maintained in line with the regulatory requirements. Staff must also be given training and information on substances and provided Personal Protective Equipment (PPE). In some instances, medical monitoring and health surveillance is required.

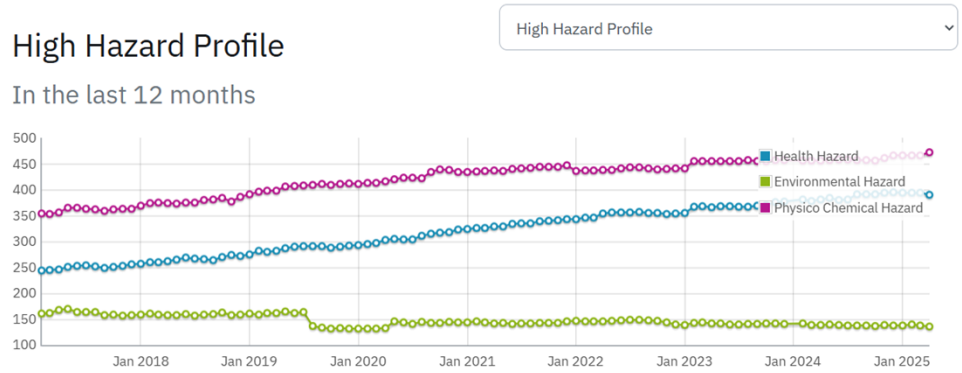
COSHH Assessments

The Trust's arrangements for hazardous substances are outlined in COSHH Policy which was reviewed in February 2025. All COSHH assessments are produced and stored on an online platform, Sypol. The system holds assessments on 1255 substances and has over 1800 COSHH assessments (some substances have additional assessments for different uses). The Health and Safety Strategy includes an objective to review and improve high-risk COSHH assessments and called for re-structure of the system to support user access.

An audit of our COSHH assessments in 2024 demonstrated that the majority of substances used have a suitable COSHH assessment and assured an overall compliance with this requirement as good. However, it was identified that a small number of the high-risk substance assessments would benefit from more detail in relation to the control process. 21% of substances are categorised as high risk to health, and 7% as high-risk to the environment.



Substances with a high health hazard profile have steadily increased over the last five years with the largest increase between 2019 and 2021 (pandemic period). These include substances such as Entonox, Actichlor and Formalin. Work will continue into 2025-2026 to reduce the number of high-risk substances if reasonably practicable.



To seek further assurance as to the accuracy of the assessments on Sypol, all departments were asked to complete a local inventory of COSHH substances. All departments in the Medical Division have responded. However, there have been 30 of 42 returns in D&S, 18 of 49 in Surgery and 3 or 4 in W&C. Returns will be pursued over the next few months.

RAG: Amber

COSHH Controls

Whilst the majority of substances are well-controlled, an area of concern remains the adequate implementation of required ventilation. The Risk, Health and Safety team have again escalated breaches to the Ventilation Group during this reporting period in relation to Nitrous Oxide, (N_2O), found in Entonox, a commonly used pain relief gas in labour and delivery suites and in other internal examination procedures such as Endoscopy and Gynaecology.

Personal monitoring completed in Maternity in 2023 highlighted that staff are exceeding the legal working exposure limit (WEL) for N_2O, which can lead to neurological symptoms and anaemia through prolonged or significant exposure. Monitoring was also undertaken in Stroud Maternity which showed the WEL had not been exceeded. However, the staff did not wear the devices long enough for an 8hr Time-Weighted Average (TWA) to be measured and monitoring will need to be repeated to confirm the results. In January 2024, Endoscopy undertook personal monitoring in relation to Entonox exposure and was also in breach of the WEL. Gynaecology, who came forward during the COSHH work programme, is due to commence monitoring shortly.

Some progress has been made in reducing the risk. The Entonox manifold in the CGH Birth Unit which was not in use and was emitting around 325,000 litres of N_2O a year has been decommissioned. An application will also be made for national funds to carry out yearly leak testing of the manifold in GRH. Steps have also been taken in all areas

to introduce masks for patients using Entonox, to re-position staff away from the high-risk zone where possible and to improve the air exchange in rooms.

However, in all areas the function of the local exhaust ventilation (LEV) is required to dilute the concentration of N_2O so that it remains below the WEL. A report was submitted to the Ventilation Group in summer 2024 which highlighted continuing non-compliance with the LEV requirements. Within Maternity, the Trust has recently invested in environmental technology aimed at improving both the safety of midwives and protecting the environment. A carbon destruction unit (CDU) has been installed which is designed to counteract the harmful effects of nitrous oxide by removing it from the air and reducing staff exposure. This new technology is also part of a wider commitment to make a significant contribution to the NHS's goal of achieving net-zero carbon emissions by 2050. The CDU collects and breaks up the Entonox, a greenhouse gas 300 times more potent than carbon dioxide, into harmless gases. Staff are currently being trained to use the new equipment effectively.

Funding has not been allocated to resolve the breaches in ventilation standards in Endoscopy and Gynaecology which have no low-level extraction as required.

Failings in Theatres ventilation also remains an issue and are well-known to the Trust. Ventilation is essential in extracting airborne contamination and hazardous substances such as anaesthetic gas. It protects both staff and patients. Some of the theatre ventilation has been addressed over the last year, while other theatres are to be included in future estates plans.

The Ventilation Group are supported by a newly appointed Authorised Engineer (AE). The Group has prioritised work around Theatres 3 and 4, with verification tests being carried out in March and the results pending from the analyst. There are currently five air handling units (AHUs) that are at end of useful life and five that are rated poor against the compliance rating, all of which should be on the replacement list. Four AHUs are marked as non-compliant with the HTM which indicates these units do not meet the air exchange rates they were designed to deliver. A ventilation sub-group will meet to review and confirm which AHUs will now be prioritised for replacement.

RAG: Red

COSHH training

Work is on-going to ensure all departments have an individual who is trained in COSHH and on SYPOL use. The target of 40% of departments or specialties for 2024-2025 has been achieved across the Trust. Some divisions well-exceeded this target e.g., Surgery achieved 76%, D&S 60% and Medicine achieved 47%. However, two divisions did not achieve it: W&C 25% and Corporate 4%.

Training opportunities will continue to be offered in 2025-2026 to improve this. To increase the ease of use of the SYPOL system, it has now been structured to accommodate separate folders for divisions and departments and provides a filterable

dashboard for tracking substances with acute, chronic, health and environmental impacts. Further information on incidents relating to substance exposure is provided in the incident analysis below.

9. Health Surveillance

Health surveillance is a system of on-going health checks designed to detect early signs of work-related ill health among staff exposed to certain health risks such as dermatitis, occupational asthma, or exposure to hazardous substances which can lead to cancer. The Trust is not assured that this data is being captured routinely by clinical departments, or stored correctly, and as such this became an objective within our Trust Health and Safety Strategy 2024-2026.

During the first year of this strategy, the Risk, Health and Safety team focussed on the proactive promotion of the health surveillance procedure at divisional bi-monthly health and safety meetings. This was effective in raising awareness and resulted in key areas implementing required health surveillance such as respiratory and noise monitoring. This work also prompted an increase in compliance amongst relevant service lines carrying out their health surveillance risk assessment. Currently, 77 areas have a health surveillance risk assessment.

Division	Health Surveillance Risk Assessment Completed	In Date
Diagnostics & Specialties	24 out of 38 (63%)	9 out of 38 (24%)
Women & Children	2 out of 12 (17%)	2 out of 12 (17%)
Surgery	29 out of 42 (69%)	24 out of 42 (57%)
Medicine	10 out of 28 (36%)	8 out of 28 (29%)
Corporate	None expected	None expected

The Risk, Health and Safety Team additionally led a targeted task and finish group to design a health surveillance application (App) which could be used for accurate recording and reporting. At present, records are held locally by line managers on their PC drives across the Trust and there is no central reporting and recording. This is a barrier to reliable evidence of compliance and hampers the Trust's ability to assure itself.

Work on the initial design of a health surveillance App was supported by the Business Intelligence Team. Following the first phase of design, five areas within the Trust tested the online forms. The test phase went well with positive feedback relating to ease of use. However, the Risk, H&S Team raised concerns relating to data protection, the management of the results and notifications. The Business Intelligence team are working on the issues raised and have contacted HR for further support. As an alternative, the Health and Safety Team, working with divisional and corporate leadership will focus heavily on compliance in this next year. A newly established Corporate Board, mirroring the process for monthly Executive Reviews with the clinical

divisions, will provide a much clearer mechanism under the Trust Performance and Accountability Framework (PAAF) to focus attention on improvements in this area.

RAG: Red

10. Fire Safety

The Regulatory Reform (Fire Safety) Order 2005 (FSO) is the main piece of legislation governing fire safety in buildings in England and Wales. The FSO applies to all workplaces and places legal duties on anyone in control of these premises to undertake and record a fire risk assessment and put in place and maintain general fire precautions. The Fire Safety (England) Regulations 2022 and s.156 of the Building Safety Act 2022 brought in additional duties for Responsible Persons under the Fire Safety Order.

The Trust is the Responsible Person in relation to fire safety law as the owner of the premises and the employer of staff. However, GMS also carry duties in relation to, and to the extent of, their control over the premises. The extent of those duties is currently under review and requires a clear SLA, as described above, to ensure that responsibilities are clear and standards are achieved and maintained. The revision of the SLA is a critical piece of work that should be aligned to the legislative requirements and the guidance in HTM05.

Fire safety has been identified as an area for improvement both through internal reviews and a Section 29a issued by the Care Quality Commission related to fire safety and evacuation within the Emergency Department, GRH. There are a number of 'live' improvement plans currently in place to respond to issues, concerns and risks.

In October 2024 a Quality Improvement Group (QIG) for fire safety was established, led by the Trust's Deputy Chief Executive, to draw together immediate improvements for fire safety. In December 2024 the Director of Improvement and Delivery and the Director of Integrated Governance established a task and finish group to oversee a review of governance and accountabilities for the key statutory requirements of fire and water safety. In order to determine broader compliance and assurance with the legislation and HTM05, a sub-group to the Fire Safety Committee was established known as the Fire Operational Delivery Group, to focus on key operational issues such as the replacement fire alarm, fire doors, compartmentation, training and evacuation.

There are currently 21 risks on the risk register associated with fire, several of which are highly-interdependent and should not be viewed in isolation. These have been reviewed with a view to amalgamating into a single overarching and comprehensive fire risk.

A review of the Fire Policy established the Chief Operating Officer (COO) as the lead executive for fire safety. The COO will lead on the revision of the SLA, and the work of the Fire QIG and T&F Group will be transferred to the delivery group in May, to create a singular improvement plan as a priority for 2025-26. To gain immediate

traction on more urgent issues a Fire Incident Management Team was established in the period under the COO.

Established areas of risk and compromise to compliance include:

- Age and condition of the fire alarm system
- Breaches in fire compartmentation e.g. penetrations where fire collars are not fitted or fire stopping is non-compliant
- Fire door damage and specification (minutes of resistance)
- Evacuation routes, signage and aids to facilitate evacuation
- Fire damper survey
- Fire loading control
- Lithium batteries located in non-rated compartments

A Retrospective Fire Strategy has been developed for the Trust. Its intention is to outline the requirements necessary to demonstrate that the current layout of the GRH Tower Block will satisfy the functional requirements of the Building Regulations 2010 regarding life safety in the instance of a fire.

RAG: Red

11. Water safety

The Health and Safety at Work etc Act requires the duty to ensure water is managed to prevent infection, and while the guidance in HTM04-01 is not statutory, in demonstrating that the Trust is closely following the document, it will generally be doing enough to comply with the law.

Following a patient safety incident in 2022, the Trust developed a number of actions designed to improve water management, the majority of which were completed during the period of this report. Improvements have included updating the Water Safety Policy, Water Safety Plan, Written Scheme and all associated procedures, improving communication between GMS and the Trust, improving record keeping and reporting, and sustained upskilling of staff to the appropriate level.

The work carried out on the Health and Safety Management Framework and for the T&F Group identified an opportunity for improvement in reporting lines from the Water Safety Group (WSG) to the Trust Health & Safety Committee. Whilst regular updates have been provided on the water safety action plan, general Water Safety Group assurance has been reported via Infection Prevention Control to the Quality Performance Committee and it is considered through the Framework, this will be strengthened by formal reporting by Infection Control from the Water Safety Group to Group H&S Committee.

By way of internal assurance, the Water Safety Group commissioned the GMS Compliance Manager to undertake an assurance audit against the HTM 04-01 standards. This is expected to be received by the Water Safety Group imminently.

The Authorising Engineer (AE) for water carried out an annual audit at the end of 2024. The draft report was presented by the AE to WSG on 25 March 2025 with the following summary:

Areas Audited	Legislation Compliance Last Audit	Legislation Compliance This Audit	Movement
Responsible Person Delegation	HIGH	HIGH	⇔
Water Safety Group	HIGH	HIGH	⇔
Water Safety Policy	HIGH	HIGH	⇧
Water Safety Plan / Written Scheme	MEDIUM	HIGH	⇧
Training Requirements	HIGH	HIGH	⇧
Legionella Risk Assessments	HIGH	HIGH	⇧
Legionella Risk Assessments Management	HIGH	HIGH	⇧
Pseudomonas aeruginosa Risk Assessments	HIGH	HIGH	⇧
Pseudomonas aeruginosa Management (Cheltenham)	HIGH	HIGH	⇧
Pseudomonas aeruginosa Management (Gloucester)	HIGH	HIGH	⇧
Ongoing Water Treatment Dosing Management	HIGH	HIGH	⇔
Planned Preventative Maintenance (Cheltenham)	HIGH	HIGH	⇔
Planned Preventative Maintenance (Gloucester)	HIGH	HIGH	⇔
Log Book Operation (Cheltenham)	HIGH	HIGH	⇧
Log Book Operation (Gloucester)	HIGH	HIGH	⇧
Flushing Regimes	MEDIUM	MEDIUM	⇔

The 2024 audit findings noted that flushing activities were reported to WSG but there was doubt as to the actual completion of the task. Flushing auditing within GMS had been recommended previously and was highlighted again in this audit.

The Trust has also commissioned an external water specialist to assess the robustness of our current water management system. This will provide an additional level of assurance through an external and independent assessment of our alignment to the HTM and the effectiveness of improvements implemented over of the last 2 years and support identification of other areas where there is opportunity to continue our focus on improvement.

RAG: Amber

12. Asbestos Management

For non-domestic premises there is a duty to manage asbestos covered under Control of Asbestos Regulations 2012. The purpose of this is to ensure that asbestos is maintained in a safe condition. Although all asbestos containing materials (ACMs) were banned from sale from 1999, many of the Trust's buildings pre-date this and still contain ACMs.

GMS is contracted to manage asbestos on behalf of the Trust. GMS held its first Asbestos Management Group meeting in October 2024, following a compliance audit report by the newly appointed authorised engineer (AE) for asbestos. The audit summary table, shown below, demonstrates that in 2023 compliance was rated as

inadequate overall. In the 2024 audit an overall rating of requires moderate improvement was given. The new H&S Framework ensures oversight through the H&S Committee and will, along with the Asbestos Management Group oversee the required ongoing improvements to demonstrably evidence compliance with the legislation and best practice in relation to asbestos.

Audit Summary Table

Areas Audited	Legislation Compliance Initial Audit – Aug 2023	Legislation Compliance This Audit – Sep 2024	Movement
Responsible Person Delegation	INADEQUATE	REQUIRES MODERATE IMPROVEMENT	→
Asbestos Safety Group	INADEQUATE	INADEQUATE	↔
Asbestos Policy	LOW	REQUIRES MODERATE IMPROVEMENT	→
Asbestos Management Plan	LOW	REQUIRES MODERATE IMPROVEMENT	↔
Training Requirements	INADEQUATE	INADEQUATE	↔
Asbestos Risk Assessments/Annual Inspections/Surveys/Register	INADEQUATE	LOW	→
Asbestos Risk Management/Emergency Planning	INADEQUATE	REQUIRES MODERATE IMPROVEMENT	→
Costed Asbestos Action Plan (PAM)	INADEQUATE	INADEQUATE	↔
Permits/Control of Staff/Contractors	INADEQUATE	INADEQUATE	↔
Staff Compliance	INADEQUATE	INADEQUATE	↔
Contractor Compliance	INADEQUATE	INADEQUATE	↔
Overall Conformance	INADEQUATE	REQUIRES MODERATE IMPROVEMENT	→

Of note, the 2024 audit indicates limitations in that not all areas had been surveyed in the previous survey and, in some instances, subsequent surveys had not always been undertaken for work likely to disturb asbestos or the fabric of the building – for instance for installing IT infrastructure. Where these were undertaken, they were not consistently added to the existing asbestos register.

As a result of the audit, an asbestos action plan has been developed to address compliance. Key next steps for 2025 include:

- Consultation via the Group H&SC on the revised Asbestos Management Policy - April 2025
- A revised asbestos management plan (AMP)
- Training of all staff working under the AMP
- Tightening of the permit to work system to protect contractors, maintenance and building users
- Asbestos management survey (currently underway)

Five asbestos-related incidents have been reported by GMS in 2024-2025.

- August 2024 (INC-7480) described as 'flooding and estates working on Asbestos tiles'. No evidence that asbestos fibres were released / exposure
- August 2024 (INC-7865) described that GMS staff engaged in removal work without checking the asbestos register. However, the investigation clarified the

register was checked and the work was completed by an asbestos removal company, no exposure occurred

- August 2024 (INC-8292) – windowsill missing an ACM sticker. The ACMs are intact, no exposure
- March 2025 (INC-23629) – Contractor cut a pipe containing asbestos residue, exposure occurred
- March 2025 (INC-23642) – Contractor used a master key without permission to enter a plant room to use it as a storage space. This area was marked with warning signage and contain ACM debris

The two most recent incidents were discovered during the asbestos management survey, which has also highlighted 8 plant rooms in GRH that contain ACM debris (where the ACM has been disturbed causing a risk of exposure) and presently 4 plant rooms in CGH (CGH survey is on-going). An Incident Management Team has been established and has been meeting daily to investigate the contractor exposures, review procedures and the safe management of areas of risk.

RAG: Red

13. Surveys

A recent review of outstanding surveys has highlighted the need for prioritisation and the clarification of roles, responsibilities and funding in relation to these statutory or 'must-do' activities (appendix 2). Majority of the elements on this list state 'unknown' in relation to the last survey date. This will require further exploration of records, systems and processes in place to ensure that the management of these tasks are clear going forward. High-priority surveys, including the asbestos, fire compartmentation and fire door surveys are underway. Further work is needed in the coming months to plan the remaining items.

RAG: Red

14. Abuse, Aggression and Violence (V&A)

The Health and Safety Strategy includes an objective to ensure staff are safer at work. This included trialling body-worn cameras in the Emergency Department, GRH in response to the high risk of V&A in this location and to staff feeling unsafe at work. Body worn cameras were introduced on a trial basis in April 2024, and the trial was extended to the Portering/Security team, and Site team (V&A response team). The introduction of cameras was intended to implement a 'de-escalation' effect, leading to a perpetrator calming down once told that staff would be filming, as well as providing clear on-scene evidence of poor behaviour towards staff or others. The trial was successful, with staff reporting feeling safer and an increased ability to evidence poor behaviours to the police in support of action. Learning in relation to our response to a situation was also key and took place through targeted debriefings.

Funding was secured to purchase 18 cameras, six of which are located in ED GRH, 6 in the GRH Porters Lodge for use by Security, and 2 cameras in each of the other 3 hotspot areas (AMU1, Gallery Ward 2, and Guiting CGH). Other departments are able to purchase cameras on a risk-based approach, using their divisional funding and add them into the main system.

The Health and Safety Strategy also included an objective to commission a security response review via an independent expert to establish the effectiveness of our current response model and review training requirements. This took place in early 2024 and highlighted the known inadequacies of the current model. Measures to reduce the V&A incidents have been slow to come to fruition due to the need for approval of a business case for a new security model for responding to incidents. This is a multi-million-pound proposal and has required a number of reiterations of the proposals to date. The initial business case was presented to the TLT in late 2024 and led to the implementation of the initial phase of dedicated security staff in ED. Insufficient time has passed at present to evaluate the impact of this on V&A. The full business case which was presented to TLT in March 2025 will undergo further clarification in relation to the financial elements before final approval is given by TLT, when presented to the April meeting.

Relevant to security is the need to include a training model for conflict resolution, de-escalation and breakaway training (how to disengage from physical confrontations), and restraint training. Whilst training has been maintained for the response team, clinical staff have not been able to access de-escalation, breakaway and restraint training. A training needs analysis has been provided to GMS, which requires costing and inclusion in a business case. This remains an important area in which to evidence improvement, as clinical staff are first on the scene for most V&A incidents.

A trial has recently commenced deploying activity coordinators to support vulnerable patients who are more likely to become anxious and agitated when in the hospital environment. It is hoped this trial will facilitate a reduction in V&A incidents in the areas where coordinators are deployed. The results of this trial will be available later this year.

RAG: Red

Sexual Safety

The Trust has signed up to the NHS Sexual Safety Charter in 2024, with the primary goal of ensuring organisational compliance with the NHS Sexual Safety Charter principles. New employment law regarding staff sexual safety has since been introduced. Given the importance of this area of work, there is senior ownership under the Chief Officer for People and OD.

This programme of work was initially developed and overseen by the V&A group, where all key stakeholders were attendees. A comprehensive action plan was developed which included drafting a policy and process, awareness and training and improving reporting mechanisms for staff-to-staff incidents. Sexual safety incidents where the alleged perpetrator is a patient or visitor are managed and responded to

through the auditable processes of the patient / visitor Behaviour Standards Panel. However, the challenges of reporting sensitive staff to staff sexual safety incidents on Datix (incident reporting system) and the risk that these were not adequately managed by local line managers was recognised. The Health and Safety Strategy included an objective for the People and OD team to develop a confidential process for reporting and managing staff to staff incidents of sexual safety – this new mechanism (Report, Support and Learn) will be implemented in Q1 2025/26.

At the start of 2025/26 a Sexual Misconduct Policy was published in March 2025 outlining the role, responsibility, expectations and escalation routes alongside a Sexual Safety Study Day held also in March. This study day demonstrated some staff continue to be exposed to inappropriate comments at work and a lack of confidence in managing staff to staff incidents. The People and OD team have developed a restorative justice process which they intend to take forward as part of their programme of work under the new group.

RAG: Amber

15. Display Screen Equipment

The Trust manages its obligations under the DSE regulations through the DSE policy. This includes a comprehensive guide to safe use and a DSE assessment process which is compliant with the Health and Safety (Display Screen Equipment) Regulations. Training provided online has a high-compliance rate.

The Trust provides eye and eyesight test support via a voucher scheme. More comprehensive ergonomic assessments are provided to individuals through qualified ergonomic assessors in the Risk, Health & Safety team who offer recommendations for specialist equipment for staff. The occupational health provider also works with the ergonomic assessors on more complex cases.

RAG: Green

16. Workplace Inspections

Workplace inspections are a statutory requirement under the Workplace (Health, Safety & Welfare) Regulations which set out the requirements in relation to the standards of a workplace and maintaining it in an efficient state. The regulations include a requirement to achieve an adequate level of hygiene and cleanliness, sufficient lighting and emergency lighting, a reasonable working temperature, suitable ventilation, washing and toilet facilities, adequate eating and drinking spaces, sufficient space to work along with defect free floors, pedestrian routes and traffic routes.

Compliance with these regulations is monitored through a programme of workplace inspections set out in the Trust policy B0747 Workplace Inspections. Reviewed in May

2024, this policy defines the inspection frequency in accordance with the level of risk in an area and the vulnerability of those using it:

- clinical areas – 3 monthly inspections
- non-clinical, communal areas and outdoor areas – 6 monthly inspections
- home-working environments – annual inspections

As a result of poor compliance in the previous reporting period, workplace inspections were included as an objective within the Health and Safety Strategy 2024-2026 and improvements in the clinical areas have been driven via the divisional health and safety meetings and reporting. Whilst some improvements have been made in the number of workplace inspections being completed, there remains a significant proportion of areas that are not recording inspections. At the close of 2024-25, less than half of all expected inspections had been recorded, with the corporate division showing poor compliance across the year.

Workplace Inspections	No. required per frequency	Q1	Q2	Q3	Q4
W&C	16	10	8	9	10
D&S	44	20	26	21	23
Medicine	34	19	13	14	12
Surgical	50	33	29	29	31
Corporate	32	3	2	0	0
Total	176	85	78	73	76

The Trust is setting up a Corporate Divisional Board from May 2025 where, amongst other matters, health and safety performance for the division will be reported and managed. The central team will continue to work with the divisions to raise the profile and importance of these inspections in order to improve compliance, which will be enhanced once a full Risk and H&S Team complement is achieved.

For those inspections that are completed, common themes include estates-related issues connected to fire safety, physical security, ventilation, insufficient or poorly managed electrical cables (trailing wires / cabling overstretched or overloaded), sanitary bin provision and the general decorative standard of buildings. These issues are well-known and tend to be associated with the aging condition of the estate as a whole.

RAG: Amber

17. Consultation with Employees

To comply with the Health and Safety (Consultation with Employees) Regulations 1996, we continue to formally discuss health and safety matters at the Trust Health and Safety Committee which met on a quarterly basis in 2024-25, increasing to bi-monthly basis from April 2025 in order to implement the improvements set out in the H&S Management Framework. The Committee members include trade union representatives and senior employees from each division, along with specialist leads.

The new Health & Safety Framework will strengthen the process for appointing and consulting with representatives and employees going forward. It sets out the reporting process for health and safety matters along with the escalation route to provide employees with a voice through our working / operational delivery groups and strategic groups, up to Board.

RAG: Green

18. Work-related Stress

There is a legal duty to assess the risk of work-related stress. An audit of our risk assessment library in 2023, noted that most departments did not have a stress risk assessment in place. An objective was included in the Health and Safety Strategy to improve compliance and identify areas of high-stress that may require intervention or support.

Year one of the Strategy identified 176 areas that required an assessment, with a target to achieve 40% compliance by March 2025. Medical, Surgical and W&C divisions achieved or exceeded the target. It was noted that in addition to the number of departments below, other departments have completed an assessment but it is not in date and so is not currently compliant.

Division	No. of Stress RAs Completed	No. of Stress RAs in Date	Achieved
Corporate	4/32	1/32	3%
D&S	16/42	9/42	21%
Medical	20/34	14/34	41%
Surgical	31/50	22/50	44%
W&C	13/18	9/18	50%
TOTAL	**84/176**	**55/176**	**31%**

A further objective for the last 12 months was the delivery of briefing(s) on the stress risk assessments process. Work-related stress guidance, including links and information on completing a risk assessment, has been created on the H&S A-Z intranet pages. All of the relevant document templates, and guidance created from the HSE Management Standards are also attached to the Workplace Wellbeing – Management of Workplace Stress policy. However, due to diminished resources in the Risk, Health and Safety Team, the delivery of briefings has not been viable. As

stated previously, when the team is at full complement, the position will improve in terms of reinstating briefings.

RAG: Amber

19. Training and Information for Employees

The Management Regulations require the Trust to have appropriate health and safety training in place. Compliance with training is outlined below and is reported on a bi-monthly basis to the divisional health and safety meetings (except corporate division).

Compliance is good for Health, Safety & Welfare training (HSW), Conflict Resolution, DSE, Sharps (non-clinical teams) and Manual Handling – Level 1. Sharps training for clinical teams and Manual handling – Level 2 remain amber. W&C are least compliant with three amber areas. The Executive Review process continues to evolve to include key oversight metrics in support of achieving ongoing improvements across divisions.

	HSW	Conflict Resolution	DSE	Sharps - clinical teams	Sharps - non clinical teams	Manual Handling Level 1	Manual Handling Level 2
GHT Total	**93%**	**95%**	**92%**	**88%**	**98%**	**93%**	**85%**
Corporate Division	94%	96%	95%	90%	97%	96%	85%
Diagnostic & Specialty Division	94%	96%	92%	91%	98%	95%	85%
Medicine Division	93%	94%	92%	87%	98%	94%	86%
Non-Division	92%	90%	81%	53%	100%	92%	100%
Surgery Division	94%	95%	92%	89%	98%	93%	82%
Women & Children Division	91%	94%	89%	85%	98%	89%	91%

RAG: Amber

Health and Safety A-Z Objective

An objective of the H&S Strategy aimed to have an online information resource available to staff on the intranet pages by March 31st, 2025. This was achieved early with the A-Z resource 'live' on the intranet in July 2024. Having a comprehensive health and safety A-Z, accessible to all colleagues working within the Trust, offers a multitude of benefits, including quick reference for guidance, improved awareness of safety protocols, and consistency in how the Trust works together safely.

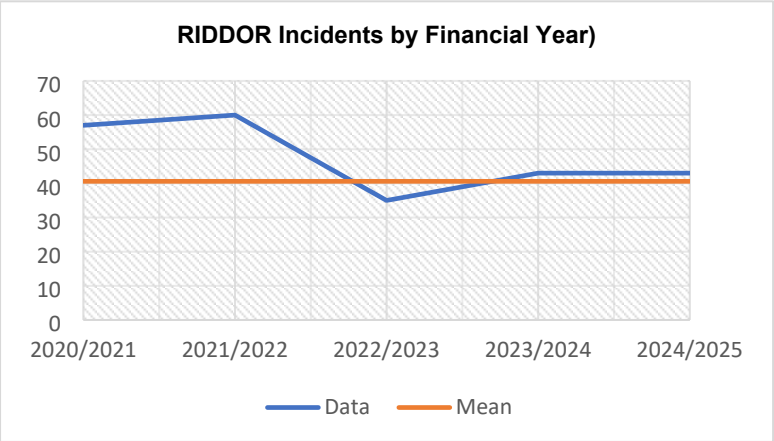
The Risk, Health and Safety team have been provided access to edit these pages ensuring that they are kept up-to-date with new and changing information in safety. As we approach year two of the Strategy, the team will continue to enhance the resources.

RAG: Green

20. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

The duty to report under RIDDOR falls upon the responsible person. In most cases this will be the employer where an accident concerns a member of their staff. The person in control of a premises, such as GMS, will also be responsible for reporting certain incidents involving members of the public or self-employed people where these arise from their activities.

In 2024-25 the Trust reported 43 RIDDOR reportable incidents. This is equal to the number of RIDDORs in the previous financial year and demonstrates a sustained reduction on the number of RIDDORS compared to 2020-2022.



Timely reporting

Of the 43 RIDDORs this financial year, 26 were reported to the Health and Safety Executive (HSE) within the statutory timeframes of 10 days (specified injuries) and 15 days (over 7 days incapacitation). Fourteen incidents (33%) were reported outside the statutory timeframe due to local investigators not marking them as RIDDOR reportable or failing to provide sufficient details to enable a report to be confirmed and submitted. Each one places the Trust at risk of prosecution for late reporting.

RIDDOR reports across the divisions are shown below. Surgery reported the highest number of RIDDOR incidents (17).

Division	Total no. of RIDDORs	Reported on time	Late submission	Not yet due
Surgery	17	11	6	--
Medical	11	5	6	--
GMS	6	3	3	1
D&S	6	5	1	--
W&C	2	--	--	2
Corporate	1	1	--	--

RIDDOR types for this financial year were as follows:

Division	Falls, Trips & Slips	Manual Handling	Contact with / Collision / Struck by	V&A	Exposure to hazardous substance (not sharps)	Sharps / splashes – Exposure	Other
Surgery	3	1	--	3	1	6	3
Medical	4	2	--	1	1	2	1
GMS	3	--	3	--	--	--	--
D&S	3	2	--	--	--	--	1
W&C	--	--	--	--	1	1	--
Corporate	1	--	--	--	--	--	--
Total	**14**	**5**	**3**	**4**	**3**	**9**	**5**

Slips, trips and falls remain the most prominent cause of RIDDOR reportable accidents and was the driver for the audit discussed above on slips and trips risk assessments. The 14 RIDDOR incidents demonstrated an increase compared to the two preceding reporting periods where there were 10 RIDDOR incidents respectively. However, this remains lower than the 5-year average of 17 RIDDOR falls.

RIDDOR reportable manual handling incidents have steadily decreased over the last 5 years from 17 reportable incidents in 2020-2021 to 5 in this reporting period. This is likely to be related to the supportive programme of work implemented by the Handling and Moving Team. There has been a slight increase in reportable sharps / splash incidents where exposure to a blood borne virus has occurred. This increased from 7 in the previous period to 9 this financial year. Theatres remain the hot spots for reportable sharps and splashes and is related to a lack of, or inappropriate, PPE being worn by staff.

A greater level of assurance that all RIDDORs incidents have been captured and reported could be achieved by exploring ways in which sickness data held by Human Resources (HR) can be cross-checked against work-related incidents reported on Datix (incident reporting system). Datix includes a specific marker for RIDDOR incidents to which is used to flag these for review and reporting to the HSE. At present, it is possible for sickness that is work-related to be reported to HR without a corresponding incident report, which could lead to missed RIDDORs. Owing to the employee personal records system (EPR) being a national tool, HR are unable to mandate the question which prompts the reporter to confirm if sickness is work-related. This means there is further scope in the system to miss work-related ill health. Where there is any doubt, HR teams will need to follow this up with the reporter and share work-related sickness data with the Risk, Health and Safety Team.

21. Investigations

Incident investigations are crucial for a robust, proactive incident management lifecycle. By scrutinising incidents and near misses, an organisation can unearth the causes of incidents, apply corrective measures and prevent similar incidents in the

future. Timely and thorough incident investigations can lead to substantial cost savings and are indispensable for fostering a safe workplace environment.

The H&S Strategy 2024-2026 includes an objective to adopt a more robust safety response via improved quality and learning from reviews and investigations. The first step in this programme of work was to develop a suitable training programme. The Risk, Health and Safety Team carried out a randomised audit of approximately 50 incidents and identified areas of weakness in incident investigation to create a focus for future training. The prioritisation of workloads to support key issues has delayed the development of the training which will recommence in Q2 2025/26 once vacancies in the team are recruited to.

22. External activities / visits

There have been no HSE inspections or investigations during 2024-2025. However, a routine inspection in the previous financial year on violence and aggression and manual handling resulted in a Letter of Contravention. The letter highlighted a number of breaches related to security and the Trust was required to produce an action plan, with particular focus on improving the security response provisions. This was provided to the HSE on 24 May 2024.

The Inspector recorded the action plan as constituting compliance with the letter but outlined five expectations as below:

Expectation	Action Progress
The continuation of access to security specialist advice (in house or via external consultants)	**Complete:** HSE followed this up directly with GMS as the inspection had highlighted gaps in competency within GMS. The GMS Security Manager has now undergone training for his role and evidence was provided to the HSE. GMS have assured the Trust all security staff are suitably trained
Suitable and sufficient resource to be available to meet the Trust's needs in terms of violence and aggression	**Incomplete:** This has yet to be resolved. A new resource model for security staff has been presented to TLT in September 2024 when approx. £400K was approved to recruit dedicated security staff for the Emergency Department in GRH. A full business case was presented in March 2025 which recommended a further 26 staff were required to create a full security provision across both sites. Further clarification has been requested by TLT.
A review of training needs to have taken place as part of the security review and training model agreed	**Complete:** This took place as part of an external consultant-led review into security at the Trust in early 2024. A training needs analysis was completed in February 2025
Actions detailed within the plan to be complete e.g. TV screens to be installed in waiting areas to display wait times	**Complete:** The TV screens were installed in the summer of 2024.
Action to have been completed or progress made towards completion in relation to manual handling issues	**Complete:** all local manual handling issues identified have been addressed.

23. Accident and Incident Analysis 2024-2025

This section outlines significant incidents and themes in 2024-2025.

23.1 Signification incidents

- Window Incident – Ward based, Gloucestershire Royal Hospital

In February 2025 a patient without capacity, experienced an unexpected psychosis, become agitated and attacked a Registered Mental-Health Nurse (RMN) providing 1:1 supervision for the patient. The patient banged the window in his side room causing the window restrictors, which prevent the window opening more than 100mm, to give way. This allowed the patient to open the window and attempt to jump from the 6th floor height. This was fortunately averted through the swift actions of staff on the ward. This incident remains under investigation pending further information on the strength-testing of the window restrictor from the contractor that installed the windows. A full report will be provided in due course.

- Weapon Incident - Ward based, Gloucestershire Royal Hospital

In June 2024 a patient attacked a member of ward staff causing significant injuries and self-harm. An investigation took place which identified a number of lessons learnt and lead to definitive actions to improve safety. These included:

  - The V&A risk assessment for the ward was not suitable and sufficient – this has now been revised
  - The analogue bleep system did not operate effectively which delayed the V&A response team – the Trust is currently introducing digital bleeps
  - The police were not called in relation to the imminent danger to life from a weapon – staff were briefed on the correct response
  - The initial V&A team response did not include enough staff to restrain safely – this is being addressed via a wider security business case
  - The V&A response staff were not wearing stab-protection vests and did not activate their body-worn cameras – GMS have purchased anti-stab vest and included these as standard unform for dedicated security staff and made them available to porters when responding
  - Restraint training for clinical staff was overdue – a revised restraint, de-escalation and trauma-led training model is being developed and will be trialled in 2025
  - Ward managers were not familiar with the wellbeing support and cold debrief process – cold debrief training has been delivered to staff by Health Psychology
  - Glass panels pose a risk and should be replaced with plexiglass or acrylic materials – this will be taken into account as refurbishments continue

- Asbestos Incident

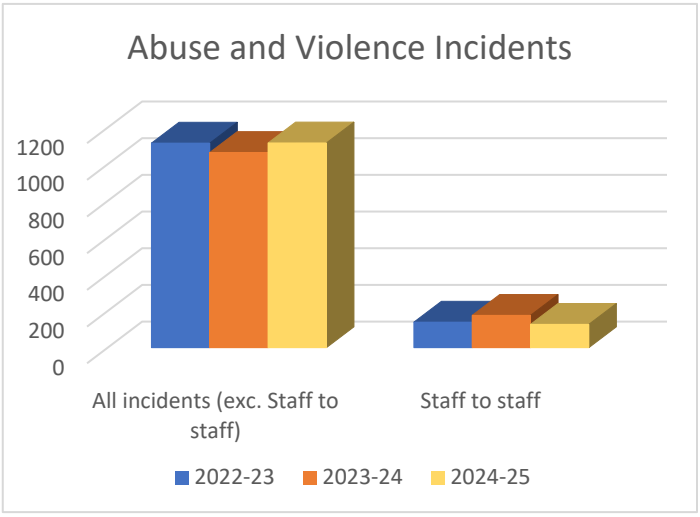
In March 2025, GMS alerted the Trust to two incidents of contractors being exposed to asbestos on the GRH site involving an external contractor and access to a plant room.

The on-going asbestos management survey has identified further plant rooms that contain disturbed asbestos debris and these have been duly restricted. A full investigation report will be provided in due course.

23.2 V&A Incidents

Incidents and analysis 1 April 2024 to 31 March 2025 shows V&A incidents have remained high.

	All incidents (exc. Staff to staff)	Staff to staff
2022-23	1115	139
2023-24	1064	176
2024-25	1116	127



Of concern is the number of staff-to-staff incidents, which remain over 100. A new Report, Support and Learn system will be in place from end of Q1 2025 which will provide a clearer mechanism for staff to report incidents such as this and most importantly, for action to be taken.

Measures to reduce the number of V&A incidents were commented upon earlier in the report which includes de-escalation training which is an essential skill for clinical staff in reducing the number of V&A incidents. A trial has recently commenced deploying activity coordinators to support vulnerable patients who are more likely to become anxious and agitated when in the hospital environment. The results of this trial will be available later this year.

Hotspots for abuse, aggression and violence continue to include the Emergency Department (ED) in GRH where interim security proposals have led to additional dedicated security resource being placed in ED Renal, Care of the Elderly (COTE), Neurology, Stroke, and Trauma also remain hotspots, with majority of the patients in these areas lacking capacity. Following a trial in ED, body-worn cameras have been deployed as a permanent safety device in the highest- risk areas which include the security team, ED GRH, AMU and Guiting (COTE) and Gallery (COTE). Footage from the cameras has provided invaluable and reliable evidence which and has been shared with the police with a view to securing appropriate action against perpetrators.

The triggers for abuse and violence vary. In approximately 50% of incidents the perpetrator (patient or visitor) is recorded as having capacity at the time of the incident. These incidents are reviewed weekly by the Behaviour Standards Panel with a view to issuing a behaviour warning letter, or conditional behaviour order. The Panel takes careful account of mitigating circumstances such as mental-health, physical health, safeguarding and clinical complaints before approving a warning letter / order. Patients are also given a right to respond via the Complaints process.

23.3 Sharps / Splash Incidents

The procedures which have shown the greatest exposure risk to bodily fluids involve the use of sharp devices such as needles and sutures or cutting tools. However, exposure can also occur during a splash incident. Exposures can be the source of a viral transmission of viruses such as Hepatitis B, Hepatitis C, and human immunodeficiency virus (HIV).

From April 2024 – March 2025, there were 234 sharps / splash-related incidents reported on Datix. This represents an overall decrease of 5% and a notable decrease of between 31% - 55% in the number of discarded or incorrectly disposed of sharps. The Trust is currently trialling a safer sharps bin which may account, in part, for this reduction.

However, sharps injuries have increased by 29%. The mean number of sharps / splash incidents in the last 12 months is 20 per month. 117 incidents were recorded as contamination incidents (e.g., blood, bodily fluids). Of these incidents, seven were reported to the HSE under RIDDOR due to the patient's blood borne virus status.

Type of sharps incident - 01/04/24 - 20/03/2025	23/24	24/25	Up/down
Sharps found (no injury)	51	23	↓ 55%
Sharps injury	121	156	↑ 29%
Sharps returned to CSSD (no injury)	14	9	↓ 36%
Sharps incorrectly disposed of / stored (no injury)	16	11	↓ 31%
Splash to skin (intact)	46	36	↓ 2%
Splash onto broken skin		9	
Total	247	234	↓ 5%

The areas that saw the highest number of sharps and splash incidents include:

- Theatres – 27 incidents, including 18 sharps injuries, 5 splashes, and 2 incidents of items being returned to CSSD in an unsafe manner
- Trauma – 16 incidents, including 11 sharps injuries and 4 splashes
- Critical Care – 16 incidents: 7 sharps injuries and 9 splashes
- Maternity – 15 incidents, including 7 sharps injuries, 5 splashes, and 3 incidents of returning sharps devices to CSSD in a hazardous state
- ED – 14 incidents, 12 of which were sharps injuries.

According to investigation findings, in 10 of these incidents staff were noted as not adhering to correct procedures (predominantly in Theatres); 8 were staff undergoing training (all in Theatres); 8 incidents were contributed to staff distraction or focus and 7 were attributed to the environment (e.g. low lighting). Other notable causes included the patient moving unexpectedly, challenges with disposing of devices in the current sharps bins, or faulty devices.

Work is currently in progress to help reduce the number of incidents:

- Review of the e-learning for sharps, with a potential additional learning 'pathway' for Pathology staff
- Auditing sharps risk assessments to ensure they are suitable and sufficient
- Sharing learning at the divisional H&S meetings
- Implementing safer sharps bins in ED initially, before rolling out across the Trust
- Focussed support in Theatres in relation to the use of PPE

23.4 Exposure to Hazardous Substances Incidents (exc. Sharps / splashes)

In 2024-2025, 96 exposure incidents were reported. These included the following:

	Asbestos	Bacteria / virus	Biohazard	Chemical	Dangerous goods	Drugs / medication	Legionella	Total
2024/2025	2	2	33	39	2	17	1	96

23.4.1 Exposure to chemicals

There were 39 incidents of exposure to chemicals.

With the exception of the Hydrogen Peroxide incidents, all incidents were recorded as no or minor harm and low risk.

An investigation has commenced into a number of Hydrogen Peroxide splashes, and in particular the availability, suitability and consistent use of PPE by a small number of staff who have reported splashes to skin and eyes causing irritation and burns.

A project has also been commenced in relation to formalin spills. This included several bespoke training and awareness sessions for staff, a review of the pots / lids used to carry specimens and the introduction of transport bags and trollies. The defective formalin cabinet in Theatres has also been replaced.

23.4.2 Exposure to biohazards (excluding sharps incidents)

Biohazards pose a risk to the health of staff. During the performance of their normal tasks, healthcare staff may be exposed to the patient's contaminated bodily fluids. Majority of these incidents related to contaminated mattresses left for portering collection which had not been correctly bagged for cleaning. This creates a risk of exposure to those handling them.

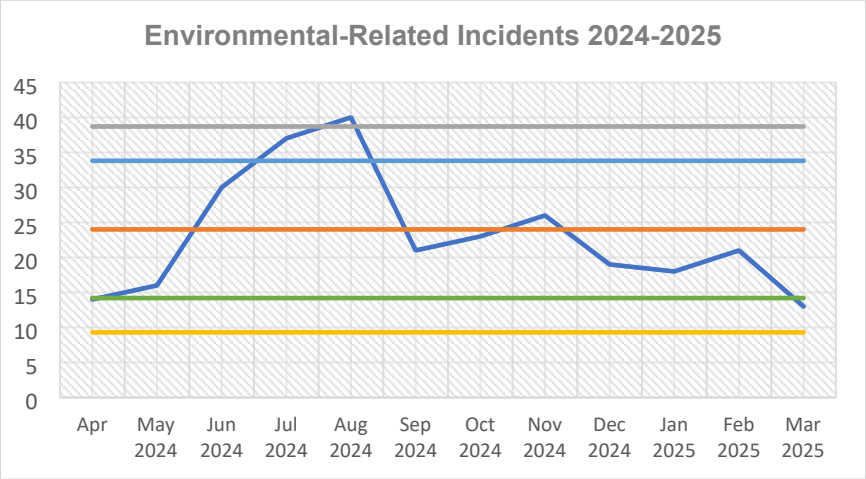
With the exception of an incident involving a Blood Borne Virus, all incidents were no or minor harm. Some incidents reflected a higher risk such as those where PPE (e.g., gloves) was unavailable. Further work has been undertaken to educate wards on the importance of bagging contaminated mattresses left for collection. Additionally, steps were taken to ensure portering staff have access to PPE on wards and in storage areas.

23.4.3 Exposure to drugs / medicine

Staff who prepare or administer hazardous drugs (e.g., some cancer therapy, antiviral, hormone therapy, and bioengineered agents) may be exposed to these agents in the workplace. A small number of incidents took place in 2024-25 where staff or patients were inadvertently exposed to a hazardous medicine due to leakage.

23.5 Environmental incidents

Between 1st April 2024 – 20th March 2025 there were 278 incidents reported for environment-related issues.



23.5.1 Thermal comfort

There are a number of well-known safety implications from poor thermal comfort which include reduced concentration, flawed / poor decision-making, the unsafe removal of PPE, dehydration, lower dexterity, higher risk of muscular injury and shorts cuts when working in a cold environment.

Thermal comfort in the workplace should be addressed through the new Estates Strategy, with poorly performing buildings addressed as a priority. Six factors account for thermal comfort: air temperature, radiant temperature, air movement / speed, humidity, clothing and PPE insulation and work rate / metabolic heat.

The rise in incidents from June to August is accounted for by uncomfortably high working temperatures across the Trust. Most areas of the Trust do not have mechanical ventilation or other solar protection measures to reduce the transfer of heat into the buildings. Instances of work areas overheating accounted for 23% of

environmental incidents over the 12-month period. Staff reported feeling ill despite introducing control measures (fans, window film, drinks, relaxed uniform rules etc.). A limited number of mobile air conditioning units are available through a risk and checklist process implemented by Estates. However, these increase the risk of overloading the electrical system and so are only permitted in a small number of areas. Heat is also occasionally attributed to incidents where staff members have fainted and recorded as falls incidents. A much smaller proportion of incidents (6%) relate to the environment being too cold.

23.5.2 Cleanliness

92 incidents related to poor standards of cleanliness in clinical and non-clinical areas. 19 of these were specifically about overflowing, dirty sanitary bins, while others were related to staff not respecting shared areas. These incidents are monitored via the Infection Control Committee.

23.5.3 Level of Harm

Environmental incidents have predominantly been reported as 'no harm', with 33 resulting in minor harm, and 9 moderate harms. However, the moderate harms do not relate to a specific injury as such, more the long-term nature of daily exposure to heat, and the impact it is having on staff (and sometimes patients).

Work is currently in progress to reduce environmental incidents and the impact they have, including:

- Proactively looking for and reporting issues as part of the workplace inspection programme
- Having risk assessments for relevant topics, such as thermal discomfort
- Relevant policies, procedures and action cards
- As the Trust is not keen to install new air conditioning units due to factors such as the environmental impact or ongoing maintenance requirements, a checklist has been created for areas struggling with the heat to help educate teams on what is available, and ensure they have implemented as many control measures as possible
- A new contractor has been sought for Sanitary bins to improve the service

23.6 Staffing

In 2024-25, 349 staffing issues were reported on Datix as having affected staff, the public or contractors. The majority of staffing incidents were reported as causing no harm (92%). However, staff may find it difficult to directly attribute harm to staffing, given the complexity of isolating one factor as the cause of a harm event.

Majority of the incident 200 incidents that refer to skills / training, identify that the skills mix to support the patients / ward was not available. Each division has relevant risks on the register in relation to staffing and workforce BAF reflects the overall risk of staffing issues.

	None (No harm caused)	Minor (Minimal harm caused)	Moderate (Short term harm caused)	Total
Lack of suitably trained / skilled staff	190	9	1	200
Staffing issues leading to suboptimal patient care	122	12	2	136
Unit / Ward Closure	2			2
Unsuitable office/working environment	1			1
Lack of/Delayed availability of Beds – General	5			5
Lack of/ Delayed availability of Operating Theatre	2			2
Total	322	21	3	346

The areas reporting the highest numbers of staffing issues are shown below. As expected, ED and Theatres are experiencing particular staffing issues.

	Lack of suitably trained / skilled staff	Staffing issues leading to suboptimal patient care	Total
Emergency Department	35	21	56
Theatres	36	8	44
Rheumatology	37	6	43
Care of the Elderly	6	21	27
Maternity	11	14	25
Acute Medicine	6	5	11
Paediatrics	7	5	12
Ophthalmology	5	6	11
Pharmacy	8	3	11

A number of staffing incidents are also reported as having affected the organisation. The majority of these are where staffing has affected patient safety rather than directly affecting the staff wellbeing. As staff report haphazardly under all these categorises there is a need for guidance as to when to report an incident as affecting staff, and when to report it as affecting the patient or organisation. This report concerns only the incidents identified as directly affecting staff (health and safety), rather than patient safety incidents which are reported through the quality workstream.

24 Key Performance Metrics

Key Performance Metrics are discussed throughout this report for year one of the Health and Safety Strategy 2024-2026. A summary is provided in appendix 1.

25 Areas for Improvement

It is recommended that the Board consider the strategic improvements identified and its confidence in the proposed actionable strategies to enhance safety protocols. A future-focused perspective is provided in the H&S Management Framework which underscores the organisation's commitment to continual improvement and adaptation to an evolving regulatory landscape. Key areas for improvement in the coming year to note are identified below, with the remedial plans/next steps identified in the body of the report:

- The implementation of the new Health and Safety Framework to improve governance, accountabilities, reporting, escalation and oversight
- The impact of resourcing issues in the H&S team on achieving 2024-25 objectives
- Focus on weak controls/compliance concerns in relation to fire, asbestos and ventilation
- The criticality of revising the SLAs for key areas of compliance, prioritising fire, water and asbestos (aligned to legislative requirements, HTMs and guidance, and clarifying roles and responsibilities)
- Addressing the outstanding surveys and inspections identified in 2024
- Final decision on security provision and the review
- Addressing inadequate functionality of the system to manage risk assessments
- Reducing where possible the number of high-risk substances in use
- The need for a workable in-house solution to health surveillance records and reporting
- The intrinsic link between accidents and incidents and the aging condition of our estate
- Correcting the absence of work-related sickness data to support a more granular analysis of areas of concern
- Addressing the trends identified in the incident data analysis

26 Recommendations

The Board is invited to:

i. Review the annual health and safety report and confirm agreement to the assurance rating assigned in the report and confirm commitment to ensuring a safe and healthy workplace for all employees and visitors by supporting the improvement activity highlighted.

ii. Confirm it is assured that the key areas of improvement activity will address any shortcomings identified in the report.

iii. Confirm it is assured that implementation of the new Health and Safety Management Framework will support the Trust and its subsidiary to address the specific risks identified in the report, and

iv. Recommend and / or take any additional actions as it sees fit, to address issues highlighted.

Progress against Year 1 Objectives and Targets 2024-26

Each objective is outlined below and progress indicated using the following key:

 Achieved

 Partially Achieved

 Not achieved

 Changed during the course of the Plan

Abuse, Violence and Aggression

Objective	Initiatives and Targets	Due Date	Achieved	Comments
To improve the quality of risk assessments	Four key themed risk assessments have been audited in each division	Year 1 (31 March 2025)		2 key assessments were completed in the first year of the Strategy. This was due to a continued 50% vacancy rate in the H&S team which meant resources were overstretched to manage 4 audits.
	80% of risk assessments audited met the standard required in year 1	Year 1 (31 March 2025)		Majority of the assessments audited did not achieve the required standard. The work to improve assessment quality will continue into 2025-26. During 2024-25 – there has been no allocated resource to support two divisions with this work due to vacancies in the H&S team
	80% of departments / specialties have at least one individual who has completed risk assessment training	Year 1 (31 March 2025)		Overall, 54% of departments have achieved this. D&S 29 of 42 areas (69%); Surgery 40 out of 58

				(69%); Medicine 22 out of 34 (65%); W&C 5 out of 17 (29%); corporate 3 out of 33 (9%).

Health and wellbeing

Objective	Initiatives and Targets	Due Date	Achieved	Comments
To protect the health of staff, patients and visitors through Control of substances hazardous to health (COSHH) assessments	Each department has an identifiable folder for their COSHH assessments on SYPOL	Year 1 (31 March 2025)		This has been set up on SYPOL and COSHH assessments specific to that department have been placed in the relevant folder.
	A master list of all substances has been established for each department	Year 1 (31 March 2025)		All medical departments have responded. However, there have been 30 of 42 returns in D&S, 18 of 49 in surgery and 3 or 4 in W&C. Returns will be pursued over the next few months.
	40% of departments / specialties have at least one individual who has completed COSHH assessment training	Year 1 (31 March 2025)		Overall, 41% of departments have achieved this. Surgery, 34 out of 45 areas have achieved this (76%). D&S 26 of 42 (60%). Medicine 16 of 34 areas (47%). W&C 4 of 16 areas (25%). Corporate 1 of 27 (4%).

To ensure staff are safer at work	Agreed process for reporting staff to staff incidents	Year 1 (31 March 2025)		This action sits with the People and OD team who are currently looking at a reporting system for sensitive incidents.
	Results of the body-worn camera trial reported to Trust H&S Committee and Board	Year 1 (31 March 2025)		The trial was reviewed and the outcome of the trial was reported to Trust H&SC and to TLT in September 2024, along with a business case for purchasing the cameras. The body-worn cameras are now in situ in the V&A response team, and other high-risk areas.
	Security Review report provided to Trust H&S Committee and Board	Year 1 (31 March 2025)		The initial business case was presented to the H&SC in 2024 and to TLT in late 2024. The full business case was presented to TLT in March 2025 and required amendments to the financial elements before final approval.
	Revised training tender published for abuse, violence and aggression / restraint training	Year 1 (31 March 2025)		A training needs analysis has been completed. The security proposal which includes future training provisions has been to TLT twice but requires further work.
	Number of V&A incidents resulting in harm has reduced by 8% from the baseline	Year 1 (31 March 2025)		Data shows that all divisions have seen a rise in abuse, violence or aggression incidents that have caused some level of harm

	Number of V&A incidents categorised as high or extreme risk has reduced by 8% in high-risk areas	Year 1 (31 March 2025)		Data shows that there has been a reduction in the risk rating given to incidents being reported across all divisions for 2024/25 when compared with 2023/24
To protect the health of staff through health surveillance	App developed and tested in an area	Year 1 (31 March 2025)		An app has been developed by the BI team and was tested in a number of clinical areas. This identified data protection issues with the App.
	Substances requiring health surveillance identified	Year 1 (31 March 2025)		Using SYPOL and audit returns from the divisions high-risk substances that require health surveillance have been identified.
	All clinical teams have an appointed person for health surveillance	Year 1 (31 March 2025)		This has not yet been confirmed by divisions
	40% of risks assessments required for health surveillance are complete	Year 1 (31 March 2025)		54% of areas that require a health surveillance risk assessment have one in place, although 9% are due for review.
To identify areas of high-stress through stress risk assessments	Delivery of briefing(s) on stress risk assessments process	Year 1 (31 March 2025)		Work-related stress guidance, including links and information on completing a risk assessment, has been created on the H&S A-Z intranet pages. All of the relevant document templates, and guidance created from the HSE Management Standards are also attached to the Workplace Wellbeing – Management of Workplace Stress policy. However, due to diminished resources in the Risk, Health and Safety Team, the delivery of briefings has not been viable.

	40% of risk assessments for work-related stress in place	Year 1 (31 March 2025)		Overall, 31% of areas have risk assessments in place. Medicine, Surgery and W&C have achieved 40% within the first year of the strategy. However, D&S achieved 21% and Corporate achieved only 3%.

Environmental Safety

Objective	Initiatives and Targets	Due Date	Achieved	Comments
To create a safer workplace through compliance with workplace inspection requirements	Implementation of an online solution (if viable)	Year 1 (31 March 2025)		Datix admin team have been asked to explore a solution using the audit model on Datix.
	90% of workplace inspections completed at the required frequency	Year 1 (31 March 2025)		None of the divisions achieved this objective. Corporate was the lowest performing division
To improve safety for vulnerable inpatients	Training video completed and available to staff	Year 1 (31 March 2025)		This was replaced with face-to-face training delivered by the GHC Mental Health Liaison Team in February 2025.

through robust anti-ligature risk assessments				The video has also been recorded but is awaiting completion by the Training team.
	Training records process communicated to staff	Year 1 (31 March 2025)		Face to face training attendees recorded by the patient safety team

Review, Investigation and Learning

Objective	Initiatives and Targets	Due Date	Achieved	Comments
To adopt a more robust safety response via improved quality and learning from reviews and investigations	Suitable training programme developed	Year 1 (31 March 2025)		This work was not commenced until late March 2025 due to a lack of resources in the Risk, H&S team and re-prioritisation of workloads to predominantly support emerging risks in water, fire and asbestos

Governance

Objective	Initiatives and Targets	Due Date	Achieved	Comments

To establish a robust reporting structure	Recommendations from the governance reviews will be implemented as appropriate	Year 1 (31 March 2025)		Recommendations were shared with the Director of Integrated Governance in the summer of 2025. A new H&S framework has been developed.
	Reporting structure (including sub-groups into Trust H&S Committee) agreed	Year 1 (31 March 2025)		The new proposed reporting structure was shared with Trust H&SC in January 2025 as part of the new H&S framework
	100% of health and safety incidents (with harm) have identified contributory factors before closure	Year 1 (31 March 2025)		95% (701/738) of relevant incidents had at least one contributory factor identified. The 37 incidents that did not have any contributory factors filled in, were all GMS.

Health and Safety Resources

Objective	Initiatives and Targets	Due Date	Achieved	Comments
Information for staff	The Risk, Health and Safety Team will develop information pages and resources for health and safety topics under a A-Z format	Year 1 (31 March 2025)		A-Z resource was developed in the early part of 2024-2025

	The A-Z will be added to the intranet by the Communications Teams	Year 1 (31 March 2025)		A-Z resource went ‘live’ on the intranet in July 2024
	Training will be provided by the Communications Teams to the Risk, Health and Safety Team to allow pages to be edited and updated	Year 1 (31 March 2025)		Training was provided in June 2025

Survey	Last Survey Date	Internal / External	Estimated Scoping Cost £	Estimated Survey Cost £	Notes	Risk Score	Owner	Requirement
Estate Strategy				TBA				CQC, ERIC requirement
Development Control Plan				TBA				Recommended strategy document
Asbestos	Not Known	E	£0.00	£68,000.00		1	H&S	Legal requirement under the Control of Asbestos Regulations 2012 (Regulation 4)
WRA	Not Known	E			Currently underway	1	Estates	Legal requirement under ACOP L8 & Requirement under HTM 04
FRA	Not Known	E			Currently underway	1	Fire	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05
External Drains	Not Known	E	£1,800.00	£40,000.00	Updating of drawings site-wide	2	Estates	Requirement under Building Regulations Approved Document H, Environmental Agency
Water Schematics	2015	E	£850.00	£250,000.00		1	Estates	Legal requirement under ACOP L8 & Requirement under HTM 04
Roofs / Barriers / Mansafe / Lighting / Gutters	Not Known	E	£1,800.00	£60,000.00		2	Estates	Legal requirement under the Health & Safety at Work Act and PUWER
Distribution Boards	Not Known		£0.00	£4,000.00	Updating of Drawings and asset register	2	Estates	Requirement under HTM 06
Emergency Lighting	Not Known	E/I	£1,800.00	£10,000.00	Updating of Drawings and asset register	1	Estates	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05 HTM 06
Fire Alarm Detection and Activation Points	Not Known	I	£0.00	£0.00	Fire Team	1	Fire	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05
Compartmentation	Not Known	E	£10,000.00	£68,000.00	Combine with Asbestos Survey	1	Fire	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05
Fire Door	Not Known	E	£0.00	£0.00	Fire Team	1	Fire	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05
Fire Extinguishers / Fire Blankets / Signage	Not Known	I	£0.00	£0.00	Fire Team	1	Fire	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05
Gas Register	Not Known	I	£0.00	£0.00	Register requires updating at GRH and verifying at CGH	1	Estates	Legal Requirement under Regulation (EU) 2024/573 (F-Gases)
MGPS / AVSU / Storage / Manifolds / VIE	Not Known	E/I	£0.00	£4,000.00	Updating of Drawings	2	Estates	Requirement under HTM 02
Roads / Paths / Signage / Markings/ DDA	Not Known	E	£10,000.00	£30,000.00		2	Estates	Highway Code and Road Traffic Act
External Lighting	Not Known	I	£0.00	£4,000.00	GMS AP	2	Estates	Requirement under HTM 06
Confined Space List	Not Known	I	£0.00	£4,000.00	List for both Sites	1	H&S	Legal requirement under ACOP L101
Safety Valves	Not Known	I	£0.00	£4,000.00	Updating of Drawings	1	Estates	Legal requirement under Pressure Systems Safety Regulations 2000 ACOP
Window Restrictors	Not Known	E	£1,000.00	£20,000.00		1	Estates	Legal Requirement under Building Regulations and HTM
COSHH Cupboards	Not Known	I	£0.00	£4,000.00	Updating of Drawings	1	H&S	Legal requirement under COSHH Regulation 200
Meters / Gas / Water / Electricity	Not Known	I	£0.00	£4,000.00	Updating of Drawings	2	Energy	PAM and 6 Facet Survey
6 Facet Survey	2020	E	£10,000.00	£100,000.00		2	Corporate	Requirement under HBN 00-09 & ERIC
Fire Dampers / Control Panels	Not Known	E	£10,000.00	£50,000.00	Update of Drawings	1	Fire	Legal requirement under Regulatory Reform (Fire Safety) Order 2005 & Requirement under HTM 05
Plant Condition Reports	Not Known	E	£10,000.00	£100,000.00		2	Estates	PAM and 6 Facet Survey

NHS
Gloucestershire Hospitals
NHS Foundation Trust

HEALTH & SAFETY MANAGEMENT FRAMEWORK

CONTENTS

1. INTRODUCTION

Safety management goes beyond compliance with prescriptive regulations, to a systematic approach where potential safety risks are identified and managed to an acceptable level. A proactive approach to managing health and safety requires it to be integrated into the organisation's day to day activities.

This framework specifies the necessary system-wide governance structure for safety management. It seeks to enable effective risk-based decision-making across the Group by proactively identifying and mitigating threats to safety before they result in undesirable outcomes.

An effective safety system and culture requires a shared understanding of safety management. Recognised areas associated with this include:

- **Health and safety policy** establishes senior management's commitment to improve safety, defines responsibilities and defines how the Trust needs to be structured to meet safety goals
- **Safety risk management** includes the identification of hazards and risks. Once risks are identified and prioritised, appropriate controls can be implemented to reduce the level of risk
- **Safety assurance** involves the monitoring and measuring of safety performance, evaluating how effectively the Trust is managing risks and the continuous improvement of the health and safety management framework
- **Safety education** includes training, information and other actions that ensure a competent response to our safety environment and a positive safety culture
- **Safety communication** supports effective two-way communication of safety issues between staff working at an operational level and the organisation's management
- **Managing change** identifying unintended consequences that might affect safety when new ways of working are introduced

2. SCOPE

This document sets out the health and safety management framework applicable to Gloucestershire Hospitals NHS Foundation Trust (**GHNHSFT**) (the parent organisation) and Gloucestershire Hospitals Subsidiary Company Limited, which trades as Gloucestershire Managed Services (**GMS**) (the wholly owned subsidiary); known together as 'the Group'.

This document aims to ensure the Group understands the safety of its services both as individual legal entities and collectively as a Group. It does not seek to control the internal health and safety processes of the subsidiary but employs an integrated and

co-operative approach to assuring compliance of the Trust's legal obligations. It is the method by which the Trust achieves due diligence.

Risks generated by the subsidiary in performing its contracted activities, or by other third parties, including but not limited to Apleona UK, must be managed by those entities in line with their own legal duties to their employees or others affected by their activities and under their contractual obligations. While the Trust's formal contractual agreements with other organisations should include provisions for the management of safety, this framework provides the governance arrangements for ensuring compliance, seeking assurance and escalating issues.

This framework document is intended to be a 'living document' which will evolve as the Trust's governance arrangements develop. It will therefore be kept under regular review, with a formal annual review by the Group Health and Safety Committee (Group H&SC) and the Trust Board.

3. GUIDING PRINCIPLES

A fundamental set of principles underpin this governance framework. These are:

- **Integrated governance and reporting (the Group)** – silo working within the Group is not only inefficient, but also leaves the Trust Board vulnerable to costly oversights. This health and safety governance structure requires an integrated approach within the Group to serve as a tool for effective Trust Board oversight.

- **Integrated approach to compliance with regulatory and industry standards** – compliance is fundamental to all Board and organisational activities and meeting both regulatory and industry standards will form the foundation of our decision-making. A cohesive approach to compliance across the Group will uncover insights that might otherwise have remained invisible.

- **Exposure of gaps or weakness** – it is essential a transparent and proactive approach is taken to identifying gaps or weakness in control structures across the Group. The Group should foster a culture which optimises opportunities for continual improvement in performance both as separate legal entities and collectively

- **Well-led** – each individual within the Trust and its subsidiary should understand their role and responsibilities in health and safety and demonstrate commitment to achieving a high standard. Accountability is key, as is enabling decision-making at the right level.

- **Strategic audit** – decision makers need data to make effective decisions on health and safety matters. The role of self-assessment, authorised engineer audits, internal auditors, external auditors and independent audits ensure that risks are identified and health and safety management is effective.

Benefits of these guiding principles include:

- **Robust and effective management** identifying, assessing, and managing risks, contributing to better risk management practices
- **Robust compliance mechanisms** and reduced risk of regulatory intervention or civil litigation
- **Clarity of accountabilities and responsibilities** across the Group and in relation to the PFI
- **Staff and patient confidence** in our values
- **Transparency** which builds trust, openness and strong relationships
- **Timely** decision-making leading to a better allocation of resources and long-term sustainability
- **Stronger financial performance** as a result of well-informed decision making, and the management of risk before it materialises

The governance structure defined in this framework directs how the Trust and GMS will interact with each other, the regulators and stakeholders on health and safety. It will give a 'safety voice' to all staff, patients and visitors.

The successful implementation of these arrangements requires commitment from all members of staff within the Group. Compliance is not just a legal obligation; it is a conscientious organisational practice.

4. LEGAL DUTIES

Both the Trust and GMS have general legal duties to their own respective employees, and others that are affected by their undertaking, to ensure as far as reasonably practicable, their health, safety and welfare under the Health and Safety at Work etc Act 1974 (HSWA) and associated sets of regulations. A breach of these duties is a criminal offence and could result in a conviction and large fines. Whilst the Trust can contract out the operational performance of its duties (e.g. to its subsidiary or a contractor), it cannot delegate the legal duties themselves.

However, both the HSWA and Regulations made under it, place the duties on those who have 'control' of premises, or plant and substances within the premises, and / or those that have contractual duties for the safety, maintenance or repair of any part of a building. GMS therefore have concurrent legal duties under the relevant legislation to the extent of their control of the estates and facilities and the extent of their contractual duties for repair, maintenance and safety.

The Corporate Manslaughter and Corporate Homicide Act 2007 also applies to the Trust, GMS and other contractual parties as separate legal entities. Under this legislation organisations can be held to account where a gross failure in the way activities were managed or organised results in a person's death. The Corporate Manslaughter Act is a stand-alone piece of criminal legislation and is not part of health and safety law. However, it is closely linked as it applies where there have been serious failures in the management of health and safety. The maximum penalty is an unlimited fine and the court can additionally make a publicity order requiring the organisation to publish details of its conviction and fine. Individuals can also be

prosecuted for gross negligence manslaughter where a grossly negligent act or omission by them personally caused the death.

Under section 37 of the HSWA a director, manager or similar can also be prosecuted where offence has been committed by an organisation with their consent or connivance or where they have been attributable to any neglect. Directors cannot avoid a charge of neglect under section 37 by arranging their organisation's business so as to leave them ignorant of circumstances which would trigger their obligation to address health and safety breaches. The result of any prosecution is liability for fines or potential imprisonment depending on the breach.

While section 7 places duties on all employees in relation to health and safety. As above, this legislation applies to the Trust, GMS and other contractual parties as separate legal entities.

The Health and Safety Executive and Care Quality Commission enforce health and safety legislation and use the associated Healthcare Technical Memorandum's (HTMs) and Approved Codes of Practices (ACOPs) to gauge compliance. The Trust may provide group health and safety standards or expectations which the subsidiary, GMS and any contractor (e.g., Apleona) is expected to follow. However, each organisation is responsible for ensuring its own legal compliance and for implementing the standards.

Approved Codes of Practice (ACOPs)

An ACOP has a special legal status. If an organisation is prosecuted for breach of health and safety law, and it is proved that it did not follow the relevant provisions of an ACOP, it will need to show that it has complied with the law in some other way or a Court will find it at fault. A non-exhaustive list of Approved Codes of Practice applicable to health care is provided in Appendix 3.

Healthcare Technical Memorandums (HTMS)

Although compliance with the HTMs may be delegated to staff or undertaken by contractors such as GMS or Apleona, duty-holder accountability remains with the Trust. Compliance with the HTMs will usually demonstrate compliance with legal duties.

HTMs provide comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare, focusing on nine different topics:

- HTM 00 – Policies and Procedures
- HTM 01 – Decontamination
- HTM 02 – Medical Gases
- HTM 03 – Heating and Ventilation Systems

- HTM 04 – Water systems
- HTM 05 – Fire safety
- HTM 06 – Electrical services
- HTM 07 – Environment and Sustainability
- HTM 08 – Specialist Services

HTM 00 confirms that the Trust, as the Healthcare provider, has a duty to ensure appropriate governance arrangements are in place and are managed effectively. These arrangements are defined in this framework and within the contractual requirements between the Trust and GMS or another third party.

5. ROLES & RESPONSIBILITIES

The responsibilities of all levels of staff and management are set out clearly in the Trust Health and Safety Policy, along with our Statement of Intent. The Trust is the duty holder in law for the health and safety of its employees, patients and staff.

GMS is the duty-holder in law for the health and safety of its employees. It also holds legal responsibilities as a controller of premises and has delegated duties under its contract with the Trust.

A summary of the key responsibilities include:

Trust

Role	Responsibilities
Chief Executive Officer and Trust Board of Directors	The Chief Executive Officer is ultimately responsible for compliance of the Health and Safety at Work Act 1974 and other relevant legislation and guidance. However, each Executive Director is an accountable officer who carries responsibility for promoting a high degree of health and safety awareness, demonstrating good leadership and ensuring a safe environment for colleagues, patients and the public. Board members must play a key role in ensuring that health and safety is adequately resourced, properly managed and that risks are controlled through a structure that delivers governance, assurance and compliance through a formal reporting mechanism. Responsible for: • Setting the health and safety policy and ensuring that policy statements reflect current board priorities • Ensuring the arrangements set out in this policy provide an effective means of hazard control and risk reduction and are fully embedded into the planning and delivery of services with appropriate levels of monitoring to ensure compliance • Ensuring that management systems provide effective monitoring and reporting procedures • Reviewing the health and safety performance regularly

	• Being kept informed about significant health and safety failures and of the outcome of the investigations into their causes • Ensuring that implications in respect of health and safety are addressed in all decisions • Makes adequate arrangements for access to competent advice on health and safety • Establishing effective communication systems for health and safety • Ensures line managers are accountable for health and safety in areas within their control and compliance is reviewed regularly via yearly appraisals Individual directors may lead on health and safety matters. However, this will not distract from the collective responsibility of the Trust Board
Director for Integrated Governance (Trust)	• Has delegated responsibilities for overseeing the health and safety management system, setting the direction for effective management of health and safety. Responsible for ensuring health and safety is integrated into key governance structures, including board subcommittees. Is the Chair of the Group Health and Safety Committee. • The role of the Director for Integrated Governance within health and safety will not detract from the responsibilities of other directors for specific areas of health and safety risk management
Executive Director of Improvement and Delivery	• Has delegated responsibilities for overseeing the provision of a safe workplace, namely the safe condition and health and safety compliance of the estate • Ensuring the Service Level Agreement (SLA) with the subsidiary and contractors are clear and are met. Addressing non-compliance issues associated with the estate • Have oversight of compliance with HMTs and ACOPs applicable to the workplace and compliance with Construction (design and management) Regulations where appropriate
Director of Finance (Trust)	• The Finance Director will provide advice to the Trust Board and Trust Leadership Team in relation to the financial implications of identified and quantified health and safety risks and requirements. • The Director must recognise that providing, and improving, safer working environments will be in direct competition with resources and allocated budgets, but has a responsibility to work with budget holders to ensure that priorities are identified and actioned
Executive Director for People and Organisational Development (OD)	• Delegated responsibilities for ensuring a robust strategic approach to address issues of employee's health, safety and wellbeing, including workplace welfare facilities. Responsible for ensuring health and safety is integrated into the People & OD workstreams. Is responsible for: • Ensuring the Service Level Agreement (SLA) of Occupational Health or other suitable provisions enables the Trust to discharge its duty in relation to statutory medicals and health surveillance for employees • Ensuring that Occupational Health or other provides provide suitable levels of service to the Trust in accordance with the SLA • The development and implementation of Human Resource (HR) policies which reflect the support mechanisms in place to assist and support employee's health, safety and wellbeing
Non-Executive Directors (NEDS)	• The role of the NEDs is to scrutinise, constructively challenge and have independent oversight of health and safety at Board level. They will receive assurance from the Chief Executive that health and safety is appropriately managed

Designated Person (**DP**) – an appointed Senior Executive (at Trust Board Level) with assigned responsibility for the service	A named individual within the Trust appointed at Trust Board level for each of the nine Healthcare Technical Memorandum (HTM) topics. • Provides the essential senior management link between the organisation and professional support, which also provides independence of the audit-reporting process. The DP will also provide an informed position at board level • Will work closely with the Senior Operational Manager (SOM) to ensure that provision is made to adequately support the specialist service • The senior executive who has responsibility for implementation of the relevant operational policies and for regularly monitoring effectiveness in line with those policies and arrangements
Senior Operational Manager (**SOM**) – does not have to be at board level	• Operational and professional responsibility for a specialist service(s) • Has access to robust, service-specific professional support which can promote and maintain the role of the "informed client" within the Trust
Authorising Engineer (**AE**) - an independent professional advisor to the healthcare organisation	• Appointed by the Trust with a brief to provide services in accordance with the relevant HTM. Will remain independent of the operational structure of the Trust • Will act as assessor and make recommendations for the appointment of Authorised Persons, monitor the performance of the service, and provide an annual audit to the DP
Associate Director of Estates (Trust)	• Provide advice on the required health and safety provisions for the estates and facilities • Have oversight of compliance with HTMs and ACOPs applicable to the workplace • Compliance with Construction (design and management) Regulations where appropriate • Ensure that contractors and sub-contractors are made aware of the Trust's health and safety requirements and that arrangement are in place monitor the implementation and compliance with safety requirements • Proactively ensure that the estate is a safe and healthy workplace • Identify and escalate health and safety issues to the Group H&S Committee and the Trust Board • To actively engage with managers in noting any estates and facilities concerns
Head of Risk, Health and Safety	Appointed and employed by the Trust as a suitably senior and competent individual(s) to oversee Health and Safety of the Trust's operations. To provide assurance to the Trust Board and appropriate committees that Health and Safety is being effectively managed and risks are recognised and understood Responsible for: • Developing and reviewing H&S policies and strategies • Establishing H&S standards and goals • Ensure safe working procedures are implemented • Conduct inspections, risk assessments, and audits • Provide advice and guidance to staff, manager and the Board • Investigating serious accidents and incidents • Liaising effectively with the Health and Safety Executive (HSE) and other safety related external agencies on behalf of the Trust • Regularly monitoring and reviewing the health and safety management system • Developing health and safety training

	• Analysing health and safety related adverse events and data, producing reports as necessary • Producing a health and safety plan and annual health and safety report • Ensuring the appointment and training of one or more competent person(s) to assist in the continuation of supporting the health and safety of all colleagues, patients and visitors
Risk, Health and Safety Team	Are responsible for: • Assisting in the development, production and delivery of strategies which ensure Trust compliance with statutory requirements, Department of Health Directives and Trust policies • Preparing and delivering as required senior management reports to various forums where health and safety is discussed • Working with colleagues to put in place an effective system in order to audit compliance with the Trust health and safety plan • Attending divisional risk meetings, developing and delivering training as required, investigating incidents • Advising managers and colleagues on risk assessments, completing and reviewing assessments • Ensuring residual unacceptable health and safety risks are placed on the divisional risk register • Continually developing skills and knowledge to be able to recognise hazards within the Trust and put sensible controls in place to protect other colleagues, visitors and patients from harm
Emergency Planning Officer	The EPRR Officer is responsible for ensuring: • An orderly and efficient transition from normal to emergency operations • Designation of emergency authority and responsibilities • Coordination with other organisations • Safe continuation of operations or return to normal operations as soon as practicable
Trust Leadership Team (TLT), including Chiefs of Service, Divisional Directors of Quality and Nursing, Divisional Operations Directors, Deputy and Associate Directors, Senior Managers	All TLT members should understand their individual and collective legal obligations in relation to compliance and hold themselves and services to account in ensuring to a good health and safety standard. TLT and senior managers shall: • Promote a high degree of health and safety awareness amongst colleagues and demonstrate good leadership skills • Ensure compliance with CQC and HSE statutory regulations and codes of practice within their areas • They should confirm their organisational structure is able to discharge the requirements of health and safety and that colleagues in their division(s) are competent to perform tasks in their area safely • They must identify forums for planning and delivery of a healthy and safe workplace and that proactive and reactive monitoring of systems is undertaken.
Health and Safety Leads	Health and Safety Leads are colleagues with responsibilities for ensuring health and safety is effective in departments and wards. They will: • Undertake designated training for risk assessment/accident investigation training • Implement a programme for undertaking, updating and disseminating risk assessments • Ensure actions are completed in the required timeframe • Escalate risks to divisional board/ health and safety committee as prescribed in Q0637 - Risk Management Procedures.

Moving/Handling Advisors	• Will act as principal advisor(s) for all Trust moving and handling activities by providing information and expertise on the suitability of moving and handling aids and delivering appropriate training • Advisors will undertake manual handling risks assessment as required and complete audits across the Trust • Will provide a detailed report to the Group Health and Safety Committee
Matrons/General Managers	Managers at ALL levels will ensure: • They have, or undertake to obtain, sufficient information, instruction and training to enable them to lead on matters of health and safety within their respective roles • All risk assessments are carried out, documented and reviewed for the area(s) within the required timeframe • Information received relating to health and safety is acted upon and passed to the appropriate people • Work with lead risk assessors, colleagues and colleague representatives to provide suitable and sufficient equipment which is serviced and maintained • Discuss and disseminate Trust safety policies and implement the requirements • Prepare / update appropriate health and safety procedures within their department(s) • Set clear health and safety performance standards and objectives for those under their supervision • Manage timely reporting and investigation of accidents and incidents in accordance to Trust policy • Intervene to prevent poor health and safety practices or procedures • Identify the level of knowledge required for all colleagues to undertake their role safely. Ensure their colleagues attend the appropriate training • Maintain a system of regular inspections and audits to determine the degree of compliance and take appropriate remedial action to address non-compliance • Afford all colleagues the same level of protection as an employee, including bank, agency colleagues, students, volunteers, work experience, temporary, young or inexperienced, disabled colleagues, pregnant and nursing mothers, lone workers, contractors and others under their supervision • Keep up to date with developments in their field of work such as safety-specific technical information or legislative change and respond as necessary • Ensure colleagues and visitors are aware of emergency procedures
Occupational Health Service / Trust Health and Wellbeing Hub	OHH is responsible for: • Pre-placement screening and health surveillance • Immunisations against infectious diseases and the management of contained sharp incidents • Colleague wellbeing support / Advice about adjustments to work on health grounds and rehabilitation back to work after illness • Advice to managers on individual risk assessments • Regular feedback to the Trust Health and Safety Committee on work related injury and ill health Health and wellbeing Hub is responsible for: • Colleague wellbeing support • Regular feedback to the Trust Health and Safety Committee on work related injury and ill health • Supporting the workplace wellbeing regulatory requirements

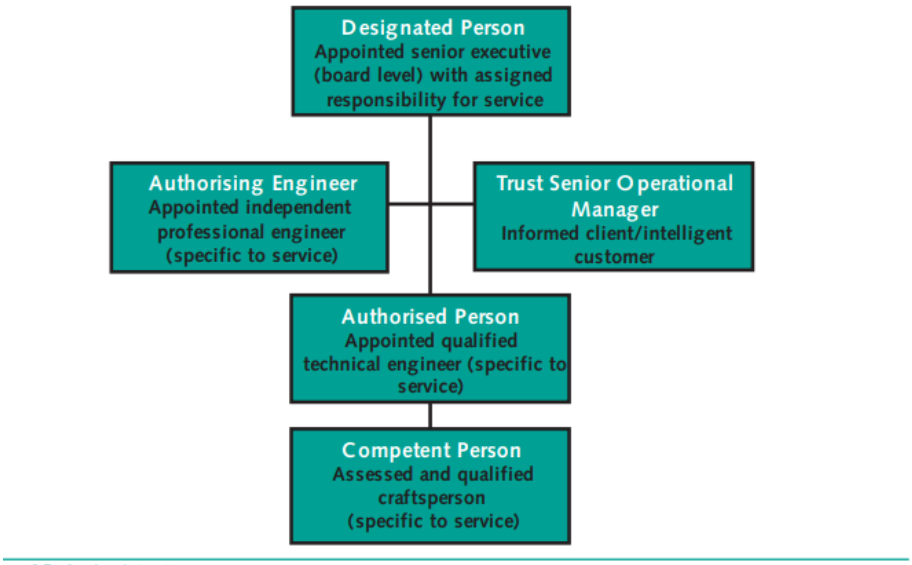
Infection Prevention Control Team	• Responsible for providing advice and guidance on infection control and reporting issues to the Group Health and Safety Committee • Ensure that professional standards and practices are followed
Trade Union Health and Safety Representatives	Assist the Group in health and safety matters by: • Consulting with union members / Attending the Group H&S Committee • Advising staff (within their competence) on effective health and safety management • Engaging in safety improvement work, safety inspections, investigations and risk assessment activity in partnership with local managers
Contractors/Sub Contractors	Contractors and sub-contractors that are under the control of, or employed, directly or indirectly, by the Trust (including those through GMS, GHP and Apleona) must comply with the requirements of the Control of Contractors Policy
Training Department	Must ensure that health and safety training is recorded and levels of compliance are monitored. Must take appropriate action to ensure responsible managers are aware of training compliance issues and support reasonable steps to address any issues that may arise.
Employees	Employees must: • Take reasonable care of their own health and safety and that of others • Cooperate with the Trust on health and safety issues • Not wilfully or intentionally interfere with or misuse anything provided for health, safety or welfare. • Use any equipment and Personal Protection Equipment (PPE) provided by the Trust, and take reasonable care of it • Report any accidents, defects, damage, unsafe acts or conditions, near misses, or loss as soon as reasonably possible • Read, understand and follow the requirements of the Trusts health and safety policies, procedures, risk assessments and safety information • Comply with all statutory and mandatory training requirements • Ensure they report immediately any ill health, stress or other medical condition which may be work related or affect their ability to work safely. The repeated refusal or wilful neglect by any employee to meet their obligations will be regarded as a matter to be dealt with under the disciplinary procedure.

GMS

Role	Responsibilities
Managing Director and GMS Executive Directors	• Each Director carries ultimate responsibility responsible for promoting a high degree of health and safety awareness, demonstrating good leadership and ensuring a safe environment for colleagues, patients and the public • Directors must play a key role in ensuring that health and safety is adequately resourced, properly managed and that risks are controlled in relation to its own staff and its activities that may affect others. This also applies to resources in accordance with the contract and budget provision between GMS and the Trust as far as is reasonably practicable and within GMS' control • Responsible for compliance of the Health and Safety at Work Act 1974 and other relevant legislation, as far as reasonably practical. • Discharging duties under the HTMs where the Trust has appointed GMS to specific the duty holder roles set out in the HTMs. Ensuring that there are

	sufficient resources within GMS to discharge these duties effectively and "in a manner consistent with the Trust discharging its statutory duties" (Operated Healthcare Facilities Agreement 2018) • Responsible for all elements of the facilities, the capital equipment and listed trust owned equipment and for building health and safety compliance within the contract between GMS and the Trust which will include the inspection and management in accordance with relevant legislation and regulations of health and safety critical risks (Estates Specification) • Escalate health and safety issues that are outside the GMS budget envelope or remit to the Trust using the established escalation route in this framework
Non-Executive Directors GMS (NEDS)	• The role of the NEDs is to scrutinise, constructively challenge and have independent oversight of health and safety at Board level. They will receive assurance from the Managing Director and Executive Directors that health and safety is appropriately managed
Authorised or Responsible Person (**AP / RP**)	• Has key operational responsibility for the specialist service. Should be qualified and sufficiently experienced to fully operate the service • Nominated by the AE and employed by the Trust • Role includes maintenance of records, quality of service and maintenance of systems safety • Responsible for establishing and maintaining the validation of the Competent Persons (CPs), who may be employees or appointed contractors
Deputy authorised or Responsible Person **(DAP / DRP**	• Supports the AP/RP in discharging operational responsibilities for the specialist service. Should be qualified and sufficiently experienced to fully operate the service • Nominated by the AE and employed by the Trust • Role includes maintenance of records, quality of service and maintenance of systems safety • Supports the AP/RP in establishing and maintaining the validation of the Competent Persons (CPs), who may be employees or appointed contractors • Deputises for the AP/RP as required during periods of annual leave or short-term sickness
Competent Person (**CP**)	• Should be qualified and sufficiently experienced • Appointed, or authorised to work (if a contractor) by the AP • Provides skilled installation and/or maintenance of the specialist service
Health and Safety / Compliance Team (GMS)	• Appointed and employed by GMS to as a suitably senior and competent individual(s) to oversee Health and Safety of GMS' own operations as well as the services it delivers to the Trust. • To provide assurance to the GMS Board and appropriate GMS committees that Health and Safety is being effectively managed and risks are recognised and understood

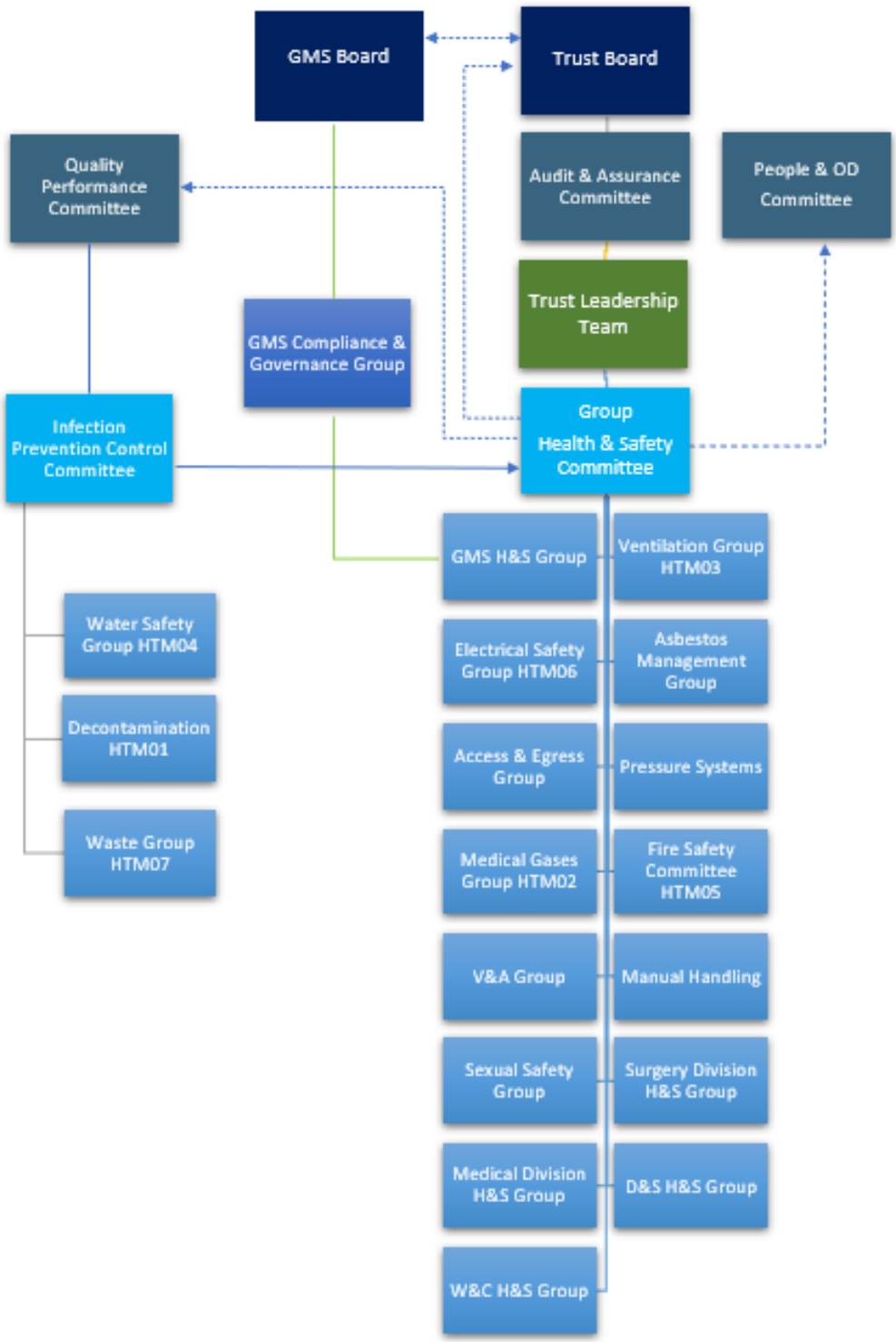
HTM 00 indicates that the Board and Chief Executive should be "accountable officers" for each of the HTM topics. Figure 2 of HTM 00 sets out the structure that underlies the approach to compliance in HTMs



The duty holder at law and under the specific HMTs are set out in Appendix 2 (roles and responsibilities).

6. GOVERNANCE STRUCTURE

Both downstream and upstream health and safety governance flows must be robust and compliance-proof. The Trust has adopted a Group governance operating model to achieve consistency in reporting, minimise duplication and prevent gaps in governance mechanisms. This structure still permits GMS to govern its own internal health and safety governance structure. The Group structure is shown below:



6.1 Sub-groups

A number of relevant sub-groups report to the Group H&SC. These sub-groups relate to functions, legislative requirements and / or relevant Healthcare Technical Memorandums (HTMs). Areas of law that which do not require a subgroup will be encompassed within compliance or health and safety reports from either the Trust or GMS in line with the primary management of the function.

Each sub group is required to oversee and review:

a) Operational effectiveness of the relevant safety risk management processes;
b) Appropriate resolution and mitigation of identified risks;
c) Assessment of the safety impact of operational changes;
d) Implementation of corrective action plans within reasonable timescales;
e) The effectiveness of safety recommendations and safety promoting
f) Results of safety data analysis

Each sub-group must have a Terms of Reference aligned to ensuring legislative compliance and the Group H&SC programme of work. It must have clear objectives and a defined and planned delivery programme / action plan to which it should hold itself to account. Agendas should include standing items as necessary to ensure continued operational oversight of compliance.

Sub-groups have the authority to work within their budget envelope and to make day to day operational decisions, or take remedial actions, to achieve compliance in their area of expertise and reduce day to day risk.

Each sub-group will present a Key Issues and Assurance Report (KIAR) to the Group Health & Safety Committee in accordance with the agreed rotation of agenda items (see Group H&S Committee Planner). This rotation is risk-based and may require sub-groups to report more frequently when risk is not assured. Where required, the sub-group will be expected to present full reports, records, presentations and other appropriate supporting documents to evidence compliance or provide assurance.

6.2 Group Health & Safety Committee (Group H&SC)

The Group H&SC is appointed by the Board, chaired by the Executive Director with responsibility for health and safety. The Group H&SC is a review and challenge body in relation to all matters connected to health and safety, the extent to which the Health and Safety strategy is being deployed, including assessing resilience and process safety.

The Group H&SC comprises of relevant senior divisional managers, sub-group chairs, specialist advisors or subject matter experts, Trade Unions and Representatives of Employee Safety.

The Committee monitors:

(a) Effectiveness of the Trust's safety management processes

(b) Effectiveness of the safety oversight of sub-contracted organisations
(c) Corrective or mitigating actions are being taken in a timely manner
(d) Reviewing and approving relevant health and safety policies
(e) Overseeing serious health and safety investigations

The Group H&SC is authorised by the Trust Leadership Team (TLT) to follow up any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees within the Group are directed to cooperate with any request made by the Group H&SC.

The Group H&SC has unrestricted access to all relevant documents and records within the Trust and GMS to assure compliance, unless access is deemed unlawful.

The Group H&SC is authorised by TLT to obtain external legal or other independent professional advice and to secure the attendance of external parties with relevant experience and expertise if it considers necessary. On occasion, the Trust, GMS, Apleona and interested third parties (e.g. terrier building managers) may find it prudent to seek separate legal or independent advice, but will, where reasonably practicable, predominantly seek to do this jointly.

The Group H&SC has delegated authority from TLT and Board to consult on, approve and ratify Trust-owned documents that support health and safety strategies and policies (such as procedures, guidance etc.) including documents relating to its sub-groups. On occasion, the Trust, GMS, Apleona and interested third parties (e.g. termitary building managers) may find it necessary to develop separate documents, but will, where reasonably practicable, predominantly seek to set health and safety standards jointly.

The Group H&SC will receive reports and will advise the TLT by exception of issues and concerns. Reports may include, but are not limited to:

- Audit reports on health and safety and related matters
- Reports on Radiation Protection and other specialist areas
- Information on changes in legislation and good practice relating to health and safety
- Health & safety risks on the register
- Incident and accident data (to include details of reportable incidents)
- Any enforcement actions
- Key Performance Indicators (KPIs) relating to health and safety
- Sub-group KIARS and reports

Group H&SC will report a minimum of **quarterly** to the Trust Leadership Team (TLT), and the Audit & Assurance Committee (A&AC), and annually to the Trust Board. This will be via a Key Issues and Assurance Report (KIAR) unless a full report, alongside other appropriate supporting documents, is required.

At least annually, the Group H&SC will review its constitution and terms of reference to ensure it is operating at maximum effectiveness. Where the review has implications for GMS' governance processes, consultation will take place to ensure the governance of all parties are aligned.

6.3 Trust Leadership Team (TLT)

The Trust senior leadership team are the principal judges of risk management within the Trust as they have a detailed collective knowledge of the organisation's capabilities. The TLT must hold themselves and others to a good health and safety standard.

All TLT members should understand their individual and collective legal obligations in relation to compliance. The TLT will need to think strategically when considering how to resolve health and safety issues within the Group and have a responsibility to make, and be able to account for, sound risk-based decisions regarding safety. TLT should seek observable outcomes in relation to planned health and safety programmes.

GMS Board have a seat on the TLT meetings to ensure that there is co-operation between the Trust and subsidiary and that health and safety information / reporting flows between the two organisations. GMS may still escalate matters through their own health and safety governance structure where appropriate.

The TLT will be required to submit a report to the Board following receipt of a report from the Group H&SC using the KIAR format on any items that require escalation or oversight.

6.4 Audit and Assurance Committee (A&AC)

A&AC is constituted as a committee of the Board. It is a non-executive committee and has no executive responsibilities nor is it charged with making any decisions unless delegated to it by the Board. It may, however, make recommendations.

A&AC has authority to seek information on health and safety governance and the effectiveness of controls. As part of its obligations A&AC will:

- Review the comprehensiveness of assurances on health and safety governance, and determine the reliability and integrity of our governance approach
- Guide the development and direction of assurance activity (including but not limited to internal and external audit) through consideration of the integrated Group assurance plan
- Review and consider the outcomes from any health and safety assurance reviews (including internal audit reports) as reported by the Internal Auditor, assessing the impact on the overall control environment
- Review the adequacy and timeliness of the implementation of management actions to address issues highlighted through health and safety assurance reviews

The A&AC will be required to submit a report to the Board following receipt of an annual report from the Group H&SC using the KIAR format on any items that require escalation or oversight. The A&AC shall make whatever recommendations to the

Board it deems appropriate on any area within its remit where action or improvement is needed.

6.5 People and OD Committee

The Group H&SC will retain links to the People and OD Committee (PODC) in relation to staff wellbeing, health surveillance and the workplace welfare provisions described in law. The POD directorate will be expected to provide relevant compliance reports to the Group H&SC on these areas.

6.6 Quality Performance Committee

The Group H&SC will retain links to the Quality Performance Committee (QPC) in relation to health and safety matters in water safety, infection control, decontamination and waste. Relevant sub-groups and / or senior quality staff will be expected to provide relevant compliance reports to the Group H&SC on these areas.

6.7 Trust Board

All Trust Board members should understand their individual and collective legal obligations in relation to compliance. Strong visible leadership is required, working together with GMS. In setting out the rules, procedures and responsibilities within the Group, the Board will ensure accountability, fairness and transparency in the management of health and safety. The Board must ensure it has the ability to exercise proper oversight of the system as a whole.

Safety information requested or received by the Board should be meaningful to ensure that the Board is able to discharge its duties in accordance with health and safety law.

Board members should ensure that staff have the time and resources to explore and address health and safety risks, control measures and concerns.

Board will as a minimum receive an Annual Health and Safety Report that summarises activities that have further developed the H&S Management system as a result of both proactive and reactive responses.

6.8 GMS Board

The GMS Board sets its own internal health and safety governance and reporting structure which is not dictated by this framework. This ensures that it can continue to independently manage its own health and safety processes. However, GMS Board will be expected to work in collaboration with the Trust Board where the activities of GMS significantly impact the Trust's abilities to meet it health and safety obligations as the duty holder.

7. CONSULTATION

There are two sets of regulations requiring an employer to consult with their employees about health and safety. These are:

- The Safety Representatives and Safety Committees Regulations 1977 (as amended); and
- The Health and Safety (Consultation with Employees) Regulations 1996 (as amended).

The first set relates to employees that are represented by a trade union that is recognised by the employer, for example, Royal College of Nursing, Unite or Unison. Anyone elected under these regulations are known as Safety Representatives. The employer is required to consult with Safety Representatives on matters that affect their members.

The second set relates to employees who are not part of a recognised trade union. In this instance an employer can choose to consult either through elected Representatives of Employees Safety, directly with individual employees or a combination of both.

7.1 Elections of Safety Representatives/Representatives of Employee Safety

Safety Representatives for a recognised trade union must be appointed by the Trade Union and agreed with the employer. The Regulations require that representatives have either worked for the Trust or GMS for two years or have had at least two years' experience in similar employment. This ensures the person has the necessary experience and knowledge to make an effective contribution to health and safety in our workplace. Representatives of Employee Safety (non-union) are elected by the workforce. Elections will be highlighted at Group H&SC to allow the workforce time to consider and elect candidates. Appendix 4 provides further detail on the:

- process and application form for appointing a representative
- resources for representatives
- the role and function of a representative

7.2 Consultation Process – staff and representatives

Staff should feel valued and should play an active role in health and safety by talking, listening and co-operating with each other in order to achieve a safer workplace. Whilst we encourage staff to do this every day, consultation with staff can take three forms including directly with employees, indirectly with employees or with their representative. Examples include:

- Directly with employees
    - informal discussions with individual employees

  - formal group meetings
  - working groups, task and finish groups
  - workshops, seminars

- Indirectly with employees
  - health and safety information provided on specialist departmental intranet pages
  - emails, global communications, surveys

- With their representatives
  - Formal consultation with Representatives and staff mainly takes place through our Group H&SC
  - Divisional health and safety meetings in relation to the members they represent
    - Sub-groups meetings

Broadly, we will consult with employees in relation to:

- The introduction of any measure which may **substantially** affect our employees' health and safety at work (e.g., significant changes rather than minor amendments)
- The **arrangements** for securing competent advice on health and safety
- Information on hazards, risk and control measures for significant risks
- The planning for health and safety training e.g., training needs analysis
- The health and safety consequences of any new technology

7.3 Consultation period

The law requires consultation to be within good time. There is no legal definition for this but in general this requires sufficient time to explain the issue to the employees (or their representatives), for them to consider it and provide an informed response. How long is given, will depend on the complexity of the issue, how many people need to be consulted, the efficiency of the method of consultation and the urgency of the issues at hand.

Simple issues are likely to be dealt with via email, with a few days allocated for responses. Urgent issues may equally need to be addressed at speed to ensure safety is preserved. In these instances, co-operation with tight / urgent deadlines is expected. Feedback is considered and, where appropriate, is incorporated.

8. RAISING HEALTH AND SAFETY ISSUES

All employees, Safety Representatives (Trade Union) and Representatives of Employee Safety are expected to follow the most appropriate route for raising an issue. Whilst it is not possible to prescribe what this might be for every potential issue; the following provides guidance on the starting point and how to escalate it within the health and safety governance structure.

8.1 Before raising an issue

It is expected that before raising a concern, employees, Safety Representatives (Trade Union) or Representatives of Employee Safety, will explore the problem as far as is reasonably practicable and gather evidence to help illustrate the issue, the scale or seriousness of it. Generalised statements without exploration, can lead to valuable resources being misdirected rather than focussed on the direct concern.

8.2 Where to raise a concern – line manager

Issues should not be escalated prematurely and must be raised with the local line manager(s) in the first instance. Representatives should encourage staff to take this step themselves to help build a trusting and proactive working relationship between managers and their teams. Where there is a genuine reason that a staff member feels unable to do this, the relevant Representative can refer the issue to the line manager on behalf of any members they represent.

It is every line manager's responsibility to ensure that all staff are included in, or have access to, a local meeting or 1:1 where they can raise health and safety issues. All issues must be raised in a professional and respectful manner. A line manager must be given reasonable opportunity to consider, investigate and respond.

8.3 Next steps – specialist guidance

Where the local line manager advises that they lack the knowledge or experience to support a solution, or where it is prudent to seek support from a specialist, issues should be referred by the employee, their manager or their representative to the most appropriate working group, specialist team or person for guidance.

This is an important step in seeking a solution, and must be taken before escalating the issue to divisional, senior or Group level (unless the imminency of the risk requires more urgent senior action). The use of specialist groups/ teams or individuals ensures all the right people, with the right knowledge and skills, have had the opportunity to support a solution. Where issues are directed straight to senior managers, directors or executives, this may delay an informed solution and is likely to be de-escalated back to those raising it, to take this step first.

In some instances, the specialist individuals or teams will be based within GMS. In these cases, employees or their representative should refer the matter to the GMS Health and Safety Manager or Compliance Manager, who will be able to direct it to the most appropriate team(s) within GMS for support.

If specialist guidance is not available or the working group / specialist team is unable to support a resolution, the issue should be escalated to the appropriate divisional health and safety meeting(s). For issues affecting corporate staff these can be passed to the Risk, Health and Safety team for support.

8.4 Escalating to the Divisional Health and Safety Meeting

These should be held as a minimum once every quarter and are Chaired by the Divisional leadership. Where it is necessary to raise an issue urgently between meetings the employee or their representative can contact the divisional Chair or the Risk, Health and Safety team (in corporate division) to ask that an issue is given due consideration between scheduled meetings.

Every effort should be made to resolve health and safety issues at divisional level. Where the Chair agrees an issue cannot be resolved at divisional level, they may refer it to the Group H&SC, unless there is a more appropriate route. Divisional Chairs should place items on the agenda for the Group H&SC in good time.

GMS as a Ltd company has its own company health and safety meeting which is directly managed and controlled by GMS. GMS employees should follow the governance process related to raising issues at the GMS health and safety meeting.

8.5 Escalating to the Group H&SC

Matters can be raised at this group Committee by the Trust or GMS where one or more of the following apply:

- It has been raised and discussed with the local line managers, specialist groups / teams or individuals and at the divisional meeting but no reasonable solution has been identified and / or implemented within a reasonable time
- It requires discussion at a higher / strategic level due to the potential for serious imminent harm
- A systematic or serious breach has been identified
- A collective decision by senior managers is required which cannot reasonably take place a local or divisional level
- Significant funding is required that is beyond the local or divisional budget
- Significant changes to working practices will impact staff beyond the local departments or a single division and cannot be agreed at a relevant specialist group or via cross divisional working
- It has been referred to a specialist Trust department, GMS or Apleona but no suitable solution has been identified and / or implemented within a reasonable time
- It is an issue that the Group should be aware of or are monitoring

The agenda for the meeting is set approximately 14 days prior to the meeting. Staff and their representatives should contact the Chair and /or the Risk, Health & Safety team for inclusion of a non-standing item.

8.6 Escalating to the Trust Leadership Team

Matters can be raised at TLT where:

- It requires senior leadership input due to the potential for serious imminent harm or a systematic or serious breach has been identified

- A collective decision by senior managers is required which cannot reasonably take place at Group H&SC without recourse to TLT
- Significant funding is required that is beyond the local or divisional budget
- Significant changes to working practices will impact the majority of staff
- It has been referred to a specialist Trust department, GMS or Apleona but no suitable solution has been identified and / or implemented within a reasonable time
- It relates to subsidiary performance standards
- It relates to likely or imminent statutory intervention in relation to the Trust, GMS or Apleona
- It is an issue that the TLT should be aware or are monitoring

The Group H&SC can raise matters on behalf of the Trust and GMS via the group reporting process to TLT. GMS and Apleona may also raise matters on health and safety or compliance to TLT separately and in their own right.

8.7 Escalating to A&AC or the Trust Board

Matters can be raised by the Trust to the A&AC or the Trust Board respectively where:

- It requires Executive Board level input due to the potential for serious imminent harm or a systematic or serious breach has been identified
- There is a systemic failure in assurance mechanisms or in timely action
- A collective decision by the Trust and /or GMS Board is required
- Significant funding is required that is requires the Trust and /or GMS Board sign-off or input
- It relates to significant performance standards concerns or clarifications within the subsidiary
- It relates to likely or imminent statutory intervention in relation to the Trust, GMS or Apleona
- It is an issue that the Board should be aware or are monitoring

A flowchart for the escalation of issues is provided in Appendix 1.

8.8 GMS Board

GMS as a Ltd company has its own internal escalation process for health and safety matters which are directly managed and controlled by GMS Board.

9. COMPETENT ADVICE

Separately and collectively the Trust and GMS will have access to competent advice.

9.1 Competent Person

The law requires that organisations should have access to competent health & safety assistance. Within the Group this is:

- Trust – Risk, Health & Safety Team
- GMS – Compliance Officers and Health & Safety Manager

If the required subject knowledge and/or level of competence does not exist within the organisation, then the duty-holder should employ a specialist adviser (or advisers) to contribute towards overall health & safety management.

9.2 Independent Authorising Engineer

In estates and facilities management, an Authorising Engineer (AE) plays a key role in ensuring safety and compliance and is typically responsible for overseeing, evaluating, and authorising specific processes or systems, such as those related to fire safety, ventilation, confined space, water safety, work at height, or asbestos management. An AE must be independent and is accountable to the Trust as the duty-holder.

Depending on the specialism, an AE will:

- Assess the competency of individuals before their appointment in key roles
- Provide independent advice on the current, relevant legislation, codes of practice, standards and technical guidance
- Carry out assessments to establish the failings in compliance with HTMs or legislation and offer solutions
- Review policies and procedures
- Support the premises assurance model within GMS
- Support action planning
- Provide input into relevant accident investigations
- Undertaking an annual management audit, that is issued to the Responsible Person

The appointment of AEs is managed by GMS on behalf of the Trust. The AE's responsibilities must be made clear with the contractual obligations agreed. GMS must escalate to the Trust as the duty-holder if there is no available AE for any area of compliance that requires one.

9.3 Responsible Person, Deputy Responsible Person and Appointed Persons

Some HTMs and guidance require the appointment of a Responsible Person (RP), Deputy Responsible Person (DRP) and Appointed Person(s) (AP). In most cases, the RP will carry specific responsibilities in relation to compliance, supported by the DRP and the APs. Where contractual requirements are such that GMS has delegated responsibilities to fulfil these roles, GMS are responsible for ensuring they are filled by suitably competent individuals (trained and experienced). A nominated RP or DRP must be approved by a relevant AE and appointed in writing via a letter of appointment.

GMS must escalate to the Trust as the duty-holder if there is no available RP, DRP or AP for any area of compliance that requires one or if there is a vacancy in one of

these roles. Escalation should be to the chair of the relevant sub-group, and the chair of the Group H&SC.

9.4 External Expertise

There may be occasions where specific expertise is required to support the identification, assessment or control of a risk. The Group H&SC has authority to either instruct such expertise in line with any budget envelope or may request TLT to support such an intervention.

10. H&S POLICIES

All Trust health and safety policies must be accessible to all staff. Where reasonably practicable, policies associated with health and safety should align across the Group to ensure that the Group maintains consistent standards.

However, as a separate legal entity, it is for the subsidiary, GMS, to implement, administer and enforce those policies within GMS via their own governance routes. GMS it able to develop its own health and safety policies, where a joint policy is impracticable or a separate policy is required by law.

11. SYSTEMATIC RISK ASSESSMENT

The Group must carry out risk assessments as part of its legal obligations to ensure that patients, staff, visitors and contractors are kept safe. A risk assessment is a careful examination of the hazards within our work activities and environment that could cause harm to people. The Group's arrangements for risk assessments are detailed in B0636 Risk Assessment and on the intranet.

12. EMERGENCY PLANNING

Emergency planning procedures which includes preparing, responding, and recovering from an unexpected and/ or disruptive event that threatens to destabilise or impact negatively the Trust or the Group, are detailed on our intranet. The Trust expects its subsidiary and partner organisations to comply with its arrangement for emergency events. Where GMS take a primary role in implementing emergency procedures (e.g., lock down) they must ensure their staff are competent and experienced to do so.

13. HEALTH AND SAFETY RISK REGISTERS

The Trust maintains its risk register on Datix, which includes health and safety related risks. Mitigation plans for Trust risks should reflect the Group response, with GMS supporting the updating of Trust risks by contributing essential information to Trust risk leads in line with their delegated or contractual responsibilities and areas of expertise. Staff should refer to Q0637 - Risk Management Procedures.

As a separate legal entity, GMS will manage its own separate corporate risk register in accordance with its own policy and procedures and report this separately reported to the GMS Board.

14. INCIDENT INVESTIGATION & RIDDOR REPORTING

The Trust has an incident investigation policy which is applicable to health and safety investigations.

As the duty holder in relation to Trust activities, the Trust will report all RIDDORs to the HSE that relate to its employees, patients or visitors. As the duty holder in relation to GMS activities, GMS will report all RIDDORs to the HSE in relation to reportable incidents involving its' own employees or where a report is required by the responsible person with control of the premises. Where both the Trust and GMS are responsible persons, the RIDDOR reporting will be discussed and agreed.

Both the Trust and GMS will report any RIDDOR incidents as part of its health and safety reporting obligations to the Group Health and Safety Committee.

15. INTERACTION WITH CQC, HSE & RELEVANT AGENCIES

The Risk, Health and Safety team will liaise with the regulatory bodies on any Trust reported RIDDORs or in relation to any health and safety inspections of the Trust. The Trust will expect GMS to cooperate in a timely manner with any requests to GMS to provide documentary or other evidence on behalf of the Trust to the regulator to satisfy the Trust's statutory obligations.

GMS will liaise with the regulatory bodies on any GMS reported RIDDORs or in relation to any inspections of GMS as a separate legal entity. However, both parties should collaborate on arrangements and as far as is reasonably practicable to support any regulatory intervention. The Trust is expected to cooperate in a timely manner with any requests from GMS to provide documentary or other evidence held solely by the Trust on behalf of GMS to the regulator to satisfy the Trust's statutory obligations.

16. MONITORING

16.1 Health & Safety Strategy

The Trust has a Health and Safety Strategy which contains objectives and targets for improvement over the period of the strategy. The strategy is risk-based and may be reviewed before the end of the period where a change in risk-profile necessitates this. Each division is monitored in relation to progress against the strategy and this is reported at the divisional health and safety meetings.

16.2 Self-Assessment

The Trust and its subsidiary should have a programme of self-assessment, which focuses on high-risk or themed areas of health and safety. A minimum of two detailed self-assessments should be carried out across the Group annually. This may be carried out in relation to the whole or part of an HTM or ACOPs or a specific topic. Self-assessments should be reported to the Group H&SC. GMS will follow its own internal reporting structure accordingly.

Any significant gaps identified should be escalated appropriately to the TLT, the Audit and Assurance Committee and the Trust Board. GMS may also independently escalate through their own structure to GMS Board respectively.

It is expected that each self-assessment will be followed up by an action plan that is monitored via the relevant sub-group, reporting progress to the Group Health and Safety Committee and the respective Committees and / or Boards.

16.3 Authorised Engineer Audits

The annual AE audits should be shared with the relevant operational sub-group, as well as the Director of Integrated Governance and the Head of Risk, Health & Safety. All AE audit reports should be presented at the Group H&SC reporting to the Audit and Assurance Committee and the Trust Board. GMS will also follow its own internal reporting structure for reporting AE audits accordingly to its Board.

It is expected that each audit will receive a timely management response and will be followed up by an action plan that is monitored via the Group H&SC and the respective Committees and / or Boards within the Trust and GMS.

16.4 Internal Audit Role

Periodic themed health and safety audits may be carried out by the Internal Auditor. These should be reported to the Group H&SC reporting to the Audit and Assurance Committee and the Trust Board.

It is expected that each audit will receive a timely management response and will be followed up by an action plan that is monitored via the relevant sub-group, reporting progress to the Group H&SC and the respective Committees and / or Boards within the Trust and GMS.

16.5 Independent audits

From time to time the Group H&SC may require additional expertise to audit more complex elements of our health and safety systems, particularly where there is high-risk. Where this necessitates significant funding, the request will need TLT approval/SFI processes. This does not prevent either the Trust or GMS separately pursuing an independent audit as it sees fit.

17. REVIEW

The Risk, Health and Safety team will prepare an annual report on the Trust's health and safety performance. Where appropriate, GMS may be asked to contribute to this. This will be submitted to the Trust Leadership Team, Audit and Assurance Committee and to the Trust Board after the end of the financial year.

The Trust Board will review health and safety performance at least once a year on receipt of the annual report. The review process should:

- Examine whether the health and safety policy reflect the organisation's current priorities, plans and targets
- Examine whether risk management and other health and safety systems have been effectively reporting to the board
- Consider actions to address any weaknesses and a system to monitor their implementation
- Consider immediate reviews in the light of any major shortcomings or events
- Consider whether the organisational strategic objectives and risk appetite reflect health and safety needs and priorities

As a separate legal entity, GMS will manage its own arrangements for annually reporting its health and safety management to the GMS Board. Where GMS health and safety performance has or will significantly impact the Trust's ability to meet its own legal obligations, GMS must highlight this to the Group H&SC. Equally, where Trust health and safety performance has or will significantly impact GMS' ability to meet its own legal obligations, the Trust must highlight this to the Group H&SC.

18. TRAINING AND EDUCATION

All staff should have an understanding of the Trust's safety policy and the principles and processes of the Safety Management Framework.

Line managers and supervisors should understand the safety process, hazard identification, risk management and the management of change. Accountable senior managers should have an awareness of safety management roles and responsibilities, safety policy, safety culture, standards and safety assurance.

A training needs analysis has been undertaken as part of the Trust's Health and Safety Policy.

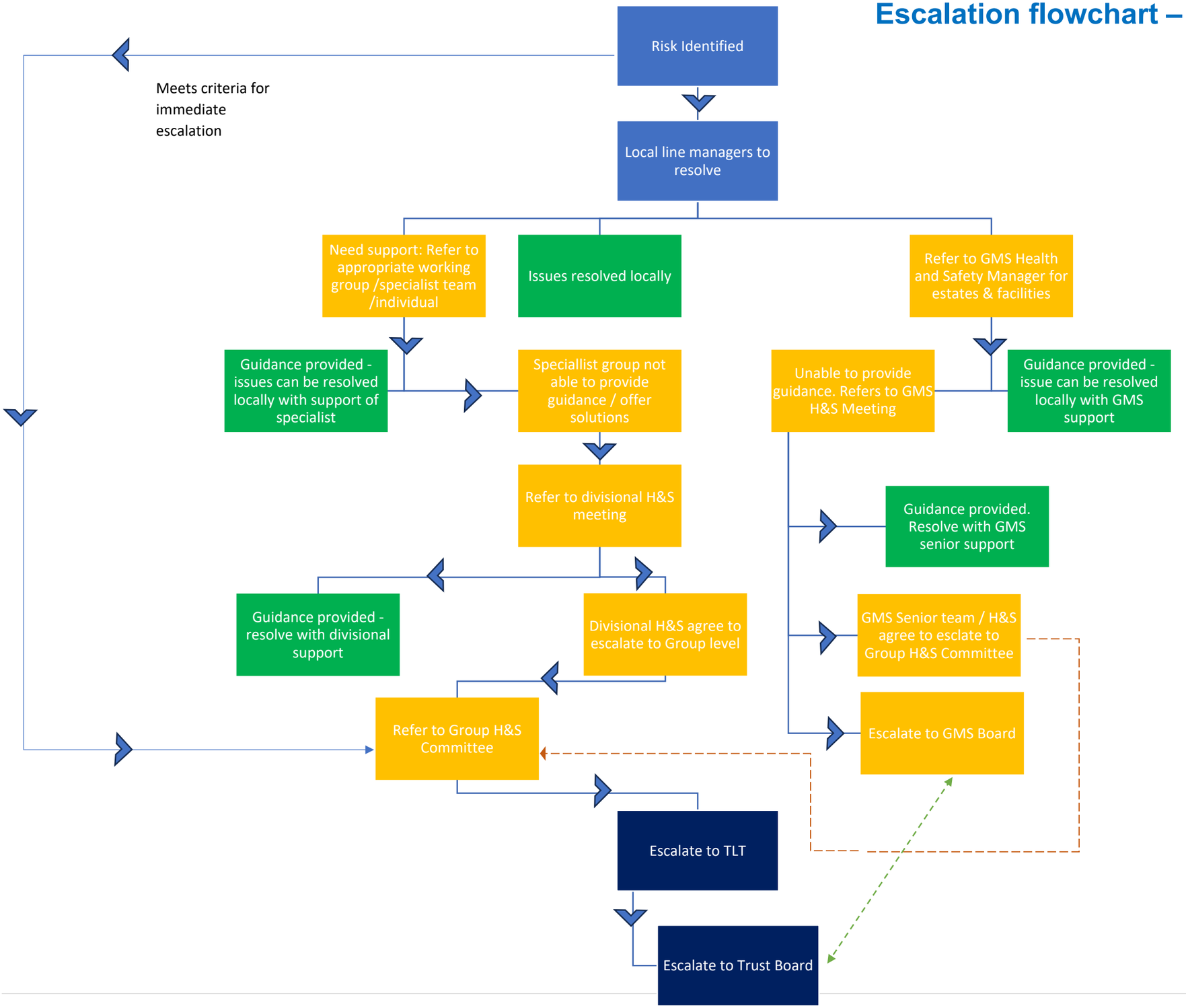
19. SAFETY COMMUNICATION

Safety communication is an essential foundation for the development and maintenance of an adequate safety culture. Information in our safety communications can be found in Trust's Health and Safety Policy.

DOCUMENT PROFILE	
Reference Number	
Title	Health and Safety Framework
Category	Non-Clinical
For Use By	GHNHST & GMS STAFF
Version	For Policy Team Completion Only (version control by Policy Team)
Issue Date	For Policy Team Completion Only (Month & Year)
Review Due	For Policy Team Completion Only (Month & Year)
Amendment Date	For Policy Team Completion Only
Extension Date	For TPAG Approval and Policy Team Completion Only
Keywords	Provide relevant keywords for easy identification, e.g. keyword 1, keyword 2, keyword 3,
Indicate if this document should be on the Trust's public page.	Yes If yes, please provide the hyperlink to the relevant page.
Document Ownership Details	
Owning Division	Corporate
Owning Specialty	Risk, Health & Safety Department
Associated Specialities	Corporate Governance
Chief Executive Officer	Kevin McNamara, CEO
Responsible Board Member / Executive Director	Kerry Rogers, Director of Integrated Governance
Divisional Director for Speciality	N/A
Divisional Director for Quality and Nursing	N/A
Author / Reviewer	Lee Troake, Head of Risk, Health and Safety
Consultation, Approval & Dissemination Details	
Consultees	Group H&S Committee Members, Trust Leadership Team, Trust Board, GMS Health and Safety
Main Local Approval Group	Group H&S Committee
Chair of the Main Local Approval Group	Kerry Rogers, Director of Integrated Governance
Additional Local Approval Group/s and their Chair	N/A
Local Approval Details	N/A
Trust Policy Assurance Group (TPAG) Ratification Date	For Policy Team Completion Only (Month & Year)
Dissemination Details	Upload to Policy Site
External Compliance and Guidance	

External Compliance Standards and/or Legislation	Specify e.g. external standards which this document has been produced to comply with (e.g., HSE, MHRA), external codes of practice legislation (please state which legislation) • HTM 00 – Policies and Procedures • HTM 01 – Decontamination • HTM 02 – Medical Gases • HTM 03 – Heating and Ventilation Systems • HTM 04 – Water systems • HTM 05 – Fire safety • HTM 06 – Electrical services • HTM 07 – Environment and Sustainability • HTM 08 – Specialist Services • Approved Codes of Practice, HSE • The importance of partnership working on health, safety and wellbeing | NHS Employers
Relevant NICE Guidance	List relevant NICE guidance and hyperlinks
Relevant Regulations	• Statutory Instruments (1974), Health and Safety at Work Act 1974. London: HMSO • Statutory Instruments (1977), Safety Representatives Safety Committee Regulations 1977. London: HMSO • Statutory Instruments (1996), Health and Safety (Consultation with Employees) Regulations 1996. London: HMSO • Statutory Instruments (1999), Management of Health and Safety at Work Regulations 1999. London: HMSO • Health and Safety Competencies for NHS Managers

Escalation flowchart – Health & Safety



HTM 01-01: Management and decontamination of surgical instruments (medical devices) in acute care

Duty holder	Key duties
Trust	• Responsibility for achieving acceptable standards of decontamination. Duties under the Health and Social Care Act 2008 in relation to infection control • Organisationally responsible for the effective, and technically compliant, provision of decontamination services. • Responsible for the implementation of operational policies for decontamination and should ensure specific operational policies are in place for the decontamination of all medical devices. • Responsible for monitoring the implementation of the policy and should have a competent understanding of the decontamination of medical devices, guidance, legislation and standards
GMS	• GMS offers decontamination to the Trust and other legal entities – GMS is subject to the requirements of MDR (regulation by MHRA and audit by a notified body)

Individual Roles	General Duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level)	• Assigned responsibility for the service - for the effective, and technically compliant, provision of decontamination services • Provides the essential senior management link between the organisation and professional support • Should provide an informed position at board level	Matt Holdaway (statutory???)		

	• Should work closely with the **Senior Operational Manager** to ensure that provision is made to adequately support the decontamination system			
Sub-Board Committee				
Executive Manager HTM01-01 (note this role is not included in HTM 00) (pg 26 HMT)	• The person with ultimate management responsibility, including allocation of resources and the appointment of personnel, for the organisation in which the decontamination equipment is installed			
Senior Operational Manager (Trust, GMS or Third party)	• SOM is technically, professionally and managerially responsible (and accountable to the Decontamination Lead) for the engineering aspects of decontamination			
Decontamination Lead with responsibility for decontamination – either at board level or who has line management responsibility to a senior responsible person at that level (Trust or GMS) The Decontamination Lead may also act as the Designated Person.	• The Decontamination Lead may delegate specific responsibilities to key personnel; the extent of such delegation should be clearly set out in the operational policy together with the arrangements for liaison and monitoring			
Authorised Engineer Decontamination	• Reports to the Decontamination Lead (pg26-27)	Deconcidal Ltd		

Responsible Person / Authorised Person (GMS)				
Deputy Responsible Person / Authorised Person (GMS)				
Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person / Authorised Person (Apleona)				
Competent Person(s) (GMS & Apleona, Trust others)				
Surgical Instrument Manager (Trust, GMS or Third party)	• Responsibility for coordinating activity between the theatre, decontamination and supply/purchase teams (their duties are set out at pg27-28)			
User	• Person designated by Management to be responsible for the management of the process. The User is also responsible for the Operators, e.g., a linen services manager • The User should liaise with the infection control team as appropriate • Principle responsibilities of User set out pg14-15			

Documentation	Period of validity
Policy document aligns to the HMT	

Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

HTM01-04: Decontamination of linen for health and social care

Duty holder	Key duties
Trust	• The Trust has duties under the Health and Social Care Act 2008 in relation to infection control – this includes the provision of linen and a laundry service that reduces the risk of cross-infection and enhances patient experience (pg1)
GMS	• As a 'linen processor' GMS should be capable of meeting the Essential Quality Requirements (EQRs) set out at pg2-3 of the HTM which encompass statutory and regulatory requirements

Individual Roles	General Duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level)	• Assigned responsibility for the service - for the effective, and technically compliant, provision of decontamination services			

	• Provides the essential senior management link between the organisation and professional support • Should provide an informed position at board level • Should work closely with the **Senior Operational Manager** to ensure that provision is made to adequately support the decontamination system			
Sub-Board Committee				
Executive Manager HTM01-04 (note this role is not included in HTM 00)	• The person with ultimate management responsibility, including allocation of resources and the appointment of personnel, for the organisation in which the laundry equipment is installed • Depending on the nature of the organisation, this role may be filled by the general manager, laundry manager, chief executive, care home manager or other person of similar authority. (pg14)			
Senior Operational Manager (Trust, GMS or Third party)	• SOM is technically, professionally and managerially responsible (and accountable to the Decontamination Lead) for the engineering aspects of decontamination			
Decontamination Lead with responsibility for decontamination – either at board level or who has line management responsibility to a senior responsible	• The Decontamination Lead may delegate specific responsibilities to key personnel; the extent of such delegation should be clearly set out in the operational policy together with the arrangements for liaison and monitoring			

person at that level (Trust or GMS) The Decontamination Lead may also act as the Designated Person.	• The Decontamination Lead may also act as the Designated Person.			
Authorised Engineer	• Reports to the Decontamination Lead (pg26-27)	Deconcidal Ltd		
Responsible Person / Authorised Person (GMS)				
Deputy Responsible Person / Authorised Person (GMS)				
Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person / Authorised Person (Apleona)				
Competent Person(s) (GMS & Apleona, Trust others)				
User	• Person designated by Management to be responsible for the management of the process. The User is also responsible for the Operators, e.g., a linen services manager • The User should liaise with the infection control team as appropriate			

	• Principle responsibilities of User set out pg14-15			

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

HMT01-06: Decontamination of flexible endoscopes

Duty holder	Key duties
Trust	• Responsibility for achieving acceptable standards of decontamination. Duties under the Health and Social Care Act 2008 in relation to infection control • Organisationally responsible for the effective, and technically compliant, provision of decontamination services. • Responsible for the implementation of operational policies for decontamination and should ensure specific operational policies are in place for the decontamination of all medical devices. • Responsible for monitoring the implementation of the policy and should have a competent understanding of the decontamination of medical devices, guidance, legislation and standards

GMS	• GMS offers decontamination to the Trust and other legal entities – GMS is subject to the requirements of MDR (regulation by MHRA and audit by a notified body)

Individual Roles	General Duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level)	• Assigned responsibility for the service - for the effective, and technically compliant, provision of decontamination services • Provides the essential senior management link between the organisation and professional support • Should provide an informed position at board level • Should work closely with the **Senior Operational Manager** to ensure that provision is made to adequately support the decontamination system			
Sub-Board Committee				
Executive Manager HTM01-01 (note this role is not included in HTM 00) (pg 26 HMT)	• The person with ultimate management responsibility, including allocation of resources and the appointment of personnel, for the organisation in which the decontamination equipment is installed			
Senior Operational Manager (Trust, GMS or Third party)	• SOM is technically, professionally and managerially responsible (and accountable to the Decontamination Lead) for the engineering aspects of decontamination			

Decontamination Lead with responsibility for decontamination – either at board level or who has line management responsibility to a senior responsible person at that level (could be someone in Trust or GMS) The Decontamination Lead may also act as the Designated Person.	• The Decontamination Lead may delegate specific responsibilities to key personnel; the extent of such delegation should be clearly set out in the operational policy together with the arrangements for liaison and monitoring			
Authorised Engineer Decontamination (pg26-27)	• Reports to the Decontamination Lead	Deconcidal Ltd		
Responsible Person / Authorised Person (GMS)				
Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person / Deputy Authorised Person (GMS)				
Deputy Responsible Person / Deputy Authorised Person (Apleona)				

Competent Person (GMS & Apleona, Trust others)				
Surgical Instrument Manager (Trust, GMS or Third party)	• Has responsibility for the endoscopes at all points in the purchase, use, decontamination and decommissioning processes, including record-keeping, governance provision in support of users, audit responsibilities • [role of Surgical Instrument Manager at pg3]			

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Health Technical Memorandum 02-01: Medical gas pipeline systems (MGPS)

Duty holder	
Trust	• The employer and ultimately accountable for the safe operation of the premises and for equipment provided for use at work. Legal responsibility cannot be delegated but performance can be
GMS	• Duties as has control of the premises and duties to repair / maintain it. Duties to employees for equipment provided for use at work to the extent of control of that work equipment

Apleona	• Duties as has control of the premises and duties to repair / maintain it. Duties to employees for equipment provided for use at work to the extent of control of that work equipment

Individual Roles	Key Duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person / Executive Manager (Executive - Trust Board level) with assigned responsibility for the service	• The person with ultimate management responsibility, including allocation of resources and the appointment of personnel, for the organisation in which the MGPS are installed. • May delegate specific MGPS responsibilities to key personnel; delegation should be clearly set out in the MGPS operational policy together with the arrangements for liaison and monitoring (pg11). • The Executive Manager is responsible for the operational policy, although responsibility for policy preparation and implementation will usually be delegated to the Authorised Person (MGPS). (pg16)	Mark P		
Sub-Board Committee				
Senior Operational Manager (Trust)		Martin Pratt		
Authorised Engineer MGPS		Health Technical Ltd		
Responsible Person / Authorised Person (GMS)	• Responsibility for policy preparation and implementation will usually be delegated to the Authorised Person • Retains effective responsibility for day-to-day management (pg11)			

Responsible Person / Authorised Person (Apleona)	• Responsibility for policy preparation and implementation will usually be delegated to the Authorised Person • Retains effective responsibility for day-to-day management (pg11)			
Deputy Responsible Person / Deputy Authorised Person (GMS)	• Responsibility for policy preparation and implementation will usually be delegated to the Authorised Person • Retains effective responsibility for day-to-day management (pg11)			
Deputy Responsible Person / Deputy Authorised Person (Apleona)	• Responsibility for policy preparation and implementation will usually be delegated to the Authorised Person • Retains effective responsibility for day-to-day management (pg11)			
Competent Persons (GMS & Apleona, Trust others)				
Chair of Medical Gases Group				

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Healthcare Technical Memorandum 03-01: Specialised ventilation in healthcare premises

Duty holder	
Trust	The employer and ultimately accountable for the safe operation of the premises
GMS	Legal duties as it has control and duties to repair / maintain
Apleona	Legal duties as it has control and duties to repair / maintain

Individual Roles	Key duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level) with assigned responsibility for the service	• Provides the essential senior management link between the organisation and professional support. Should also provide an informed position at board level and confirm the appointment of post holders: o Authorising Engineer (Ventilation) o Authorised Person (Ventilation) o Competent Person (Ventilation) • To ensure that inspection, service and maintenance activities are carried out, safely without hazard to staff, patients or members of the public • Ensure those who monitor/maintain equipment are competent to do so • Periodically review maintenance procedures to ensure they remain appropriate • Preservation of records of ventilation systems and their performance (legal requirement – system records must be kept for at least 5 years, or 25 for a manufacturing pharmacy and there is a statutory right of inspection)	Will		

	• (pg3-5) • The responsibility for monitoring specific aspects may be delegated to appropriate key personnel (HTM 0 para 3.45)			
Sub-Board Committee				
Senior Operational Manager (Trust)		Bernie		
Authorised Engineer Ventilation		Andrew Poplett Enterprises Ltd		
Responsible Person / Authorised Person (GMS)				
Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person / Deputy Authorised Person (GMS)				
Deputy Responsible Person / Deputy Authorised Person (Apleona)				

Responsible Person / Authorised Person (GMS)				

Chair of Ventilation Group	• Multi-disciplinary group that oversees management of the ventilation systems of a healthcare provider and reports to the Designated Person at board level. (the Designated Person may also chair the group).
	• VSG informs:
	  ○ The design process for new and existing premises
	  ○ Commissioning and validation process
	  ○ Operational management and maintenance
	  ○ Annual verification and performance testing
	  ○ Prioritising the plant replacement programme
	  ○ Decommissioning and removal of redundant equipment			

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

HMT04-01: Safe water in healthcare premises

Duty holder	
Trust	• The employer and ultimately accountable for the safe operation of the premises. Appoint a Water Safety Group (WSG) to implement their legal duties. Though compliance with this guidance may be delegated to staff or undertaken by contractors, accountability cannot be delegated
GMS	• Legal duties as it has control and duties to repair / maintain. Contractual duties -management contract should clearly specify who has responsibility for maintenance and safety checks, including managing the risk from waterborne hazards
Apleona	• Legal duties as it has control and duties to repair / maintain. Contractual duties -management contract should clearly specify who has responsibility for maintenance and safety checks, including managing the risk from waterborne hazards

Individual Roles	Key Duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level) with assigned responsibility for the service	Appoint a Water Safety Group (WSG) to implement their legal duties	Matt H		
Sub-Board Committee				
Senior Operational Manager (Trust)		Bernie / Craig		
Authorised Engineer Water		Tetra Consulting Ltd		
Responsible Person / Authorised Person (GMS)				

Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person / Deputy Authorised Person (GMS)				
Deputy Responsible Person / Deputy Authorised Person (Apleona)				
Responsible Person / Authorised Person (GMS)				
Chair of Water Safety Group	• A multidisciplinary group formed to undertake the commissioning and development and ongoing management of the water safety plan (WSP). • Identify and assess sources of risk			

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Fire Safety - HTM 05-01, HTM 05-02, HTM 05-03

Duty holder	
Trust	The employer and ultimately accountable for the safe operation of the premises. Legal responsibility can not be delegated but performance can be
GMS	Legal duties as it has control and duties to repair / maintain. Duties under Article 5(3) of the Fire Safety Order
Apleona	Legal duties as it has control and duties to repair / maintain. Duties under Article 5(3) of the Fire Safety Order

Individual Roles	Key duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level) with assigned responsibility for the service	• Responsibility is responsible for ensuring that fire safety issues are highlighted at Board level • Responsibility for complying with the Fire Safety Order [page 5]	Al		
Sub-Board Committee				
Senior Operational Manager (Trust)		Bernie?		
Fire Safety Manager (GMS)	• Day-to-day fire safety duties delegated to the Fire Safety Manager by the Board level director (pg17)	Jayne Taylor		
Authorised Engineer Fire		Wessex H&S Ltd trading as Fire Safety Partnership		
Responsible Person / Authorised Person (GMS)				

Deputy Responsible Person (GMS)				
Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person (Apleona)				
Competent Person (GMS)	• Installs and maintains fire safety equipment			
Competent Person (Apleona)	• Installs and maintains fire safety equipment			
Chair of Fire Safety Committee				

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Electrical Safety - HTM 06-01, HTM 06-02, HTM 06-03

Duty holder	
Trust	The employer and ultimately accountable for the safe operation of the premises
GMS	Legal duties as it has control and duties to repair / maintain.
Apleona	Legal duties as it has control and duties to repair / maintain.

Individual Roles	Key duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)

Designated Person (Executive - Trust Board level) with assigned responsibility for the service (can be the same for all 06 HTMs or different ones)	• Develop and update:
	  ○ a clearly defined electrical safety policy
	  ○ appropriate structure and procedures for implementing the policy
	  ○ a system of monitoring in place to ensure that the policy is being effectively pursued
	  ○ a program of training for staff
	  ○ procedures for dealing with emergencies
	  ○ an electrical business continuity plan for prolonged loss of power
	• Establish an Electrical Safety Group (ESG)
	• Formally appoint an independent electrical engineer as an **Authorising Engineer (LV)**
		Will		

	• Monitor the effectiveness of the Authorising Engineer (LV) in fulfilling the role and review the appointment annually • Appoint the **Senior Operational Manager (SOM)** • Appoint sufficient Authorised Persons (LV) (on the recommendation of the Authorising Engineer (LV)) – person responsible for the practical implementation and operation with regard to the work on, or the testing of, defined electrical equipment under this HTM (pg5)			
Sub-Board Committee				
Senior Operational Manager (Trust or GMS or third party)	• Operational and professional responsibility for the electrical services – can be outside the Trust (pg5, pg12)			
Authorised Engineer (LV)		Avonside Safety Management		
Responsible Person / Authorised Person LV (GMS)				
Deputy Responsible Person LV (GMS)				
Responsible Person / Authorised Person LV (Apleona)				
Deputy Responsible Person LV (Apleona)				

Competent Person (GMS & Apleona, Trust others)				
Chair of Electrical Safety Group	• Multidisciplinary group formed to assess all aspects of electrical safety and resilience required for the safe development and operation of healthcare premises (pg9-10). Should be led by and chaired by a person who has appropriate management responsibility, knowledge, competence and experience. Should report to the designated person at board level • [pg11-12 sets out the remit of the ESG]			

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Environment and Sustainability - HTM 07-01 healthcare waste, MHT07-02 – energy, HMT07-04 water management and water efficiency

Duty holder	
Trust	• The employer and ultimately accountable for the safe operation of the premises and in the waste management chain (i.e. anyone who produces, carries, deals, brokers or manages controlled waste). • Responsibility to be energy and resource efficient by minimising unnecessary energy costs and thereby associated environmental impacts, to comply with relevant legislation • Responsibility of all public bodies to conserve water. • General responsibility on NHS Trusts to manage water efficiently across the healthcare estate
GMS	• Duties within the waste management chain (i.e. anyone who produces, carries, deals, brokers or manages controlled waste) • Duties under contract for energy
Apleona	• Duties within the waste management chain (i.e. anyone who produces, carries, deals, brokers or manages controlled waste) • Duties under contract for energy

Individual Roles	Key duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level) with assigned responsibility for the HTMs	• Ensure governance procedures required in HTM 07-01 are established across the health organisation • Provide capital resources to implement HTM 07-01 across the organisation (pg86) • Follow Defra's statutory guidance 'Waste duty of care: code of practice' (Defra, 2018).	Matt H		

Energy Champion (Trust Board) (HMT07-02) (can be same as above)	• Responsibility for energy and carbon management and environmental policy. Their role is to keep energy on senior managers' agenda • The Energy and carbon management policy and environmental policy should be signed off by the Chief Executive "to signal commitment at the highest level" (pg25) • Development and approval of Sustainable Development Management Plan including sections on energy and carbon management and environmental policy			
Water Champion (designated by senior management) – should be someone with an overview of the building's facilities, someone in charge of financial management or someone who is keen on the subject)	• Development of a water strategy • Provide the necessary resources and power to conduct a water audit • Co-ordinate the water strategy • Act a co-ordinator for the implementation, a source of information and a channel for reporting to senior management (pg10)			
Sub-Board Committee				
Estates and facilities Director responsible for waste (Trust)	• Ensure the safe and compliant management of waste			

	• Direct and support the establishment and management of on-site waste infrastructure and services (pg86)			
Senior Operational Manager (Trust or GMS or third party)				
Waste Manger (Trust or GMS)	• Accountable individual – employee with specific responsibility for all aspects of waste management and procurement within the Trust • Develop and implement waste policies and organisation-specific guidance in line with current legislation; be accountable for implementation of HTM 07-01 • Promote and provide the structure and resources to allow the effective segregation of clinical waste • Collate and report all accurate waste data as required in ERIC and ensure compliance with duty of care responsibilities (pg86)			
Energy Manager (Trust, GMS or third party) (may be a designated role or shared with another organisation, or among several members of a team with a broader remit)	• Implementation of the Energy Management and Carbon Reduction strategies (pg32 – 34)			
Responsible Person / Authorised Person (GMS)				

Deputy Responsible Person (GMS)				
Responsible Person / Authorised Person (Apleona)				
Deputy Responsible Person (Apleona)				
Competent Person (GMS & Apleona, Trust others)				
Chair of Waste Group				

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Lifts - HTM 08-02 lifts, HTM08-03 – Bedhead services

Duty holder	
Trust	The employer who has provided lifting equipment used by employees
GMS	Duty holder due to control of lifting equipment and to the extent of that control
Apleona	Duty holder due to control of lifting equipment and to the extent of that control

Individual Roles	Key Duties	Identified Individual	Signed Appointment Letter	Period of Appointment (to / from)
Designated Person (Executive - Trust Board level) with assigned responsibility for the service	who has overall authority and responsibility for lifts and their safe operation (pg8) - Maintaining the lift so it is safe to use - Selecting and instructing the competent person under LOLER - Ensuring the lift is examined at statutory intervals (6-12mths) - Keeping the competent person informed of any changes in lift operating or changes that may affect the risk assessment - Making relevant documentation available to the competent person - Acting promptly to remedy any defects - Ensuring all documentation complies with regulations Record-keeping	AI		

	Ensure that their premises and bedhead services are safe, fit for purpose, and comply with all statutes, relevant codes of practice and standards Ensure that appropriate risk assessments are carried out and suitable contingency plans recorded and tested consistent with emergency plans throughout the healthcare facility Ensure that an operational plan is in place for each site under their control (see pg8 for what it should comprise) Appoint trained, authorised and competent persons to control the operation of emergency services and to service/ maintain the elements of bedhead services On completion of the installation of bedhead services or modification of an existing system, each system should undergo a process involving witness testing to ensure that the systems function correctly, as specified, before handover. All test results should be recorded and held by the healthcare organisation for future reference Ensure all staff who operate the various bedhead systems are adequately trained Ensure all bedhead services are regularly tested and maintained			

	(pg4, 8-9)			
Sub-Board Committee				
Senior Operational Manager (Trust)		Neil ?		
Authorised Engineer Lifts		ILECS Ltd		
Responsible Person / Authorised Person Lifts (GMS)	The Authorised Person (Lifts) (pg9) - maintenance of records - quality of service - maintenance of system safety (integrity) - establishing and maintaining the validity of Competent persons (CPs – not the same as competent persons under LOLER) – employees or contractors - overseeing duties carried out by Lift Stewards - overseeing annual training of Lift Release Wardens			
Deputy Responsible Person Lifts (GMS)	As above			
Responsible Person / Authorised Person Lifts (Apleona)	As above			
Deputy Responsible Person Lifts (Apleona)	As above			
Competent Person (GMS & Apleona, Trust others)				

Documentation	Period of validity
Policy document aligns to the HMT	
Key responsibilities set out in the policy document aligned to HTM	
KPIs for GMS– SLA specification GMS review	
KPIs for Apleona – SLA specification review	
KPIs – Trust / others	
TOR review – aligned to HTM	
Standard reporting template aligned to HTM	
Standing agenda items aligned to HTM	
Last AE audit	

Approved Codes of Practice

- L5: Control of substances hazardous to health (Sixth edition)
- L8: Legionnaires' disease. The control of legionella bacteria in water systems. Approved Code of Practice and guidance
- L24: Workplace health, safety and welfare. Workplace (Health, Safety and Welfare) Regulations 1992. Approved Code of Practice
- L25: Personal protective equipment at work (Second edition)
- L56: Safety in the installation and use of gas systems and appliances
- L74: First aid at work. The health and safety (First Aid) Regulations1981
- L80: A guide to the Gas Safety (Management) Regulations 1996. Guidance on Regulations
- L101: Safe work in confined spaces. Confined Spaces Regulations 1997
- L108: Controlling noise at work
- L113: Safe use of lifting equipment. Lifting Operations and Lifting Equipment Regulations 1998
- L114: Safe use of woodworking machinery. Provision and Use of Work Equipment regulations 1998 as applied to woodworking machinery
- L121: Work with ionising radiation
- L122: Safety of pressure systems
- L126: A guide to the Radiation (Emergency Preparedness and Public Information) Regulations 2001
- L143: Work with materials containing asbestos. Control of Asbestos Regulations 2012
- L146: Consulting workers on health and safety. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended)
- L153: Managing health and safety in construction - Construction (Design and Management) Regulations 2015. Guidance on Regulations

Healthcare Technical Memorandums

- HTM 00: Policies and principles of healthcare engineering
- HMT01-01 Management and decontamination of surgical instruments
- HMT01-04 Decontamination of bed linen for health and social care
- HMT01-06 Decontamination of flexible endoscopes
- HTM02 Medical gas pipeline systems
- HTM03 Specialised Ventilation for healthcare premises

- HTM04 Safe Water in healthcare
- HTM05-01 Manging healthcare fire safety
- HMT05-02 Firecode
- HMT05-03 Firecode
- HMT06-01 Electrical services supply and distribution
- HMT06-02 Electrical safety guidance for low voltage systems
- HTM06-03 Electrical safety guidance for high voltage systems
- HMT07-01 Safe and sustainable management of healthcare waste
- HMT07-02 Making energy work in healthcare
- HMT07-03 NHS car-park management
- HMT07-04 water management and water efficiency
- HMT08-01 Acoustics
- HMT08-02 Lifts
- HMT08-03 Bedhead services
- HMT67 Laboratory fitting out system

Report to Board

Date	8 May 2025			
Title	Modern Slavery Statement and Bribery & Corruption Statement			
Author / Presenter **Sponsoring Director**	Kerry Rogers, Director of Integrated Governance			
Purpose of Report (Tick all that apply ✓)				
To provide assurance	x	To obtain approval	x	
Regulatory requirement		To highlight an emerging risk or issue		
To canvas opinion		For information		
To provide advice		To highlight patient or staff experience		

Summary of Report

Modern Slavery Statement

The annual Modern Slavery and Human Trafficking Statement is presented to the Board for approval and signature by the Chief Executive.

1. The Statement has been reviewed and updated having been last published by the Trust in 2020. It has been the subject of review and commentary by the People and Organisational Development team, the Lead for Safeguarding and the Trust's Procurement Service.

2. The Modern Slavery Statement was approved by Audit and Assurance Committee on 23 April 2025 and recommended for approval by the Board.

3. The attached statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Trust's Slavery and Human Trafficking statement for the financial year ending 31 March 2025.

4. The statement affirms the following:

- The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. We expect our suppliers and business partners to adhere to the same high standards and to take all reasonable steps to combat slavery and human trafficking.

- The Trust has in place due diligence procurement and tendering processes to ensure all its selected suppliers and any third parties are compliant with the Model Slavery Act (2015)

- The Trust has in place measures to ensure appropriate and robust recruitment processes which recognise the risk of modern slavery in the employment sphere.

- The Trust's focus on its culture; particularly Equality, Diversity and Inclusion programmes and Raising Concerns policies provide a forum to enable staff to raise concerns regarding

modern slavery and human trafficking of individuals or colleagues.

- The Trust provides safeguarding training to staff to enable the identification and escalation of concerns regarding modern slavery and human trafficking in the context of patients and service users.

Bribery and Corruption Statement

1. The draft annual Bribery and Corruption Statement is presented on behalf of the Head of Counter-Fraud Service for approval and for subsequent signature by the Chief Executive.
2. The Statement remains substantially unaltered from previous annual statements but has been updated to reflect changes to senior personnel within the Trust.
3. The Statement has been reviewed before the Audit and Assurance Committee on 23 April 2025 and is recommended for signature.

Financial Implications

None

Approved by: Director of Finance / Director of Operational Finance	**Date:**

Recommendation

The Board is asked to:

1. APPROVE the Modern Slavery and Human Trafficking Statement for signature by the Chief Executive and publication.
2. APPROVE the Bribery and Corruption Statement for signature by the Chief Executive and publication.

Enclosures

Draft Modern Slavery and Human Trafficking Statement for Financial Year 2024/2025
Draft Bribery and Corruption Statement for Financial Year 2024/2025

Modern Slavery Statement 2024/2025

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Trust's Slavery and Human Trafficking statement for the financial year ending 31 March 2025

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

Gloucestershire Hospitals NHS Foundation Trust ("The Trust") fully supports the Government's objective to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

The Trust's Commitments

The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. We believe in treating individuals with respect and dignity, and do not condone the use of our products or services which infringe the basic human rights of others. We expect our suppliers and business partners to adhere to the same high standards and to take all reasonable steps to combat slavery and human trafficking. The Trust has in place due diligence procurement and tendering processes to ensure all its selected suppliers and any third parties are compliant with the Modern Slavery Act (2023)

The procurement of goods and services

- Procurement ensures all procurement activates are undertaken in line with UK legislation, industry best practice and national policy on tackling modern slavery in government supply chains. The embedding of social value and associated modern slavery elements into all procurements and contracts.
- All procurement staff have completed eLearning on the Government Commercial College (GCC) with the Chartered Institute of Procurement and Supply (CIPS) qualified members also completing the annual CIPS Ethical Procurement and Supply e-learning.
- A large proportion of the goods and services are procured through national Government supply frameworks and contracts also require suppliers to comply with relevant legislation. We continue to work with our suppliers directly and via partners, such as NHS Supply Chain and Crown Commercial Services, to support initiatives related to modern slavery.

The recruitment of staff

Our robust recruitment processes are in line with relevant employment legislation and adhere to safe recruitment principles:

- We confirm the identities of all new employees and their right to work in the United Kingdom.
- All staff are appointed subject to references, health checks, immigration checks and identity checks in line with NHS employment check standards. This ensures that we can be confident, before staff commence duties, that they have a legal right to work within our Trust.
- Only approved frameworks are used for the recruitment of temporary agency staff.
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process.
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage.

The working conditions and practices for our employees

The Trust is committed to ensure that:

- Employment with the Trust and our suppliers is voluntary;
- Our workplace and those of our suppliers are free from discrimination or harassment based on race, colour, religion, gender (including pregnancy), sexual orientation, marital status, gender identity, national origin, age, disability, or any other characteristic protected by applicable law;
- Our workplaces are safe and healthy;
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation.
- Our Equality, Diversity and Inclusion policies, together with our Grievance, Dignity at Work and Raising Concerns policies additionally give a platform for our employees to raise concerns about poor working practices.
- Our policies and practices promote and support equality, diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities.

- Our Freedom to Speak: Raising Concerns (whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and safeguarding teams actively ensure they are accessible to staff.
- We provide advice, training and support about modern slavery and human trafficking to all staff through our safeguarding children and adults mandatory training, our safeguarding policies and procedures and our safeguarding teams.
- Our Trust “Safeguarding Adults at Risk Policy”, and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites.

Review of effectiveness

The Trust will continue to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- raise awareness and support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- embed social value best practice into commercial processes which will achieve improved social value awareness and compliance across all our commercial activities
- impact assess all new or reviewed policies for diversity and inclusion compliance.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Signed

Kevin McNamara, Chief Executive April 2025

ANTI-BRIBERY AND CORRUPTION STATEMENT: OUR COMMITMENT

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is committed to applying the highest standards of ethical conduct and integrity in its business activities. Every employee and individual acting on behalf of GHNHSFT is responsible for maintaining the organisation's reputation and for conducting GHNHSFT's business lawfully and professionally.

The Trust defines bribery as a financial advantage or other reward that is offered to, given to, or received by an individual or company (whether directly or indirectly) to induce or influence that individual or company to perform public or corporate functions or duties improperly. Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event. Employees and others acting for or on behalf of the organisation are strictly prohibited from making, soliciting or receiving any bribes or unauthorised payments. Employees and other individuals acting for the organisation should note that bribery is a criminal offence that may result in up to 10 years' imprisonment and/or an unlimited fine for the individual and an unlimited fine for the organisation.

Bribery and corruption has a detrimental impact on the GHNHSFT business by undermining good governance and organisational integrity. We benefit from carrying out our functions in a transparent and ethical way and thereby helping to ensure that there is honest, open and fair competition in the NHS. Where there is a level playing field, GHNHSFT can lead by example and deliver excellent services to our patients.

The Board and senior management team are committed to implementing and enforcing effective systems throughout GHNHSFT to prevent, monitor and eliminate bribery, in accordance with the Bribery Act 2010.

The GHNHSFT has developed, and regularly reviews, key policies outlining our position on preventing and prohibiting fraud and bribery, promoting the highest standards of business conduct and managing conflicts of interest. These policies include the Counter Fraud, Bribery and Corruption Policy, Conflicts of Interest and the Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy. These policies, which are available on the GHNHSFT intranet, apply to all employees as well as temporary and agency workers, management consultants and contractors acting for or on behalf of the GHNHSFT. All employees and other individuals acting for the GHNHSFT are required to familiarise themselves with the GHNHSFT policies and comply with any amendments with immediate effect.

As part of its anti-bribery measures, the organisation is committed to transparent, proportionate, reasonable and bona fide hospitality and promotional expenditure. Such expenditure must only be offered or accepted in accordance with the procedures set out in the organisation's policies. A breach of the organisation's Conflicts of Interest by an employee will be treated as grounds for disciplinary action, which may result in a finding of gross misconduct, and immediate dismissal.

GHNHSFT will not conduct business with service providers, agents or representatives that do not support the organisation's anti-bribery objectives. We reserve the right to terminate its contractual arrangements with any third parties acting for, or on behalf of, the organisation with immediate effect where there is evidence that they have committed acts of bribery.

The success of the organisation's anti-bribery measures depends on all employees, and those acting for the organisation, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for, or on behalf of, the organisation are encouraged to report any suspected bribery. Employees are encouraged to use internal reporting procedures as set out in the Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy and the Counter Fraud, Bribery and Corruption policy. GHNHSFT will support any individuals who make such a report, provided that it is made in good faith.

However, employees can also report their concerns externally as an alternative to internal reporting procedures if they wish to remain anonymous to the Local Counter Fraud Service on ghn-tr.fraudaccountmailbox@nhs.net or call 0300 422 2726 https://intranet.gloshospitals.nhs.uk/departments/corporate-division/counter-fraud/ or via

The NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or by filling in an online form at www.reportnhsfraud.nhs.uk This provides an easily accessible route for the reporting of genuine suspicions of fraud / bribery within or affecting the NHS. All calls are dealt with by experienced caller handlers.

Kevin McNamara
Chief Executive Officer
On behalf of the Gloucestershire Hospitals NHS Foundation Trust Board of Directors

Trust Board

Date	8 May 2025
Title	Gloucestershire Managed Services Reserved Matters
Author / Sponsoring Director/ Presenter	Kerry Rogers, Director Integrated Governance Kaye Law Fox, Chair GMS

Purpose of Report (Tick all that apply ✓)

To provide assurance		To obtain approval	✓
Regulatory requirement		To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Regularly reviewing Gloucestershire Hospitals Subsidiary Company Limited (GMS) governance arrangements includes GMS Articles of Association, Schedule of Matters Reserved (RMs), Standing Financial Instructions, Standing Orders and Board Terms of Reference, and is essential to ensure governance frameworks remain effective and aligned with current legislation, regulatory requirements, and organisational objectives. This is the first full review and revision and synchronisation of GMS governing documents with Trust since 2019.

This paper deals with the matters of: -

1. Appointment of GMS Company Secretary
2. GMS Articles of Association (Articles) – proposed changes
3. GMS Board Terms of Reference (ToR) – term review, no changes

1. RM 10 *Appointment and removal of directors and the company secretary for GMS* reserves the approval of GMS Company Secretary to Trust Board. Following the departure of the Interim Trust Secretary / GMS Company Secretary, Company Secretarial responsibilities transferred to Kerry, Rogers, Director of Integrated Governance. All appropriate fit and proper persons tests have been completed per Trust requirements.

2. RM 9 *Approval and amendment of GMS' Articles of Association* and

3. RM 16 *Approval of the responsibilities of the GMS Board of Directors as expressed in the GMS Board Terms of Reference*

   reserve the approval of the Articles and GMS Board ToR to Trust Board. They are part of the suite of documents [including Standing Financial Instructions and Standing Orders] that define the delegation of authority, financial control, and operational procedures, ensuring transparency, accountability, and compliance with Companies Act 2006, Trust and NHS guidelines.

Regular updates allow GMS to adapt to changes in policies, financial management standards, and procurement regulations, reducing risks of mismanagement, non-compliance, or inefficiency. Such reviews also ensure that decision-making structures are fit for purpose, promote effective resource allocation and safeguard public funds

GMS legal advisers, Bevan Brittan, have been engaged to undertake this work, with Finance & Commercial Director GMS and Chair contributing.

In accordance with the overarching requirement of the RMs, the Articles of Association and GMS Board Terms of Reference have been scrutinised by GMS Boad and Trust Finance and Resources Committee and are recommended for approval by Trust Board.

Going forward, the Trust Corporate GovernanceTeam will provide this review service to ensure consistency across both organisations. It is recommended that governing documentation for both organisations are reviewed and aligned at the same time.

In accordance with the RMs the Standing Financial Instructions and Standing Orders have been approved by GMS Board.

Any necessary amendments because of the implementation of the Procurement Act 2023 will be completed in due course.

Risks or Concerns	
Risk of not being consistent with good governance practice or regulatory requirements resulting in documentation not being as fit for purpose as would be preferable.	
Financial Implications	
Approved by:	**Date:**

Recommendation

Gloucestershire Managed Service Board and Finance & Resource Committee recommend and ask Trust Board to approve:

1. Kerry Rogers, Director of Integrated Governance as Company Secretary for GMS.
2. GMS Articles of Association (as amended) of Gloucestershire Hospitals Subsidiary Company
3. Gloucestershire Hospitals Subsidiary Company Limited Board of Directors Terms of Reference

Enclosures

- GMS Board Terms of Reference
- GMS Articles of Association

Company number: 11124256

ARTICLES OF ASSOCIATION
of
GLOUCESTERSHIRE HOSPITALS SUBSIDIARY COMPANY LIMITED

(Adopted by special resolution on 11 June 2020. Amended and reinstated by special resolution on [insert date of amendment])

PART 1

INTERPRETATION AND LIMITATION OF LIABILITY

1. DEFINED TERMS

1.1 In the articles, unless the context requires otherwise:

"articles"	means GMS's articles of association;
"bankruptcy"	includes individual insolvency proceedings in a jurisdiction other than England and Wales and Northern Ireland which have an effect similar to that of bankruptcy;
"Chair"	has the meaning given in article 12;
"chair of the meeting"	has the meaning given in article 54;
"Companies Acts"	means the Companies Acts (as defined in section 2 of the Companies Act 2006), in so far as they apply to GMS;
"company"	means Gloucestershire Hospitals Subsidiary Company Limited;
"conflict"	has the meaning given in article 14;
"controlling shareholder"	is any holder who owns not less than 75% in nominal value of the equity share capital of GMS from time to time;
"director"	means a director of GMS, and includes any person occupying the position of director, by whatever name called;
"distribution recipient"	has the meaning given in article 44;
"document"	includes, unless otherwise specified, any document sent or supplied in electronic form;
"electronic form"	has the meaning given in section 1168 of the Companies Act 2006;
"eligible GMS director"	means a GMS director who would be entitled to vote on the matter at a meeting of GMS directors (but excluding any GMS director whose vote is not to be counted in respect of that particular matter);
"Financial Interest"	means an interest in which an individual may get direct financial benefit;
"GMS"	means Gloucestershire Hospitals Subsidiary Company Limited, GMS, trading as Gloucestershire Managed Services;
"GMS Board"	means GMS's board of directors as established in accordance GMS's board terms of reference and
"hard copy form"	has the meaning given in section 1168 of the Companies Act 2006;
"holder"	in relation to shares means the person whose name is entered in the register of members as the holder of the shares;

"Indirect Interest"	means an interest in which an individual (the "**First Individual**") has a close association with another individual ("**Second Individual**") who has a Financial Interest, a Non-Financial Professional Interest or a Non-Financial Personal Interest and the Second Individual could stand to benefit from the First Individuals decision making;
"instrument"	means a document in hard copy form;
"Non-Financial Personal Interest"	means an interest in which an individual may benefit personally but in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit;
"Non-Financial Professional Interest "	means an interest in which an individual may obtain a non-financial professional benefit, such as increasing their professional reputation or promoting their professional career;
"operational agreement"	means any agreement entered into between the Trust and GMS relating to the operation and management of GMS;
"ordinary resolution"	has the meaning given in section 282 of the Companies Act 2006;
"paid"	means paid or credited as paid;
"participate"	in relation to a GMS directors' meeting, has the meaning given in article 10;
"proxy notice"	has the meaning given in article 61;
"shareholder"	means a person who is the holder of one or more shares;
"shares"	means shares in GMS;
"special resolution"	has the meaning given in section 283 of the Companies Act 2006;
"subsidiary"	has the meaning given in section 1159 of the Companies Act 2006;
"transmittee"	means a person entitled to one or more shares by reason of the death or bankruptcy of a shareholder or otherwise by operation of law;
"Trust"	means Gloucestershire Hospitals NHS Foundation Trust; and
"writing"	means the representation or reproduction of words, symbols or other information in a visible form by any method or combination of methods, whether sent or supplied in electronic form or otherwise.

1.2 Unless the context otherwise requires, other words or expressions contained in these articles bear the same meaning as in the Companies Act 2006 as in force on the date when these articles become binding on GMS.

1.3 The regulations contained in the model articles for private companies limited by shares (as set out in schedule 1 of the Companies (Model Articles) Regulations 2008 (SI 3229/2008)) shall not apply to GMS.

2. LIABILITY OF MEMBERS

The liability of the members is limited to the amount, if any, unpaid on the shares held by them.

PART 2

DIRECTORS

DIRECTORS' POWERS AND RESPONSIBILITIES

3. DIRECTORS' GENERAL AUTHORITY

Subject to the articles, the GMS directors are responsible for the management of GMS's business, for which purpose they may exercise all the powers of GMS.

4. SHAREHOLDERS' RESERVE POWER

4.1 Subject always to the provisions of the articles and the Companies Acts, the shareholders may, by special resolution, direct the GMS directors to take, or refrain from taking, specified action.

4.2 No such special resolution invalidates anything which the GMS directors have done before the passing of the resolution.

5. DIRECTORS MAY DELEGATE

5.1 Subject to the articles, the GMS directors may delegate any of the powers which are conferred on them under the articles:

5.1.1 to such person or committee;

5.1.2 by such means (including by power of attorney);

5.1.3 to such an extent;

5.1.4 in relation to such matters or territories; and

5.1.5 on such terms and conditions,

as they think fit.

5.2 If the GMS directors so specify, any such delegation may authorise further delegation of the GMS directors' powers by any person to whom they are delegated.

5.3 The GMS directors may revoke any delegation, in whole or part, or alter its terms and conditions.

6. COMMITTEES

6.1 Committees to which the GMS directors delegate any of their powers must follow procedures which are based as far as they are applicable on those provisions of the articles which govern the taking of decisions by GMS directors.

6.2 The GMS directors may make rules of procedure for all or any committees which prevail over rules derived from the articles if they are not consistent with them.

DECISION-MAKING BY DIRECTORS

7. DIRECTORS TO TAKE DECISIONS COLLECTIVELY

7.1 The general rule about decision-making by GMS directors is that any decision of the GMS directors must be either a majority decision at a meeting or a decision taken in accordance with article 8.

7.2 If:

7.2.1 GMS only has one director; and

7.2.2 no provision of the articles requires it to have more than one director,

the general rule does not apply, and the GMS director may (for so long as he remains the sole GMS director) take decisions without regard to any of the provisions of the articles relating to GMS directors' decision-making.

8. UNANIMOUS DECISIONS

8.1 A decision of the GMS directors is taken in accordance with this article when all eligible GMS directors indicate to each other by any means that they share a common view on a matter.

8.2 Such a decision may take the form of a resolution in writing where each eligible GMS director has signed one or more copies of it, or to which each eligible GMS director has otherwise indicated agreement in writing.

8.3 A decision may not be taken in accordance with this article if the eligible GMS directors would not have formed a quorum at such a meeting.

9. CALLING A DIRECTORS' MEETING

9.1 Any GMS director may call a GMSdirectors' meeting by giving reasonable notice of the meeting to the GMS directors or by authorising GMS secretary (if any) to give such notice.

9.2 Notice of any GMS directors' meeting must indicate:

9.2.1 its proposed date and time;

9.2.2 where it is to take place; and

9.2.3 if it is anticipated that GMS directors participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

9.3 Notice of a GMS directors' meeting must be given to each GMS director, but need not be in writing.

9.4 Notice of a GMS directors' meeting need not be given to GMS directors who waive their entitlement to notice of that meeting, by giving notice to that effect to GMS not more than seven days after the date on which the meeting is held. Where such waiver is given after the meeting has been held, that does not affect the validity of the meeting, or of any business conducted at it.

10. PARTICIPATION IN DIRECTORS' MEETINGS

10.1 Subject to the articles, GMS directors participate in a GMS directors' meeting, or part of a GMS directors' meeting, when:

10.1.1 the meeting has been called and takes place in accordance with the articles; and

10.1.2 they can each communicate to the others any information or opinions they have on any particular item of the business of the meeting.

10.2 In determining whether GMS directors are participating in a GMS directors' meeting, it is irrelevant where any GMS director is or how they communicate with each other.

10.3 If all the GMS directors participating in a meeting are not in the same place, the meeting shall be deemed to take place where the largest number of participators is assembled or, if no such group can be identified, the GMS directors may decide that the meeting is to be treated as taking place wherever any of them is.

11. QUORUM FOR DIRECTORS' MEETINGS

11.1 At a GMS directors' meeting, unless a quorum is participating, no proposal is to be voted on, except a proposal to call another meeting.

11.2 Subject to article 7.2 and the following provisions of this article 11, the quorum for GMS directors' meetings is three eligible GMS directors with at least two independent GMS non-executive GMS directors and one GMS executive Director.

11.3 For the purposes of any meeting (or part of a meeting) held pursuant to article 14 to authorise a conflict, if there is only one eligible GMS director in office other than the conflicted GMS

director(s), the quorum for such meeting (or part of a meeting) shall be two eligible GMS directors.

11.4 If the total number of GMS directors for the time being is less than the quorum required, the GMS directors must not take any decision other than a decision:

11.4.1 to appoint further GMS directors pursuant to article 17.1.2; or

11.4.2 to call a general meeting so as to enable the shareholders to appoint further GMS directors.

12. CHAIRING OF DIRECTORS' MEETINGS

12.1 Subject to the terms of any operational agreement, the GMS directors may appoint a GMS director to chair their meetings.

12.2 The person so appointed for the time being is known as the Chair.

12.3 Subject to the terms of any operational agreement, the GMS directors may terminate the Chair's appointment at any time.

12.4 If the Chair is not participating in a GMS directors' meeting within ten minutes of the time at which it was to start, the participating GMS directors must appoint one of themselves to chair it.

13. CASTING VOTE

If the numbers of votes for and against a proposal are equal, the Chair or other GMS director chairing the meeting shall not have a casting vote. Should a situation arise where a decision cannot be reached through majority vote, the item in question would be reviewed and if necessary resubmitted to the GMS Board with any additional information. Failing that the Chair would direct the decision to the Trust for consideration.

14. CONFLICTS AND DECLARATIONS OF INTEREST

14.1 Without prejudice to articles 14.6 and 14.7, the GMS directors shall, for the purposes of section 175 of the Companies Act 2006, have the power to authorise any matter which would or might otherwise constitute or give rise to a breach of the duty of a GMS director under that section to avoid a situation in which he has, or can have, a direct or indirect interest that conflicts, or possibly may conflict, with the interests of GMS ("**conflict**"). For the purposes of this article 14, an interest that conflicts, or possibly may conflict, with the interests of GMS may include, but not be limited to, any Financial Interests, Non-Financial Professional Interests, Non-Financial Personal Interests and Indirect Interests.

14.2 Authorisation of a matter under article 0 shall be effective only if:

14.2.1 the matter in question shall have been proposed in writing for consideration at a meeting of the GMS directors in accordance with the GMS directors' normal procedures or in any other manner as the GMS directors may determine;

14.2.2 any requirement as to the quorum at the meeting of the GMS directors at which the matter is considered is met without counting the GMS director in question or any other interested GMS director (together the "**Interested Directors**", and each an "**Interested Director**"); and

14.2.3 the matter was agreed to without any Interested Director voting or would have been agreed to if the votes of the Interested Directors had not been counted.

14.3 Any authorisation of a matter under article 0 shall be subject to such conditions or limitations as the GMS directors may determine (including, without limitation, such conditions or limitations as are contemplated by article 14.17), whether at the time such authorisation is given or subsequently and may be terminated by the GMS directors at any time. A GMS director shall comply with any obligations imposed on him by the GMS directors pursuant to any such authorisation.

14.4 Any authorisation of a matter under article 0 extends, subject to any conditions or limitations imposed under article 14.3, to any actual or potential conflict which may reasonably be expected to arise out of the matter so authorised.

14.5 Subject to any conditions or limitations imposed under article 14.3, a GMS director shall not, save as otherwise agreed by him, be accountable to GMS for any benefit which he (or any person connected in any way with him) derives from any matter authorised by the GMS directors under article 0 and no contract, transaction, arrangement or proposal relating thereto shall be liable to be avoided on the grounds of any such benefit.

14.6 Article 0 does not apply to a conflict arising in relation to a transaction or arrangement with GMS.

14.7 Subject to compliance with article 14.8, a GMS director may, notwithstanding his office, have any interest of any of the following kinds (and no authorisation under article 0 shall be necessary in respect of any such interest):

14.7.1 where the GMS director (or any person connected in any way with him) is a GMS director or other officer of, is employed by or is otherwise interested (including, without limitation, by the holding of shares or other securities) in any body corporate with which GMS is associated (within the meaning of section 256(a) of the Companies Act 2006);

14.7.2 where the GMS director (or any person connected in any way with him) is a party to, or otherwise interested in, any contract, transaction, arrangement or proposal with GMS or any body corporate with which GMS is associated (within the meaning of section 256(a) of the Companies Act 2006), or in which GMS is otherwise interested;

14.7.3 an interest such that the situation or the interest cannot reasonably be regarded as likely to give rise to a conflict;

14.7.4 an interest, or a contract, transaction, arrangement or proposal giving rise to an interest, of which the GMS director is not aware; and

14.7.5 any other interest authorised by an ordinary resolution of GMS.

14.8 Subject to sections 177 and 182 of the Companies Act 2006, the GMS director concerned shall declare the nature and extent of any interest, whether direct or indirect, referred to in article 14.7 and not falling within article 14.9 at the first meeting of the GMS directors held after the GMS director becomes aware of the interest by written declaration to GMS (or in a form or any other manner as the GMS directors may determine) or by general notice in accordance with section 177(2)(b)(ii) or section 182(2)(c) (as the case may be) and section 185 of the Companies Act 2006. Any interests declared by GMS directors shall be recorded in a form to be determined by the GMS directors.

14.9 No declaration of an interest shall be required by a GMS director under article 14.8 in relation to an interest:

14.9.1 falling within article 14.7.3 or article 14.7.4;

14.9.2 if, or to the extent that, the other GMS directors are already aware of such interest (and for this purpose the other GMS directors are treated as being aware of anything of which they ought reasonably to be aware); or

14.9.3 if, or to the extent that, it concerns the terms of his service contract (as defined in section 227 of the Companies Act 2006) that have been or are to be considered by a meeting of the GMS directors or by a committee of GMS directors appointed for the purpose under these articles.

14.10 A GMS director shall not, save as otherwise agreed between him and GMS, be accountable to GMS for any benefit which he (or any person connected in any way with him) derives from any interest referred to in article 14.7 and no contract, transaction, arrangement or proposal shall be liable to be avoided on the grounds of any such interest.

14.11 Provided he has disclosed to the GMS directors any interest of which he is aware (not being an interest which cannot reasonably be regarded as likely to give rise to a conflict) in accordance with the requirements of the Companies Act 2006 and these articles, a GMS director shall, subject to any applicable conditions or limitations imposed under article 14.3, be entitled to vote at a meeting of the GMS directors or of a committee of the GMS directors in respect of any contract, transaction, arrangement or proposal in which he is interested and shall also be counted in determining whether a quorum is present at such a meeting.

14.12 Without prejudice to article 14.11, if a question arises at any time as to whether any interest of a GMS director prevents him or should prevent him from voting or being counted in the quorum under this article 14 and such question is not resolved by his voluntarily agreeing to abstain from voting and/or attending, such question shall be referred to the chairman of the meeting and his ruling in relation to any GMS director other than himself shall be final and conclusive, except in a case where the nature or extent of the interest of such GMS director (so far as it is known to him) has not been fairly disclosed.

14.13 Without prejudice to article 14.11, if any question as to the right to participate in the meeting (or part of the meeting) should arise in respect of the Chair, the question shall be decided by a decision of the GMS directors, for which purpose the Chair is not to be counted as participating in the meeting (or part of the meeting) for voting and quorum purposes, and the decision shall be conclusive, except in a case where the nature or extent of the interest of the chair of the meeting (so far as it is known to the chair of the meeting) has not been fairly disclosed to the GMS directors.

14.14 Subject to article 14.15, if a GMS director, otherwise than by virtue of his position as a GMS director, receives information in respect of which he owes a duty of confidentiality to a person other than GMS, he shall not be required to disclose such information to GMS or the GMS directors or any of them, or otherwise use or apply such confidential information for the purpose of or in connection with the performance of his duties as a GMS director.

14.15 Where a duty of confidentiality as referred to in article 14.14 arises out of a situation in which the GMS director has, or can have, a direct or indirect interest that conflicts, or possibly may conflict, with the interests of GMS, article 14.14 shall apply only if the conflict arises out of a matter which has been authorised under article 0 or falls within article 14.7.

14.16 Article 14.14 is without prejudice to any enactment, equitable principle or rule of law which may excuse or release a GMS director from disclosing information in circumstances where disclosure may otherwise be required.

14.17 Where a GMS director has an interest which can reasonably be regarded as likely to give rise to a conflict, the GMS director may, and shall if so requested by the GMS directors, take such additional steps as may be necessary or desirable for the purpose of managing such conflict, including compliance with any procedures laid down from time to time by the GMS directors for the purpose of managing conflicts generally and/or any specific procedures approved by the GMS directors for the purpose of or in connection with the relevant matter or situation, including without limitation:

14.17.1 absenting himself from any meeting or part of a meeting of the GMS directors or of any committee of the GMS directors at which the relevant matter or situation falls to be considered or is otherwise significant; and

14.17.2 not reviewing documents or information made available to the GMS directors generally in relation to such matter or situation.

14.18 The company may by ordinary resolution ratify any contract, transaction, arrangement or proposal not properly authorised by reason of a contravention of any provision of this article 14.

14.19 For the purposes of this article 14, where the context permits, any reference to an interest includes a duty and any reference to a conflict of interest includes a conflict of interest and duty and a conflict of duties.

14.20 For the purposes of this article, references to proposed decisions and decision-making processes include any GMS directors' meeting or part of a GMS directors' meeting.

14.21 In addition to the above provisions of this article 14, subject to the provisions of the Companies Acts and provided (if these articles so require) that he has declared to the GMS directors in accordance with the provisions of these articles, the nature and extent of his interest, a GMS director may (save to the extent not permitted by law from time to time), notwithstanding his office, have an interest arising from any duty he may owe to, or interest he may have as an employee, GMS director, trustee, member, partner, officer or representative of, or a consultant to, the Trust.

15. RECORDS OF DECISIONS TO BE KEPT

The GMS directors must ensure that GMS keeps a record, in writing, for at least ten years from the date of the decision recorded, of every unanimous or majority decision taken by the GMS directors.

16. DIRECTORS' DISCRETION TO MAKE FURTHER RULES

Subject to the articles, the GMS directors may make any rule which they think fit about how they take decisions, and about how such rules are to be recorded or communicated to GMS directors.

APPOINTMENT OF DIRECTORS

17. METHODS OF APPOINTING DIRECTORS

17.1 Any person who is willing to act as a GMS director, and is permitted by law to do so, may be appointed to be a GMS director:

17.1.1 by ordinary resolution; or

17.1.2 by a decision of the GMS directors (with the prior consent of the holders of a majority of the shares).

17.2 In any case where, as a result of death or bankruptcy, GMS has no shareholders and no GMS directors, the transmittees of the last shareholder to have died or to have a bankruptcy order made against him (as the case may be) have the right, by notice in writing, to appoint a natural person who is willing to act (and is permitted to do so) to be a GMS director.

17.3 For the purposes of paragraph 17.2, where two or more shareholders die in circumstances rendering it uncertain who was the last to die, a younger shareholder is deemed to have survived an older shareholder.

18. REMOVAL OF DIRECTORS

18.1 A controlling shareholder may at any time and from time to time by notice in writing to GMS remove any GMS director or GMS directors or GMS secretary from office.

18.2 Any removal of a GMS director pursuant to article 18.1 shall be without prejudice to any claim for breach of contract under any employment agreement between GMS and the GMS director so removed.

19. TERMINATION OF DIRECTOR'S APPOINTMENT

19.1 A person ceases to be a GMS director as soon as:

19.1.1 that person ceases to be a GMS director by virtue of any provision of the Companies Act 2006 or is prohibited from being a GMS director by law;

19.1.2 a bankruptcy order is made against that person;

19.1.3 a composition is made with that person's creditors generally in satisfaction of that person's debts;

19.1.4 a registered medical practitioner with appropriate qualifications and experience gives a written opinion to GMS stating that that person has become physically or mentally

incapable of acting as a GMS director and, on the balance of probabilities, is likely to remain so for more than three months;

19.1.5 the board serves notice on that person to the effect that his appointment is terminated by reason of repeated non-attendance at meetings of the board (without the consent of the other GMS directors, such consent not to be unreasonably withheld or delayed) over a period of six consecutive months;

19.1.6 by reason of that person's mental health, a court makes an order which wholly or partly prevents that person from personally exercising any powers or rights which that person would otherwise have; or

19.1.7 notification is received by GMS from the GMS director that the GMS director is resigning from office, and such resignation has taken effect in accordance with its terms; or

19.1.8 notification of his removal is received by GMS from a controlling shareholder pursuant to article 18.1.

20. DIRECTORS' REMUNERATION

20.1 Subject to the terms of any agreement in writing between GMS and the holders of a majority of the shares, the GMS directors are entitled to such remuneration as the GMS directors determine:

20.1.1 for their services to GMS as GMS directors; and

20.1.2 for any other service which they undertake for GMS.

20.2 Unless the GMS directors decide otherwise, GMS directors are not accountable to GMS for any remuneration which they receive as GMS directors or other officers or employees of GMS's subsidiaries or of any other body corporate in which GMS is interested.

21. EXPENSES

21.1 Subject to the terms of any agreement in writing between GMS and the holders of a majority of the shares, GMS may pay any reasonable expenses which the GMS directors and the secretary properly incur in connection with their attendance at:

21.1.1 meetings of GMS directors or committees of GMS directors;

21.1.2 general meetings; or

21.1.3 separate meetings of the holders of any class of shares or of debentures of GMS,

or otherwise in connection with the exercise of their powers and the discharge of their responsibilities in relation to GMS.

22. SECRETARY

An ordinary resolution of the shareholder (the Trust Board.), is required to appoint any person who is willing to act as the secretary for such term, at such remuneration and upon such conditions as they may think fit and from time to time remove such person and appoint a replacement, in each case by a decision of the Trust Board.

Commented [BB1]: If GMS has amended the Schedule of Matters Reserved to also reflect that the GMS Board can also appoint a company secretary, then this section can remain unchanged.
If the Schedule of Matters Reserved remains only allowing the Trust Board of Directors, then this section needs to be updated to require an ordinary resolution of the shareholder (the Trust Board).

PART 3

SHARES AND DISTRIBUTIONS

SHARES

23. COMPANY'S LIEN OVER SHARES

23.1 The company has a lien (the "**company's lien**") over every share, whether or not fully paid, which is registered in the name of any person indebted or under any liability to GMS, whether

he is the sole registered holder of the share or one of several joint holders, for all monies payable by him (either alone or jointly with any other person) to GMS, whether payable immediately or at some time in the future.

23.2 The company's lien over a share:

23.2.1 takes priority over any third party's interest in that share; and

23.2.2 extends to any dividend or other money payable by GMS in respect of that share and (if the lien is enforced and the share is sold by GMS) the proceeds of sale of that share.

23.3 The GMS directors may at any time decide that a share which is or would otherwise be subject to GMS's lien shall not be subject to it, either wholly or in part.

24. ENFORCEMENT OF THE COMPANY'S LIEN

24.1 Subject to the provisions of this article, if:

24.1.1 a lien enforcement notice has been given in respect of a share; and

24.1.2 the person to whom the notice was given has failed to comply with it,

GMS may sell that share in such manner as the GMS directors decide.

24.2 A lien enforcement notice:

24.2.1 may only be given in respect of a share which is subject to GMS's lien, in respect of which a sum is payable and the due date for payment of that sum has passed;

24.2.2 must specify the share concerned;

24.2.3 must require payment of the sum within 14 clear days of the notice (that is, excluding the date on which the notice is given and the date on which that 14 day period expires);

24.2.4 must be addressed either to the holder of the share or to a transmittee of that holder; and

24.2.5 must state GMS's intention to sell the share if the notice is not complied with.

24.3 Where shares are sold under this article:

24.3.1 the GMS directors may authorise any person to execute an instrument of transfer of the shares to the purchaser or to a person nominated by the purchaser; and

24.3.2 the transferee is not bound to see to the application of the consideration and the transferee's title is not affected by any irregularity in or invalidity of the process leading to the sale.

24.4 The net proceeds of any such sale (after payment of the costs of sale and any other costs of enforcing the lien) must be applied:

24.4.1 first, in payment of so much of the sum for which the lien exists as was payable at the date of the lien enforcement notice; and

24.4.2 second, to the person entitled to the shares at the date of the sale, but only after the certificate for the shares sold has been surrendered to GMS for cancellation, or an indemnity in a form reasonably satisfactory to the GMS directors has been given for any lost certificates, and subject to a lien equivalent to GMS's lien for any money payable (whether payable immediately or at some time in the future) as existed upon the shares before the sale in respect of all shares registered in the name of such person (whether as the sole registered holder or as one of several joint holders) after the date of the lien enforcement notice.

24.5 A statutory declaration by a GMS director or GMS secretary that the declarant is a GMS director or GMS secretary and that a share has been sold to satisfy GMS's lien on a specified date:

24.5.1 is conclusive evidence of the facts stated in it as against all persons claiming to be entitled to the share; and

24.5.2 subject to compliance with any other formalities of transfer required by the articles or by law, constitutes a good title to the share.

25. CALL NOTICES

25.1 Subject to the articles and the terms on which shares are allotted, the GMS directors may send a notice (a "**call notice**") to a shareholder requiring the shareholder to pay GMS a specified sum of money (a "**call**") which is payable to GMS at the date when the GMS directors decide to send the call notice.

25.2 A call notice:

25.2.1 may not require a shareholder to pay a call which exceeds the total amount of his indebtedness or liability to GMS;

25.2.2 must state when and how any call to which it relates is to be paid; and

25.2.3 may permit or require the call to be made in instalments.

25.3 A shareholder must comply with the requirements of a call notice, but no shareholder is obliged to pay any call before 14 clear days (that is, excluding the date on which the notice is given and the date on which that 14 day period expires) have passed since the notice was sent.

25.4 Before GMS has received any call due under a call notice the GMS directors may:

25.4.1 revoke it wholly or in part; or

25.4.2 specify a later time for payment than is specified in the notice,

by a further notice in writing to the shareholder in respect of whose shares the call is made.

26. LIABILITY TO PAY CALLS

26.1 Liability to pay a call is not extinguished or transferred by transferring the shares in respect of which it is required to be paid.

26.2 Joint holders of a share are jointly and severally liable to pay all calls in respect of that share.

26.3 Subject to the terms on which shares are allotted, the GMS directors may, when issuing shares, provide that call notices sent to the holders of those shares may require them:

26.3.1 to pay calls which are not the same; or

26.3.2 to pay calls at different times.

27. WHEN CALL NOTICE NEED NOT BE ISSUED

27.1 A call notice need not be issued in respect of sums which are specified, in the terms on which a share is issued, as being payable to GMS in respect of that share:

27.1.1 on allotment;

27.1.2 on the occurrence of a particular event; or

27.1.3 on a date fixed by or in accordance with the terms of issue.

27.2 But if the due date for payment of such a sum has passed and it has not been paid, the holder of the share concerned is treated in all respects as having failed to comply with a call notice in

respect of that sum, and is liable to the same consequences as regards the payment of interest and forfeiture.

28. FAILURE TO COMPLY WITH CALL NOTICE: AUTOMATIC CONSEQUENCES

28.1 If a person is liable to pay a call and fails to do so by the call payment date:

28.1.1 the GMS directors may issue a notice of intended forfeiture to that person; and

28.1.2 until the call is paid, that person must pay GMS interest on the call from the call payment date at the relevant rate.

28.2 For the purposes of this article:

28.2.1 the "call payment date" is the time when the call notice states that a call is payable, unless the GMS directors give a notice specifying a later date, in which case the "call payment date" is that later date; and

28.2.2 the "relevant rate" is:

28.2.2.1 the rate fixed by the terms on which the share in respect of which the call is due was allotted;

28.2.2.2 such other rate as was fixed in the call notice which required payment of the call, or has otherwise been determined by the GMS directors; or

28.2.2.3 if no rate is fixed in either of these ways, five per cent per annum.

28.3 The relevant rate must not exceed by more than five percentage points the base lending rate most recently set by the Monetary Policy Committee of the Bank of England in connection with its responsibilities under Part 2 of the Bank of England Act 1998.

28.4 The GMS directors may waive any obligation to pay interest on a call wholly or in part.

29. NOTICE OF INTENDED FORFEITURE

29.1 A notice of intended forfeiture:

29.1.1 may be sent in respect of any share in respect of which a call has not been paid as required by a call notice;

29.1.2 must be sent to the holder of that share (or all the joint holders of that share) or to a transmittee of that holder;

29.1.3 must require payment of the call and any accrued interest and all expenses that may have been incurred by GMS by reason of such non-payment by a date which is not less than 14 clear days after the date of the notice (that is, excluding the date on which the notice is given and the date on which that 14 day period expires);

29.1.4 must state how the payment is to be made; and

29.1.5 must state that, if the notice is not complied with, the shares in respect of which the call is payable will be liable to be forfeited.

30. DIRECTORS' POWER TO FORFEIT SHARES

If a notice of intended forfeiture is not complied with before the date by which payment of the call is required in the notice of intended forfeiture, the GMS directors may decide that any share in respect of which it was given is forfeited, and the forfeiture is to include all dividends or other moneys payable in respect of the forfeited shares and not paid before the forfeiture.

31. EFFECT OF FORFEITURE

31.1 Subject to the articles, the forfeiture of a share extinguishes:

31.1.1 all interests in that share, and all claims and demands against GMS in respect of it; and

31.1.2 all other rights and liabilities incidental to the share as between the person whose share it was prior to the forfeiture and GMS.

31.2 Any share which is forfeited in accordance with the articles:

31.2.1 is deemed to have been forfeited when the GMS directors decide that it is forfeited;

31.2.2 is deemed to be the property of GMS; and

31.2.3 may be sold, re-allotted or otherwise disposed of as the GMS directors think fit.

31.3 If a person's shares have been forfeited:

31.3.1 GMS must send that person notice that forfeiture has occurred and record it in the register of shareholders;

31.3.2 that person ceases to be a shareholder in respect of those shares;

31.3.3 that person must surrender the certificate for the shares forfeited to GMS for cancellation;

31.3.4 that person remains liable to GMS for all sums payable by that person under the articles at the date of forfeiture in respect of those shares, including any interest (whether accrued before or after the date of forfeiture); and

31.3.5 the GMS directors may waive payment of such sums wholly or in part or enforce payment without any allowance for the value of the shares at the time of forfeiture or for any consideration received on their disposal.

31.4 At any time before GMS disposes of a forfeited share, the GMS directors may decide to cancel the forfeiture on payment of all calls and interest and expenses due in respect of it and on such other terms as they think fit.

32. PROCEDURE FOLLOWING FORFEITURE

32.1 If a forfeited share is to be disposed of by being transferred, GMS may receive the consideration for the transfer and the GMS directors may authorise any person to execute the instrument of transfer.

32.2 A statutory declaration by a GMS director or GMS secretary that the declarant is a GMS director or GMS secretary and that a share has been forfeited on a specified date:

32.2.1 is conclusive evidence of the facts stated in it as against all persons claiming to be entitled to the share; and

32.2.2 subject to compliance with any other formalities of transfer required by the articles or by law, constitutes a good title to the share.

32.3 A person to whom a forfeited share is transferred is not bound to see to the application of the consideration (if any) nor is that person's title to the share affected by any irregularity in or invalidity of the process leading to the forfeiture or transfer of the share.

32.4 If GMS sells a forfeited share, the person who held it prior to its forfeiture is entitled to receive from GMS the proceeds of such sale, net of any commission, and excluding any amount which:

32.4.1 was, or would have become, payable; and

32.4.2 had not, when that share was forfeited, been paid by that person in respect of that share,

but no interest is payable to such a person in respect of such proceeds and GMS is not required to account for any money earned on them.

32.5 Any sale of a forfeited share shall be subject to the pre-emption rights contained in article 39.

33. SURRENDER OF SHARES

33.1 A shareholder may surrender any share:

33.1.1 in respect of which the GMS directors may issue a notice of intended forfeiture;

33.1.2 which the GMS directors may forfeit; or

33.1.3 which has been forfeited.

33.2 The GMS directors may accept the surrender of any such share.

33.3 The effect of surrender on a share is the same as the effect of forfeiture on that share.

33.4 A share which has been surrendered may be dealt with in the same way as a share which has been forfeited.

34. SHARE CAPITAL

34.1 The issued share capital of GMS as at the date of adoption of these articles is £1.00, comprising one hundred ordinary shares with a nominal value of £0.01 each.

34.2 The GMS directors of GMS may not exercise any power of GMS to:

34.2.1 allot shares in GMS; or

34.2.2 grant any right to subscribe for, or to convert any security into, shares in GMS,

other than to the extent authorised by resolution of GMS from time to time. For the avoidance of doubt, the prohibition set out in this article 33.2 extends to shares or rights granted in pursuance of employees' share scheme as defined in section 1166 of the Companies Act 2006.

35. COMPANY NOT BOUND BY LESS THAN ABSOLUTE INTERESTS

Except as required by law, no person is to be recognised by GMS as holding any share upon any trust, and except as otherwise required by law or the articles, GMS is not in any way to be bound by or recognise any interest in a share other than the holder's absolute ownership of it and all the rights attaching to it.

36. SHARE CERTIFICATES

36.1 The company must issue each shareholder, free of charge, with one or more certificates in respect of the shares which that shareholder holds.

36.2 Every certificate must specify:

36.2.1 in respect of how many shares, of what class, it is issued;

36.2.2 the nominal value of those shares; and

36.2.3 any distinguishing numbers assigned to them.

36.3 No certificate may be issued in respect of shares of more than one class.

36.4 If more than one person holds a share, only one certificate may be issued in respect of it.

36.5 Certificates must:

36.5.1 have affixed to them GMS's common seal; or

36.5.2 be otherwise executed in accordance with the Companies Acts.

37. REPLACEMENT SHARE CERTIFICATES

37.1 If a certificate issued in respect of a shareholder's shares is:

37.1.1 damaged or defaced; or

37.1.2 said to be lost, stolen or destroyed,

that shareholder is entitled to be issued with a replacement certificate in respect of the same shares.

37.2 A shareholder exercising the right to be issued with such a replacement certificate:

37.2.1 may at the same time exercise the right to be issued with a single certificate or separate certificates;

37.2.2 must return the certificate which is to be replaced to GMS if it is damaged or defaced; and

37.2.3 must comply with such conditions as to evidence and indemnity as the GMS directors decide.

38. SHARE TRANSFERS

38.1 Subject to article 39, shares may be transferred by means of an instrument of transfer in any usual form or any other form approved by the GMS directors, which is executed by or on behalf of the transferor.

38.2 No fee may be charged for registering any instrument of transfer or other document relating to or affecting the title to any share.

38.3 The company may retain any instrument of transfer which is registered.

38.4 The transferor remains the holder of a share until the transferee's name is entered in the register of members as holder of it.

38.5 The GMS directors may refuse to register the transfer of a share; if they do so, the instrument of transfer must be returned to the transferee with the notice of refusal within two months unless they suspect that the proposed transfer may be fraudulent.

39. TRANSFER OF SHARES SUBJECT TO PRE-EMPTION RIGHTS

39.1 In this article, references to a transfer of a share include the transfer or assignment of a beneficial or other interest in that share or the creation of a trust or encumbrance over that share and reference to a share includes a beneficial or other interest in a share.

39.2 Any transfer of shares by a shareholder shall be subject to the pre-emption rights in this article.

39.3 A shareholder wishing to transfer some or all of his shares ("**Seller**") shall, before transferring or agreeing to transfer any shares, give a notice in writing to GMS ("**Transfer Notice**") specifying:

39.3.1 the number of the shares for sale ("**Sale Shares**");

39.3.2 if the Seller wishes to sell the Sale Shares to a third party, the name of the proposed transferee;

39.3.3 the price (in cash) per share at which he wishes to transfer the Sale Shares subject to the GMS directors being satisfied (and to that end being provided with such evidence as they may reasonably require) that the proposed price represents a fair value for the

Sale Shares and, if the GMS directors are not satisfied with the specified price, it shall be determined in accordance with article 39.4 ("**Transfer Price**"); and

39.3.4 whether the Transfer Notice is conditional on all, or a specific number of, the Sale Shares being sold ("**Minimum Transfer Condition**").

39.4 If the GMS directors are not satisfied with the price specified in the Transfer Notice then within ten days of the Transfer Notice being received:

39.4.1 the Seller and the GMS directors shall use all reasonable endeavours to agree the fair value of the Sale Shares; or

39.4.2 if no such agreement can be reached within the said ten day period, fair value for the Sale Shares shall be determined by the auditors for the time being of GMS or (if the Seller shall require) by some other chartered accountant to be nominated by the President for the time being of the Institute of Chartered Accountants in England and Wales who shall act as an expert and not as an arbitrator, and whose determination as to the fair value of the Sale Shares shall be conclusive.

39.5 Within 48 hours of the fair value being determined in accordance with article 39.4.2 the GMS directors shall notify the Seller of the fair value of the Sale Shares. If the Seller disputes the fair value, he may, by written notice to the GMS directors within 48 hours of receiving notice of the same, withdraw the Transfer Notice. If the Seller does not withdraw the Transfer Notice within the 48 hour period or he indicates his agreement to the fair value during that time, the GMS directors shall, as soon as practicable thereafter, offer the Sale Shares for sale to the shareholders in the manner set out in article 39.8. Each offer shall be in writing and give details of the number and Transfer Price of the Sale Shares offered.

39.6 Otherwise than in accordance with article 39.5 once given (or deemed to have been given) under these articles, a Transfer Notice may not be withdrawn.

39.7 A Transfer Notice appoints GMS the agent of the Seller for the sale of the Sale Shares at the Transfer Price.

39.8 The GMS directors shall offer the Sale Shares to all shareholders other than the Seller ("**Continuing Shareholders**"), inviting them to apply in writing within 28 days of the date of the offer ("**First Offer Period**") for the maximum number of Sale Shares they wish to buy.

If the Sale Shares are subject to a Minimum Transfer Condition, any allocation made under this article 39.8 and article 39.9 shall be conditional on the fulfilment of the Minimum Transfer Condition.

If, at the end of the First Offer Period, the number of Sale Shares applied for is equal to or exceeds the number of Sale Shares, the GMS directors shall allocate the Sale Shares to each Continuing Shareholder who has applied for Sale Shares in the proportion which his existing holding of shares bears to the total number of shares held by those Continuing Shareholders who have applied for Sale Shares. Fractional entitlements shall be rounded to the nearest whole number. No allocation shall be made to a Continuing Shareholder of more than the maximum number of Sale Shares which he has stated he is willing to buy.

If, at the end of the First Offer Period, the total number of Sale Shares applied for is less than the number of Sale Shares, the GMS directors shall allocate the Sale Shares to the Continuing Shareholders in accordance with their applications. The balance ("**Initial Surplus Shares**") shall be dealt with in accordance with article 39.9.

39.9 At the end of the First Offer Period, the Board shall offer the Initial Surplus Shares to all the Continuing Shareholders, inviting them to apply in writing within 28 days of the date of the offer ("**Second Offer Period**") for the maximum number of Initial Surplus Shares they wish to buy.

If, at the end of the Second Offer Period, the number of Initial Surplus Shares applied for exceeds the number of Initial Surplus Shares, the GMS directors shall allocate the remaining Initial Surplus Shares to each Continuing Shareholder who has applied for Initial Surplus Shares in the proportion that his existing holding of shares (including any Sale Shares) bears to the total number of shares (including any Sale Shares) held by those Continuing Shareholders who have applied for Initial Surplus Shares during the Second Offer Period. Fractional entitlements shall

be rounded to the nearest whole number. No allocation shall be made to a Continuing Shareholder of more than the maximum number of Initial Surplus Shares which he has stated he is willing to buy.

If, at the end of the Second Offer Period, the number of Initial Surplus Shares applied for is less than the number of Initial Surplus Shares, the GMS directors shall allocate the Initial Surplus Shares to the Continuing Shareholders in accordance with their applications. The balance ("**Second Surplus Shares**") shall be dealt with in accordance with articles 39.14 and 39.15.

39.10 If the Transfer Notice includes a Minimum Transfer Condition and the total number of Sale Shares applied for is less than the number of Sale Shares specified in the Minimum Transfer Condition, GMS itself may, subject to compliance with all statutory requirements, purchase the Sale Shares not accepted by the Continuing Shareholders on the terms set out in the Transfer Notice. If GMS does not purchase the Sale Shares, the GMS directors shall notify the Seller and all those to whom Sale Shares have been conditionally allocated under article 39.8 and article 39.9, stating that the Minimum Transfer Condition has not been met and that the relevant Transfer Notice has lapsed with immediate effect.

39.11 If:

39.11.1 the Transfer Notice includes a Minimum Transfer Condition and such Minimum Transfer Condition has been satisfied, or the Transfer Notice does not include a Minimum Transfer Condition; and

39.11.2 allocations under article 39.8 and, if necessary, article 39.9 have been made in respect of some or all of the Sale Shares,

the GMS directors shall give written notice of allocation ("**Allocation Notice**") to the Seller and each Continuing Shareholder to whom Sale Shares have been allocated (including GMS if it is willing to purchase any Sale Shares in accordance with article 39.10) ("**Applicant**"). The Allocation Notice shall specify the number of Sale Shares allocated to each Applicant, the amount payable by each Applicant for the number of Sale Shares allocated to him ("**Consideration**") and the place and time for completion of the transfer of the Sale Shares (which shall be not more than the later of 28 days after the date of the Allocation Notice or, if GMS is an Applicant, the date upon which GMS complies, in full, with all statutory requirement in relation to the purchase of the Sale Share).

39.12 On the service of an Allocation Notice, the Seller shall, against payment of the Consideration, transfer the Sale Shares allocated in accordance with the requirements specified in the Allocation Notice.

39.13 If the Seller fails to comply with the requirements of the Allocation Notice:

39.13.1 the Chair of GMS (or, failing him, one of the other GMS directors, or some other person nominated by a resolution of the GMS directors) may, on behalf of the Seller:

39.13.1.1 complete, execute and deliver in his name all documents necessary to give effect to the transfer of the relevant Sale Shares to the Applicants;

39.13.1.2 receive the Consideration and give a good discharge for it; and

39.13.1.3 (subject to the transfers being duly stamped) enter the Applicants in the register of shareholders as the holders of the shares purchased by them; and

39.13.2 GMS shall pay the Consideration into a separate bank account in GMS's name on trust (but without interest) for the Seller until he has delivered his certificate for the relevant shares (or an indemnity, in a form reasonably satisfactory to the GMS directors, in respect of any lost certificate, together with such other evidence (if any) as the GMS directors may reasonably require to prove good title to those shares) to GMS.

39.14 If an Allocation Notice does not relate to all of the Sale Shares then GMS itself may, subject to compliance with all statutory requirements, purchase the remaining Sale Shares on the terms set out in the Transfer Notice.

39.15 If GMS does not purchase the Sale Shares in accordance with article 39.14 then, subject to article 39.16 and within four weeks following service of the Allocation Notice, the Seller may transfer the Second Surplus Shares to any person at a price at least equal to the Transfer Price.

39.16 The Seller's right to transfer shares under article 39.15 does not apply if the GMS directors, acting reasonably, are of the opinion that:

39.16.1 the transferee is a person (or a nominee for a person) who is a competitor with (or an associate of a competitor with) the business of GMS or with an associated company (companies being associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate); or

39.16.2 the sale of the Sale Shares is not bona fide or the price is subject to a deduction, rebate or allowance to the transferee; or

39.16.3 the Seller has failed or refused to provide promptly information available to the Seller and reasonably requested by the GMS directors to enable them to form the opinion mentioned above.

39.17 The restrictions imposed by this article may be waived in relation to any proposed transfer of Shares with the consent of shareholders who, but for the waiver, would or might have been entitled to have such shares offered to them in accordance with this article.

40. TRANSMISSION OF SHARES

40.1 If title to a share passes to a transmittee, GMS may only recognise the transmittee as having any title to that share.

40.2 A transmittee who produces such evidence of entitlement to shares as the GMS directors may properly require:

40.2.1 may, subject to the articles, choose either to become the holder of those shares or to have them transferred to another person; and

40.2.2 subject to the articles, and pending any transfer of the shares to another person, has the same rights as the holder had.

40.3 Transmittees do not have the right to attend or vote at a general meeting, or agree to a proposed written resolution, in respect of shares to which they are entitled, by reason of the holder's death or bankruptcy or otherwise, unless they become the holders of those shares.

41. EXERCISE OF TRANSMITTEES' RIGHTS

41.1 Transmittees who wish to become the holders of shares to which they have become entitled must notify GMS in writing of that wish.

41.2 If the transmittee wishes to have a share transferred to another person, the transmittee must execute an instrument of transfer in respect of it.

41.3 Any transfer made or executed under this article is to be treated as if it were made or executed by the person from whom the transmittee has derived rights in respect of the share, and as if the event which gave rise to the transmission had not occurred and all the provisions of the articles relating to transfers of shares shall apply.

42. TRANSMITTEES BOUND BY PRIOR NOTICES

If a notice is given to a shareholder in respect of shares and a transmittee is entitled to those shares, the transmittee is bound by the notice if it was given to the shareholder before the transmittee's name, or the name of any person(s) named as the transferee(s) in an instrument

of transfer executed under article 41.2, has been entered in the register of members.

DIVIDENDS AND OTHER DISTRIBUTIONS

43. PROCEDURE FOR DECLARING DIVIDENDS

43.1 The company may by ordinary resolution declare dividends, and the GMS directors may decide to pay interim dividends.

43.2 A dividend must not be declared unless the GMS directors have made a recommendation as to its amount. Such a dividend must not exceed the amount recommended by the GMS directors.

43.3 No dividend may be declared or paid unless it is in accordance with shareholders' respective rights.

43.4 Except as otherwise provided by the rights attached to shares, all dividends shall be declared and paid according to the amounts paid up on the shares on which the dividend is paid. All dividends shall be apportioned and paid proportionately to the amounts paid up on the shares during any portion or portions of the period in respect of which the dividend is paid. However, if any share is issued on terms providing that it shall rank for dividend as from a particular date, that share shall rank for dividend accordingly.

43.5 If GMS's share capital is divided into different classes, no dividend may be paid on shares carrying deferred or non-preferred rights if, at the time of payment, any preferential dividend is in arrears.

43.6 The GMS directors may pay at intervals any dividend payable at a fixed rate if it appears to them that the profits available for distribution justify the payment.

43.7 If the GMS directors act in good faith, they do not incur any liability to the holders of shares conferring preferred rights for any loss they may suffer by the lawful payment of an interim dividend on shares with deferred or non-preferred rights.

44. PAYMENT OF DIVIDENDS AND OTHER DISTRIBUTIONS

44.1 Where a dividend or other sum which is a distribution is payable in respect of a share, it must be paid by one or more of the following means:

44.1.1 transfer to a bank or building society account specified by the distribution recipient, either in writing or as the GMS directors may otherwise decide;

44.1.2 sending a cheque made payable to the distribution recipient by post to the distribution recipient at the distribution recipient's registered address (if the distribution recipient is a holder of the share), or (in any other case) to an address specified by the distribution recipient, either in writing or as the GMS directors may otherwise decide;

44.1.3 sending a cheque made payable to such person by post to such person at such address as the distribution recipient has specified, either in writing or as the GMS directors may otherwise decide; or

44.1.4 any other means of payment as the GMS directors agree with the distribution recipient, either in writing or by such other means as the GMS directors decide.

44.2 In the articles, "the distribution recipient" means, in respect of a share in respect of which a dividend or other sum is payable:

44.2.1 the holder of the share; or

44.2.2 if the share has two or more joint holders, whichever of them is named first in the register of members; or

44.2.3 if the holder is no longer entitled to the share by reason of death or bankruptcy, or otherwise by operation of law, the transmittee.

45. NO INTEREST ON DISTRIBUTIONS

45.1 The company may not pay interest on any dividend or other sum payable in respect of a share unless otherwise provided by:

45.1.1 the terms on which the share was issued; or

45.1.2 the provisions of another agreement between the holder of that share and GMS.

46. UNCLAIMED DISTRIBUTIONS

46.1 All dividends or other sums which are:

46.1.1 payable in respect of shares; and

46.1.2 unclaimed after having been declared or become payable;

may be invested or otherwise made use of by the GMS directors for the benefit of GMS until claimed.

46.2 The payment of any such dividend or other sum into a separate account does not make GMS a trustee in respect of it.

46.3 If:

46.3.1 twelve years have passed from the date on which a dividend or other sum became due for payment; and

46.3.2 the distribution recipient has not claimed it,

the distribution recipient is no longer entitled to that dividend or other sum and it ceases to remain owing by GMS.

47. NON-CASH DISTRIBUTIONS

47.1 Subject to the terms of issue of the share in question, GMS may, by ordinary resolution on the recommendation of the GMS directors, decide to pay all or part of a dividend or other distribution payable in respect of a share by transferring non-cash assets of equivalent value (including, without limitation, shares or other securities in any company).

47.2 For the purposes of paying a non-cash distribution, the GMS directors may make whatever arrangements they think fit, including, where any difficulty arises regarding the distribution:

47.2.1 fixing the value of any assets;

47.2.2 paying cash to any distribution recipient on the basis of that value in order to adjust the rights of recipients; and

47.2.3 vesting any assets in trustees.

48. WAIVER OF DISTRIBUTIONS

48.1 Distribution recipients may waive their entitlement to a dividend or other distribution payable in respect of a share by giving GMS notice in writing by way of a deed to that effect, but if:

48.1.1 the share has more than one holder; or

48.1.2 more than one person is entitled to the share, whether by reason of the death or bankruptcy of one or more joint holders, or otherwise,

the notice is not effective unless it is expressed to be given, and signed, by all the holders or persons otherwise entitled to the share.

CAPITALISATION OF PROFITS

49. AUTHORITY TO CAPITALISE AND APPROPRIATION OF CAPITALISED SUMS

49.1 Subject to the articles, the GMS directors may, if they are so authorised by an ordinary resolution:

49.1.1 decide to capitalise any profits of GMS (whether or not they are available for distribution) which are not required for paying a preferential dividend, or any sum standing to the credit of GMS's share premium account or capital redemption reserve; and

49.1.2 appropriate any sum which they so decide to capitalise (a "capitalised sum") to the persons who would have been entitled to it if it were distributed by way of dividend (the "persons entitled") and in the same proportions and apply such sum on their behalf either towards paying up the amounts, if any, for the time being unpaid on any shares held by them respectively.

49.2 Capitalised sums must be applied:

49.2.1 on behalf of the persons entitled; and

49.2.2 in the same proportions as a dividend would have been distributed to them.

49.3 Any capitalised sum may be applied in paying up new shares of a nominal amount equal to the capitalised sum which are then allotted credited as fully paid to the persons entitled or as they may direct.

49.4 A capitalised sum which was appropriated from profits available for distribution may be applied in paying up new debentures of GMS which are then allotted credited as fully paid to the persons entitled or as they may direct.

49.5 Subject to the articles the GMS directors may:

49.5.1 apply capitalised sums in accordance with paragraphs 49.3 and 49.4 partly in one way and partly in another;

49.5.2 make such arrangements as they think fit to deal with shares or debentures becoming distributable in fractions under this article (including the issuing of fractional certificates or the making of cash payments); and

49.5.3 authorise any person to enter into an agreement with GMS on behalf of all the persons entitled which is binding on them in respect of the allotment of shares and debentures to them under this article.

PART 4

DECISION-MAKING BY SHAREHOLDERS

ORGANISATION OF GENERAL MEETINGS

50. CALLING A GENERAL MEETING

50.1 The GMS directors may call general meetings of GMS.

50.2 In accordance with the provisions of the Companies Act 2006, and on the requisition of shareholders representing at least 5% of the paid up capital of GMS carrying the right to vote at general meetings, the GMS directors shall forthwith convene a general meeting.

51. NOTICE OF GENERAL MEETINGS

51.1 General meetings (other than adjourned meetings) shall be called on at least 14 days' notice.

51.2 General meetings may be called by shorter notice if agreed to by a majority in number of the shareholders having the right to attend and vote at the meeting, being a majority who together hold not less than 90% in nominal value of the shares giving a right to attend and vote at the meeting.

51.3 Subject to the provisions of the articles and any restrictions imposed on any shares, the notice shall be given to all shareholders, to all transmittees and to the GMS directors and auditors.

51.4 Subject to the provisions of the Companies Act 2006, the accidental omission to give notice of a meeting to, or the non-receipt of notice of a meeting by, any person entitled to receive notice shall not invalidate the proceedings at that meeting.

51.5 Notice of a general meeting must be given:

51.5.1 in hard copy form;

51.5.2 in electronic form; or

51.5.3 subject to the provisions of the Companies Act 2006, by means of a website.

51.6 Notice of a general meeting must state:

51.6.1 the time and date of the meeting;

51.6.2 the place of the meeting; and

51.6.3 the general nature of the business to be transacted at the meeting.

52. ATTENDANCE AND SPEAKING AT GENERAL MEETINGS

52.1 A person is able to exercise the right to speak at a general meeting when that person is in a position to communicate to all those attending the meeting, during the meeting, any information or opinions which that person has on the business of the meeting.

52.2 A person is able to exercise the right to vote at a general meeting when:
52.2.1 that person is able to vote, during the meeting, on resolutions put to the vote at the meeting; and

52.2.2 that person's vote can be taken into account in determining whether or not such resolutions are passed at the same time as the votes of all the other persons attending the meeting.

52.3 The GMS directors may make whatever arrangements they consider appropriate to enable those attending a general meeting to exercise their rights to speak or vote at it.

52.4 In determining attendance at a general meeting, it is immaterial whether any two or more members attending it are in the same place as each other.

52.5 Two or more persons who are not in the same place as each other attend a general meeting if their circumstances are such that if they have (or were to have) rights to speak and vote at that meeting, they are (or would be) able to exercise them.

53. QUORUM FOR GENERAL MEETINGS

53.1 Save in the case where GMS has a single shareholder, two persons entitled to vote on the business to be transacted at the meeting, each being a shareholder or a proxy for a shareholder or a duly authorised representative of a corporate shareholder, shall be a quorum.

53.2 No business other than the appointment of the chair of the meeting is to be transacted at a general meeting if the persons attending it do not constitute a quorum.

54. CHAIRING GENERAL MEETINGS

54.1 If the GMS directors have appointed a Chair, the Chair shall chair general meetings if present and willing to do so.

54.2 If the GMS directors have not appointed a Chair, or if the Chair is unwilling to Chair the meeting or is not present within ten minutes of the time at which a meeting was due to start:

54.2.1 the GMS directors present; or

54.2.2 (if no GMS directors are present) the meeting,

must appoint a GMS director or shareholder to chair the meeting, and the appointment of the chair of the meeting must be the first business of the meeting.

54.3 The person chairing a meeting in accordance with this article is referred to as "the chair of the meeting".

55. ATTENDANCE AND SPEAKING BY DIRECTORS AND NON-SHAREHOLDERS

55.1 Directors may attend and speak at general meetings, whether or not they are shareholders.

55.2 The chair of the meeting may permit other persons who are not:

55.2.1 shareholders of GMS; or

55.2.2 otherwise entitled to exercise the rights of shareholders in relation to general meetings,

to attend and speak at a general meeting.

56. ADJOURNMENT

56.1 If the persons attending a general meeting within half an hour of the time at which the meeting was due to start do not constitute a quorum, or if during a meeting a quorum ceases to be present, the chair of the meeting must adjourn it.

56.2 The chair of the meeting may adjourn a general meeting at which a quorum is present if:

56.2.1 the meeting consents to an adjournment; or

56.2.2 it appears to the chair of the meeting that an adjournment is necessary to protect the safety of any person attending the meeting or ensure that the business of the meeting is conducted in an orderly manner.

56.3 The chair of the meeting must adjourn a general meeting if directed to do so by the meeting.

56.4 When adjourning a general meeting, the chair of the meeting must:

56.4.1 either specify the time and place to which it is adjourned or state that it is to continue at a time and place to be fixed by the GMS directors; and

56.4.2 have regard to any directions as to the time and place of any adjournment which have been given by the meeting.

56.5 If the continuation of an adjourned meeting is to take place more than 14 days after it was adjourned, GMS must give at least seven clear days' notice of it (that is, excluding the day of the adjourned meeting and the day on which the notice is given):

56.5.1 to the same persons to whom notice of GMS's general meetings is required to be given; and

56.5.2 containing the same information which such notice is required to contain.

56.6 If at an adjourned meeting a quorum is not present within half an hour from the time appointed, then, provided that the shareholders present hold at least 75% in nominal value of the ordinary

shares of GMS in issue, any resolution agreed to by such members shall be valid and effectual as if it had been passed unanimously at a general meeting of GMS duly convened and held.

56.7 No business may be transacted at an adjourned general meeting which could not properly have been transacted at the meeting if the adjournment had not taken place.

VOTING AT GENERAL MEETINGS

57. VOTING

57.1 On a vote on a resolution on a show of hands at a meeting, each shareholder present in person has one vote.

57.2 Subject to article 57.3, on a vote on a resolution on a show of hands at a meeting, every proxy present who has been duly appointed by one or more shareholders entitled to vote on the resolution has one vote.

57.3 On a vote on a resolution on a show of hands at a meeting, a proxy has one vote for and one vote against the resolution if:

57.3.1 the proxy has been duly appointed by more than one shareholder entitled to vote on the resolution; and

57.3.2 the proxy has been instructed by one or more of those shareholders to vote for the resolution and by one or more other of those shareholders to vote against it.

57.4 On a poll taken at a meeting of GMS all or any of the voting rights of a shareholder may be exercised by one or more duly appointed proxies.

57.5 Where a shareholder appoints more than one proxy, article 57.3 does not authorise the exercise by the proxies taken together of more extensive voting rights than could be exercised by the shareholder in person.

58. ERRORS AND DISPUTES

58.1 No objection may be raised to the qualification of any person voting at a general meeting except at the meeting or adjourned meeting at which the vote objected to is tendered, and every vote not disallowed at the meeting is valid.

58.2 Any such objection must be referred to the chair of the meeting, whose decision is final.

59. POLL VOTES

59.1 A poll on a resolution may be demanded:

59.1.1 in advance of the general meeting at which that resolution is to be put to the vote; or

59.1.2 at a general meeting, either before a show of hands on that resolution or immediately after the result of a show of hands on that resolution is declared.

59.2 A poll may be demanded by:

59.2.1 the chair of the meeting;

59.2.2 the GMS directors;

59.2.3 two or more persons having the right to vote on the resolution;

59.2.4 a person or persons representing not less than one tenth of the total voting rights of all the shareholders having the right to vote on the resolution; or

59.2.5 a person or persons holding shares conferring the right to vote on the resolution, being shares on which an aggregate sum has been paid up equal to not less than 10% of the total sum paid up on all the shares conferring the right to vote on the resolution,

and a demand by a person as proxy for a shareholder shall be the same as a demand by the shareholder.

59.3 A demand for a poll may be withdrawn if:

59.3.1 the poll has not yet been taken; and

59.3.2 the chair of the meeting consents to the withdrawal.

59.4 A demand so withdrawn shall not invalidate the result of a show of hands declared before the demand was made.

59.5 Polls must be taken immediately upon demand (subject to being withdrawn in accordance with article 59.3) and in such manner as the chair of the meeting directs.

60. RIGHT TO APPOINT PROXIES

60.1 A shareholder is entitled to appoint another person as his proxy to exercise all or any of his rights to attend and speak and vote at a meeting of GMS.

60.2 A shareholder may appoint more than one proxy in relation to a meeting, provided that each proxy is appointed to exercise the rights attached to a different share or shares held by him.

61. CONTENT OF PROXY NOTICES

61.1 Proxies may only validly be appointed by a notice in writing (a "proxy notice") which:

61.1.1 states the name and address of the shareholder appointing the proxy;

61.1.2 identifies the person appointed to be that shareholder's proxy and the general meeting in relation to which that person is appointed;

61.1.3 is signed by or on behalf of the member appointing the proxy, or is authenticated in such manner as the GMS directors may determine;

61.1.4 is delivered to GMS in accordance with the articles not less than 48 hours before the time appointed for holding the meeting at which the right to vote is being exercised and in accordance with any instructions contained in the notice of the general meeting or adjourned meeting to which they relate;

61.1.5 in the case of a poll taken more than 48 hours after it is demanded, is delivered to GMS after the poll has been demanded and not less than 24 hours before the time appointed for the taking of the poll; and

61.1.6 where the poll is not taken forthwith but is taken not more than 48 hours after it was demanded, is delivered at the meeting at which the poll was demanded to the Chair or any GMS director or GMS secretary.

61.2 A proxy notice which is not delivered in accordance with article 61.1 shall be invalid unless the GMS directors, in their discretion, accept the notice at any time before the meeting.

61.3 The company may require proxy notices to be delivered in a particular form, and may specify different forms for different purposes.

61.4 Proxy notices may specify how the proxy appointed under them is to vote (or that the proxy is to abstain from voting) on one or more resolutions.

61.5 Unless a proxy notice indicates otherwise, it must be treated as:

61.5.1 allowing the person appointed under it as a proxy discretion as to how to vote on any ancillary or procedural resolutions put to the meeting; and

61.5.2 appointing that person as a proxy in relation to any adjournment of the general meeting to which it relates as well as the meeting itself.

62. DELIVERY OF PROXY NOTICES

62.1 A person who is entitled to attend, speak or vote (either on a show of hands or on a poll) at a general meeting remains so entitled in respect of that meeting or any adjournment of it, even though a valid proxy notice has been delivered to GMS by or on behalf of that person.

62.2 An appointment under a proxy notice may be revoked by delivering to GMS a notice given by or on behalf of the person by whom or on whose behalf the proxy notice was given.

62.3 A notice revoking a proxy appointment only takes effect if it is delivered before the start of the meeting or adjourned meeting to which it relates.

62.4 If a proxy notice is not executed by the person appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the appointor's behalf.

63. AMENDMENTS TO RESOLUTIONS

63.1 An ordinary resolution to be proposed at a general meeting may be amended by ordinary resolution if:

63.1.1 notice of the proposed amendment is given to GMS in writing by a person entitled to vote at the general meeting at which it is to be proposed not less than 48 hours before the meeting is to take place (or such later time as the chair of the meeting may determine); and

63.1.2 the proposed amendment does not, in the reasonable opinion of the chair of the meeting, materially alter the scope of the resolution.

63.2 A special resolution to be proposed at a general meeting may be amended by ordinary resolution, if:

63.2.1 the chair of the meeting proposes the amendment at the general meeting at which the resolution is to be proposed; and

63.2.2 the amendment does not go beyond what is necessary to correct a grammatical or other non-substantive error in the resolution.

63.3 If the chair of the meeting, acting in good faith, wrongly decides that an amendment to a resolution is out of order, the chair of the meeting's error does not invalidate the vote on that resolution.

PART 5

ADMINISTRATIVE ARRANGEMENTS

64. MEANS OF COMMUNICATION TO BE USED

64.1 Subject to the articles, anything sent or supplied by or to GMS under the articles may be sent or supplied in any way in which the Companies Act 2006 provides for documents or information which are authorised or required by any provision of that Act to be sent or supplied by or to GMS.

64.2 Subject to the articles, any notice or document to be sent or supplied to a GMS director in connection with the taking of decisions by GMS directors may also be sent or supplied by the means by which that GMS director has asked to be sent or supplied with such notices or documents for the time being.

64.3 A GMS director may agree with GMS that notices or documents sent to that GMS director in a particular way are to be deemed to have been received within a specified time of their being sent, and for the specified time to be less than 48 hours.

65. COMPANY SEALS

65.1 Any common seal may only be used by the authority of the GMS directors.

65.2 The GMS directors may decide by what means and in what form any common seal is to be used.

65.3 Unless otherwise decided by the GMS directors, if GMS has a common seal and it is affixed to a document, the document must also be signed by at least one authorised person in the presence of a witness who attests the signature.

65.4 For the purposes of this article, an authorised person is:

65.4.1 any GMS director of GMS;

65.4.2 GMS secretary (if any); or

65.4.3 any person authorised by the GMS directors for the purpose of signing documents to which the common seal is applied.

66. NO RIGHT TO INSPECT ACCOUNTS AND OTHER RECORDS

Except as provided by law or authorised by the GMS directors or an ordinary resolution of GMS, no person is entitled to inspect any of GMS's accounting or other records or documents merely by virtue of being a shareholder.

67. PROVISION FOR EMPLOYEES ON CESSATION OF BUSINESS

The GMS directors may decide to make provision for the benefit of persons employed or formerly employed by GMS or any of its subsidiaries (other than a GMS director or former GMS director or shadow GMS director) in connection with the cessation or transfer to any person of the whole or part of the undertaking of GMS or that subsidiary.

DIRECTORS' INDEMNITY AND INSURANCE

68. INDEMNITY

68.1 Subject to paragraph 68.2, but without prejudice to any indemnity to which a relevant officer is otherwise entitled, a relevant officer of GMS or an associated company may be indemnified out of GMS's assets against:

68.1.1 any liability incurred by that relevant officer in connection with any negligence, default, breach of duty or breach of trust in relation to GMS or an associated company;

68.1.2 any liability incurred by that relevant officer in connection with the activities of GMS or an associated company in its capacity as a trustee of an occupational pension scheme (as defined in section 235(6) of the Companies Act 2006); and

68.1.3 any other liability incurred by that relevant officer as an officer of GMS or an associated company,

including (in each case) any liability incurred by him in defending any civil or criminal proceedings, in which judgment is given in his favour or in which he is acquitted or the proceedings are otherwise disposed of without any finding or admission of any material breach of duty on his part or in connection with any application in which the court grants him, in his capacity as a relevant officer, relief from liability for negligence, default, breach of duty or breach of trust in relation to GMS's (or any associated company's) affairs.

68.2 This article does not authorise any indemnity which would be prohibited or rendered void by any provision of the Companies Acts or by any other provision of law.

68.3 In this article:

68.3.1 companies are associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate; and

68.3.2 a "relevant officer" means any GMS director or secretary or former GMS director or secretary of GMS or an associated company.

69. INSURANCE

69.1 The GMS directors may purchase and maintain insurance, at the expense of GMS, for the benefit of any relevant officer in respect of any relevant loss.

69.2 In this article:

69.2.1 a "relevant officer" means any GMS director or secretary or former GMS director or secretary of GMS or an associated company;

69.2.2 a "relevant loss" means any loss or liability which has been or may be incurred by a relevant GMS director in connection with that relevant GMS director's duties or powers in relation to GMS, any associated company or any pension fund or employees' share scheme of GMS or an associated company; and

69.2.3 companies are associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate.

MISCELLANEOUS

70. OPERATIONAL AGREEMENT

The GMS directors shall, to the fullest extent permissible under all applicable laws and regulations, exercise their powers in relation to GMS in compliance with, and in a manner which is consistent with, the terms of any operational agreement.

NHS
Gloucestershire
Managed Services

GLOUCESTERSHIRE HOSPITALS SUBSIDIARY COMPANY LIMITED
BOARD OF DIRECTORS
TERMS OF REFERENCE

Chair	Independent Non-Executive Director
Frequency of Meetings	10 x per annum
Quorum	Three members (including one executive and two independent non-executive directors)
Approval	July 2023
Review date	July 2024

Purpose of Board of Directors

The Board of Directors ("the Board") is established as the principal forum through which the directors of Gloucestershire Hospitals Subsidiary Company Limited (SubCo), trading as Gloucestershire Managed Services (GMS) will fulfil their responsibilities as defined in company law and in the governance arrangements agreed between GMS and its sole shareholder, Gloucestershire Hospitals NHS Foundation Trust (the Trust).

Responsibilities

The Board shall:

Governance and company law matters

- Provide advice, information and recommendations as required to the Trust's board of directors and the Finance and Resources Committee to enable them to fulfil their responsibilities as defined in their terms of reference and the Schedule.
- Approve any responsibilities and authority delegated to the Chair, Managing Director, directors, or managers of GMS.
- Establish committees of the Board where necessary and approve their responsibilities, authority, and membership.
- Approve risk management arrangements for GMS, consulting as necessary with the Finance and Resources Committee in respect of risks for the Trust.
- Approve any necessary governance policies for GMS.
- Ensure that GMS is compliant with all relevant legal and regulatory requirements and consult as necessary with the Finance and Resources Committee such that it may fulfil its responsibilities in this respect as defined in the Schedule of Matters Reserved agreed between GMS and the Trust (the Schedule).

Legal and regulatory compliance

- Approve the issuing, defence, or settlement of and litigation or other legal proceedings as defined in the Schedule.
- Monitor GMS's compliance with all relevant regulatory requirements and require that action is taken to address any non-compliance.
- Where necessary to ensure compliance with regulatory requirements, agree with the Finance and Resources Committee any action which must be taken jointly by the Trust and GMS.

Strategy, Planning and Control

- Through discussion with the Finance and Resources Committee develop any corporate strategy which the Trust requires for GMS and present it for assurance by the Finance and Resources Committee.
- Oversee the development of, and recommend for approval in accordance with the Schedule, the following:
    - The corporate and annual business plans, and strategies for GMS, and any amendments to them.
    - Proposals for any change to the nature of GMS's business which is not ancillary or incidental to the business; and

- Proposals for any of GMS' services to be sub-contracted to another provider.

- Monitor delivery of objectives in any strategy and the business plan to ensure that they are delivered as required.
- Monitor GMS's performance to ensure that it provides its services in accordance with its agreement(s) with the Trust, including by reference to relevant key performance indicators or other measures.

Risk management

- Ensure that GMS has in place appropriate risk management arrangements, including a risk register.
- Review regularly the risks which are relevant to GMS and the management of them by directors and senior managers.
- Where necessary to manage any joint risks, agree with the Finance and Resources Committee any action which must be taken jointly by the Trust and GMS.

Financial matters and internal control

- Consult with the Group Audit and Assurance Committee as necessary to enable it to approve the appointment or removal of the external and internal auditors for GMS.
- Consider and approve the statutory accounts and annual report for GMS.
- Monitor the systems of internal controls and risk management framework for GMS, including by considering reports from the internal auditor, or other source of external validation, and ensure agreed recommendations are delivered.
- Approve the acquisition or disposal of assets as defined in the Schedule.
- Approve any loan agreement with the Trust or another lender, including any mortgage or other charge, as defined in the Schedule.
- Oversee the development of a financial plan for GMS, ensuring that it is consistent with Trust's financial objectives, and recommend it for approval by the Finance and Resources Committee.
- Develop a budget for each financial year, ensuring that it is consistent with the strategy, annual business plan and any financial plan for GMS, and recommend it for approval by the Finance and Resources Committee.
- Monitor GMS's performance against any financial plan and the annual budget to ensure that they are delivered.
- Ensure that GMS has in place, and approve, appropriate insurance policies and associated arrangements.
- Ensure that GMS has in place, and approve, appropriate accounting policies and procedures. Approve the accounting reference date. Make recommendations to the Finance and Resources Committee to open or close any bank account.
- Approve proposals for GMS to enter into a contract or series of connected capital and revenue contracts for any material matter(s) as defined in the Schedule.
- Approve revenue transactions not within the approved business plan as defined in the Schedule.

Resourcing

- Approve the appointment of professional advisors or consultants required by GMS with fees or other costs in excess of the threshold defined in the Schedule.
- Approve or recommend for approval, as defined in the Schedule, staffing establishment and structure that could adversely affect services provided to a client or have significant impact on the staffing structure not within the approved plan for the year.
- Develop and recommend for approval by the Trust's board of directors any proposals for changes to the terms and conditions, including pension arrangements, of staff who transfer from the Trust.

- Approve the terms and conditions, including pension arrangements, for staff appointed by GMS (who do not transfer from the Trust).
- Approve any significant contractual employment issues (e.g., redundancy business cases and termination payments) or non- standard contractual arrangements.

Other matters

- Ensure that GMS has in place, and approve, appropriate policies.
- Ensure that GMS has in place, and approve, appropriate employment policies, and pay frameworks.
- Monitor and approve GMS's communication with, and accountability to, stakeholders
- Approve Terms of Reference for any Committee or Group reporting into this Board, including approval of any matters delegated to any Committee or Group.

GMS Board accountability arrangements

- Agree with the Finance and Resources Committee the arrangements through which the Board will give account to that committee, including the information which the Finance and Resources Committee requires in order to exercise its responsibilities as defined in these TOR.

Membership

The Board shall comprise:

- Four Independent Non-executive Directors (one of whom shall be the Chair and one the Vice-Chair)
- Three Executive Directors

The quorum for meetings will be three members with at least two Independent Non-Executive Director and one Executive Director.

The GMS Heads of Service shall normally attend Board meetings (as attendees) to contribute to discussions, but they shall not form part of the quorum or have any decision-making authority.

The Board may decide that any other person must attend one or all of its meetings to contribute to discussions, but no such person shall form part of the quorum and or have decision-making authority.

Accountability and reporting

After each of its meetings the Board shall report to the Finance and Resources Committee such issues as it considers should be brought to that committee's attention or require a decision, including on the matters in respect of which authority is reserved to the Finance and Resources Committee or the Trust's board of directors (as defined in the Schedule).

Reporting to this Board will be:

- GMS Remuneration Committee
- Any other GMS Committee or Group established by this Board

Conduct of business and administrative matters

The proceedings of the Board shall be in accordance with GMS's Articles of Association, these Terms of Reference and the Schedule of Matters Reserved and Delegated (the Schedule) agreed between GMS and the Trust. Where there is any inconsistency between these Terms of Reference and the Articles of Association, the Articles of Association shall prevail.

Review

These Terms of Reference will be reviewed at least annually. Any review of these Terms of Reference shall adopt the change control procedure defined in the Operational Agreement between the Trust and GMS.

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 11 February and 10th April 2025

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meetings are available.

Items rated RED

Item	Rationale for rating	Actions/Outcome
Health and Safety including Violence and Aggression	Committee received report from Health and Safety Committee at the February meeting highlighting the operational in focus with plans to enhance to a more strategic level. At the April committee, it was confirmed that broader Health and Safety would no longer be reviewed by the P&OD committee. The February meeting highlighted the governance review conducted, leading to the development of a health and safety framework that included the following key areas of focus: • Leadership visibility regarding health and safety, including the role of board members in site visits and decision-making. • Clarity on accountabilities and consistent definitions in health and safety policies, addressing inconsistencies in legislation. • Oversight of health and safety reporting, including both preventative measures and incident reporting. • Periodic audits of health and safety structures and controls beyond just fire and water safety, to encompass a wider range of health and safety concerns. • Workforce health and safety data, focusing on cultural aspects and worker involvement in assessing their working conditions, such as the quality of breakout areas and sanitation facilities. Importance of developing group-wide health and safety policies and ensuring that the Health and Safety Committee functioned as a group health and safety committee was key. Legal responsibility of directors for health and safety within the Trust was noted. Committee noted the report	Outcome: From 1st April 2025, the Health & Safety Committee will report directly to the TLT through a biannual report. This will include an Annual Health & Safety Report, which will first be reviewed and recommended by the Audit & Assurance Committee before being submitted to the Board of Directors. Action: HR and the Health & Safety Team to propose a suite of reporting metrics to PODC, aligned with Health & Safety at Work Regulations and related wellbeing obligations.

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

	Annual report on health and safety to be provided to the Board. Planned Board training session in 2025 led by legal experts to include input from wholly owned subsidiaries with overall aim to improve health and safety management and evidence progress since the Pseudomonas incident. Report setting out structure for health and safety moving away from direct reporting to the People and Organisational Development committee and into new arrangements with the Trust Leadership Team will be replaced by specific metrics, yet to be defined.	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Recruitment and Attraction	Key activities: - Progress was noted in time-to-hire, now included in the national workforce monthly return. Recruitment and retention risks both score 16, approved by corporate board. These risks where link to the work sustainability programme; currently under review. Despite some progress, risk score remains at 16 due to challenges in specialist recruitment. Progress noted in reducing temporary staffing and time to hire, however these remain a priority. The committee noted the progress made with the workforce sustainability programme and in particular the focus on key priorities for 25/26, Refining of workstream to achieve efficiency gains, financial savings and enhance customers experiences. (February KIAR) Other areas of work included streamlining processes through greater use of AI and automation. Other impacts such as dealing with estates issues took up valuable clinical time away from patient care and this needed to be addressed as part of the wider strategy.	Action: Continued focus on internal reporting systems to ensure consistent and accurate data Outcomes: Reduces vacancies in Midwifery thanks to creative and sensitive approach. Action: explore providers collaboration to address recruitment gaps. Incorporate lessons learnt from national benchmarking efforts. Action: clarifying reporting mechanism. Further refining workstream – continued focus on delivering measurable benefits.

		Importance of assessing both qualitative and quantitative impacts, especially considering new workforce targets to understand the impact on both staff and patients.
EDI Recruitment Plan	Committee noted the percentage of workers from Black and ethnic minority in the Trust is significantly higher than that of the Gloucestershire population however requires improved representations in senior roles (bands 8B, 8D and VSM). Ethnicity Pay gap analysis outcome also favour black and ethnic minorities; however, it was noted that figures were inflated due to the disproportionate number of consultants from Ethnic Minority backgrounds.	Actions: provide a clear narrative that contextualise data. Enhance data collection and evaluation. Improve accuracy of demographic data.
Gender Pay Gap	22% of workers are male, against 78% Female. There is an average pay gap of £6 per hour in favour of male employees. This gap drops significantly when excluding medical and dental staff (0.62%). The bonus gap between male and female consultant is equally marked – 35.9% pay gap. The ethnicity pay gap is 12%, however this includes consultants. The board noted the need to have a breakdown excluding consultants and medical staff in a similar way to gender pay gap analysis.	Actions: Include narrative on the ethnicity pay gap in future reports. Exclude medical and dental staff from pay gap comparisons for accuracy. Ensure reports are presented in a timely manner to inform relevant decisions.

	The board noted that pay gap is traditionally reviewed at the nomination and remuneration committee.	
Culture, experience, and retention	The staff experience improvement programme has been updated with focus on initiatives shaped by the Staff Survey. Committee noted launch of new campaign led by the engagement team as an integral part of the 'Report, Support, and Learn' initiative. The campaign focuses on behaviour standards, staff support and allyship. People Promise Programme extension to 18 months aims to sustain its impact and embedding outcomes. New starter packs, to be implemented with support from the charity. Below are from February KIAR: Apprenticeship pay review now amber due to a delay in this being taken forward across the System. Discussions however are underway. The need for a review to keep apprenticeship roles attractive acknowledged and clearer links with ICS in relation to future planning and development. Importance of terminology used in anti-racism efforts was key and an important part of upcoming board development and part of a broader conversation on inclusion and organisational practices. Creation of a language guide in consultation with the Ethnic Minority Network was planned.	Future workstreams, shaped by ongoing evaluations will be outlined at the next P&OD committee.
People Performance Dashboard (February KIAR)	Ongoing work to improve the appraisal process and safeguarding compliance continued with a shift from moving away from a once-a-year conversation to a more continuous dialogue between staff and managers. Aim is to ensure that there were no surprises during annual appraisal, ongoing discussions contributing to the final conversation, ensure appraisals reflected	Report was noted

	all conversations throughout year and allowed both staff and line manager to track progress and address any issues promptly. This was supported by the Committee. Improvements in safeguarding compliance noted.	
Annual Staff Survey Results **(Mostly February KIAR).**	Staff experience metrics showed improvements across various areas along with those that required further attention. Significant improvement is evident across the results, and of the 58 Trusts that use Picker as their survey provider, the Trust is the 5th most improved. However, the Trust is still below the national average against almost all metrics (Picker Average). Committee noted results in teamwork and leadership had improved; the gap to the national average had narrowed significantly, however, improvements were slower than anticipated, particularly given the level of investment in the teamwork aspect. National quarterly Pulse survey results showed moderate progress but improvements not as significant as hoped. More focus needed to boost leadership scores within certain divisions of the organisation. Committee noted that while some areas had seen improvements, there was still much work to be done, particularly in reward and recognition. The April committee focused on the data from slide 18 relating to race equality and disability equality. The committee noted that the improvement there were not as strong and some metrics are static. These have been used to info the EDI action plan.	Action: Explore and analyse intersectional data to identify overlapping risks and challenges within the organisation
FTSU Annual report	There has been a marked improvement in staff engagement with Freedom to Speak Up with 230 cases handled—though this is fewer than anticipated.	

	Concerns raised include an increase in issues related to managerial behaviours and a near doubling of patient safety concerns. Detriment remains an area for improvement, with inconsistencies noted in how it is reported.	Actions: Improve data capture for detriment cases. Prioritise deeper investigations into issues like detriment, patient safety and discrimination.
Health and wellbeing **Annual Report**	41% of staff reported experiencing stress, 35% reported below-average mental health, one-third reported musculoskeletal issues, and 54% reported experiencing presenteeism. The Committee noted the range of initiatives underway to raise awareness of available support and the plans to work with the Inclusion Network to improve access and enhance manager training to provide better support. The Committee also noted inconsistencies between survey data and Datix reporting and recognised the need to address these discrepancies to ensure more accurate data and more effective support for staff.	Action: Provide regular update on workforce initiatives. Investigate discrepancies in stress / MSK data. Hold follow up meetings to review findings and determine actions.
Audit Update **(February KIAR)**	Payroll Additions more comprehensive than originally planned and required deeper analysis leading to review of policies that required additional attention. Workforce Controls Audit - currently live as a requirement from NHS England examining the Trust's organisational workforce controls to strengthen financial performance and ensure the effectiveness and robustness of those controls. Vacancy controls is a key focus of the audit, and Committee noted need for more rigorous checks to ensure vacancies were genuinely necessary and alternative methods of filling roles considered. Medical Recruitment Audit - focused on pre-employment checks for new medical staff underway. Organisational Readiness Audit - assessed whether trust was set up for success, ensuring necessary structures, frameworks, governance, and processes were in place to deliver revised strategy. Committee	

	assured trust was on track with the findings from this audit. Freedom to Speak Up Audit - identified areas of improvement. Committee noted progress was on track. Assurance given that live audits, working through recommendations, and regularly reporting to the Audit and Assurance Committee was on track.	

Items not Rated

Risk Register

- One emerging risk going through governance process and to come to next committee – related to recruitment
- No closed risks to report.

Report to Board of Directors			
Date	8 May 2025		
Title	Gender Pay Gap Report		
Author / Sponsoring Director/ Presenter	Coral Boston, Equality, Diversity and Inclusion Lead		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	
Regulatory requirement	✓	To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Introduction: This report presents the Gender Pay Gap (GPG) analysis of men and women for Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), in compliance with national reporting requirements. The data used for this report is based on information extracted from March 2024. It is important to note that Gloucestershire Managed Services (GMS) are excluded from this analysis, as they are required to collate, write and submit their own data and report.

For the purpose of this report, the term "Ethnic Minority" will be used to refer to our Black and Asian staff. This terminology has been chosen for consistency within the report; however, we acknowledge the evolving discussions around language and inclusivity

Overview of Findings: The report examines the GPG for all staff at GHNHSFT, both including and excluding Medical and Dental staff on the date 31st March 2024.

The key findings are:

- When Medical and Dental staff, along with their Local Clinical Excellence Awards (LCEA), are excluded from the analysis, the GPG disappears.
- For non-medical staff, the Mean Pay Gap is 0.62% in favour of men, while the Median Pay Gap is -5.3%, indicating that pay equity exists for most staff. The significant pay gap seen overall is primarily influenced by the medical workforce.

Factors Contributing to the Pay Gap:

The Trust's annual LCEA scheme, which rewarded consultants for outstanding care, ended in 2020. Funds were then equally shared among all substantive consultants, regardless of hours worked. Local CEAs were formally abolished under the new consultant contract. A small number of consultants still receive national CEAs, which continue to impact the gender pay gap.

There is no significant Gender Pay Gap among non-medical staff, who represent approximately 81.6% of the Trust's workforce.

Bonus Payments: 399 bonus payments were made to Medical and Dental staff: 64% awarded to men and 36% awarded to women.

- Mean Bonus Pay Gap: Male Consultants earned an average bonus of £8,802.24, compared to £5,644.48 for women – a 35.90% pay gap.
- Median Bonus Pay Gap: No gap using the median calculation.

Recommendations and Actions: The report outlines several recommendations and actions aimed at reducing the Trust's GPG. These measures will focus on ensuring equitable career progression opportunities, supporting female staff in senior roles, and reviewing pay structures where feasible.

This report demonstrates the Trusts commitment to promoting Gender Pay equity and addressing any disparities within the workforce.

From April 2023 to March 2024, GHNHSFT employed 9,192 staff, with 78.1% Women and 21.9% men, reflecting a 1.2% increase for men and 1.2% decrease for women.

The measured position on the GPG for GHNHSFT at 31 March 2024 is as follows:

- The average Mean Gender Pay Gap for men is £6.05 or 23.3% higher, reflecting a 2.4% decrease from 25.7% in 2024.

- The Median Gender Pay Gap for men is £3.75 or 17.2% higher reflecting a 1.9% decrease from 19.1% in 2024.

Trust's Gender Pay Gap summary:

- The Trust's Mean Gender Pay Gap **is** 23.3%
- The Trust's Median Gender Pay Gap is 17.2%
- The Trust's mean Bonus Gender Pay Gap is 35.9%
- The Trust's median Bonus Gender Pay Gap is 0.00%
- The proportion of men receiving a Bonus payment is 64%
- The proportion of women receiving a Bonus payment is 36%

Ethnicity Pay Gap:

Ethnicity Pay Gap is not yet a legal requirement. In 2023, guidance was introduced for voluntary Ethnicity Pay Gap (EPG) reporting. While the Trust is not yet required to publish ethnicity pay data, we have included an Ethnicity Pay Gap Report.

The Mean pay gap between EM and White staff shows that EM staff earn an average hourly rate of £22.17, while White staff earn £21.49. This results in a difference of £0.68, representing a gap of 3.2%.

The Median pay gap reveals that EM staff earn £19.48 per hour, compared to £18.50 for White staff. The difference is £0.98, equating to a gap of 5.25%.

- The Mean average for NULL is £18.85 and Median of £16.11.
- The Mean average for Not Stated is £20.76 and Median £18.98.
- The Mean average for Other is £24.32 and Median £21.80

EM staff currently appear to earn slightly more than white staff, which may be influenced by a few factors. EM staff are often in their pay bands longer, allowing them to reach higher incremental points, and they are more likely to work unsocial hours—such as nights, weekends, or bank shifts—that come with additional pay. Meanwhile, white staff may be promoted more often to higher bands, though they may start at lower incremental points. These patterns may help explain the current pay differences.

Ethnicity Bonus Payments:

Average LCEA Bonus Gender Pay Gap as a mean and median average Consultants

399 bonus payments were made to Medical and Dental staff: in 2024. There are 295 (74%) white Consultants, compared to 89 (23%) EM Consultants and 14 (4%) of those not stated their ethnicity.

Risks or Concerns

N/A

Financial Implications

N/A

Approved by: Director of Finance / Director of Operational Finance	**Date:**

Recommendation

The **GPG** was presented to the Equality, Diversity, and Inclusion Steering Group and subsequently circulated to the People & Organisational Delivery Group for review. It has also been reviewed and discussed by People and OD Committee. Feedback primarily received what is covered in the NULL category of the EPG. LCEA and the impact of the pay gap if consultant grades were excluded.

The Committee are asked to note the contents of the report as a source of information and assurance. In line with reporting requirements, this report will also be made available via the Trust intranet and Internet following approval from the Board.

Enclosures

Gender Pay Gap Report.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Gender Pay Gap Report

2025

the **Best Care for Everyone**
care / listen / excel

Gloucestershire Hospitals Gender Pay Gap 2024

Introduction

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require public sector organisations with over 250 employees to report and publish their Gender Pay Gap (GPG) annually.

In 2023, guidance was introduced for voluntary Ethnicity Pay Gap (EPG) reporting. While the Trust is not yet required to publish ethnicity pay data, we have included an Ethnicity Pay Gap analysis at the end of this report. Both reports will be published on the Trust website.

We take pride in creating a workplace where staff and patients feel we provide equal opportunities and actively challenge discrimination. However, we recognise that there is still progress to be made. Addressing the GPG remains a priority, and we are committed to advancing equality, diversity, and inclusion across our workforce.

To continue improving the GPG, we will work to implement the recommendations outlined at the end of this report and remain dedicated to meaningful change.

At the time of compiling this report the Trust employed 9192 employees in a number of Staff Groups, including: bank staff, administrative; nursing; allied health; and medical roles. All staff except for medical and Very Senior Managers (VSMs) are on Agenda for Change pay-scales, which provide a clear process of paying employees equally, irrespective of their gender or ethnicity.

What is the Gender Pay Gap

The GPG measures the difference between the average (Mean or Median) earnings of men and women, expressed as a percentage of men's earnings. For example, a 20% gap means that, on average, women earn 20% less than men.

When used effectively, GPG reporting serves as a valuable tool for evaluating workplace equality, assessing Women and Men's participation, and understanding how well talent is being utilised

What is the difference between the Gender Pay Gap and Equal Pay?

The GPG is different from equal pay. Equal pay refers to the legal requirement to pay men and women the same for doing the same job, similar jobs, or work of equal value. It is unlawful to pay someone differently based on their gender.

In contrast, the GPG measures the average pay difference between all men and women across an organisation. A significant GPG may indicate underlying issues that need to be addressed, and detailed calculations can help identify specific areas for improvement. While the GPG may sometimes reflect unlawful pay inequality, this is not always the case.

Managing Gender Pay Gap Reporting

Gender Pay Gap (GPG) Reporting Reminder – Public Sector

In line with the legal requirements under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, all public sector employers must submit their Gender Pay Gap (GPG) data using a **snapshot date of 31 March 2024** for the 2024 reporting year.

The deadline to submit this data is **March 2025**.

Please note:

- The data you must report reflects your workforce as it stood on **31 March 2024**.
- You are legally required to submit this data via the GOV.UK Gender Pay Gap reporting service by **30 March 2025**.

Employers must follow the rules in the regulations to calculate the following information:

- The Trust's Mean Gender Pay Gap
- The Trust's Median Gender Pay Gap
- The Trust's Mean Bonus Gender Pay Gap
- The Trust's Median bonus Gender Pay Gap
- The proportion of Men receiving a Bonus payment
- The proportion of Women receiving a Bonus payment

Who Is included?

This report includes all relevant staff employed by the Trust on 31st March 2024, in line with GPG reporting requirements. This includes bank staff.

Pay data is based is sourced from the national Electronic Staff Record (ESR). As of this date, GHNHSFT data shows a 1.2% decrease in the proportion of women (previously 79.3% in 2023), with a corresponding increase in the proportion of men. This report fully complies with the Equality Act 2010 regulations, including the GPG Information Regulations 2017.

This data does not include Gloucestershire Managed Service (GMS). GMS Collate and submit their own GPG data and report

What Pay Elements are included?

The statutory calculations have been carried out using the standard national Electronic Staff Record (ESR)

In accordance with NHS Employers guidance, Clinical Excellence Awards and the methodology for awarding them have been classified as bonuses.

Pay includes basic salary, fully paid leave (such as annual leave, sick leave, maternity, paternity, adoption, or parental leave), Bonus pay and shift Pay. Most staff except medical staff, and very senior Managers were on the Agenda for Change pay scales.

Executive Summary

This is Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) GPG Report, based on a workforce snapshot as of 31 March 2024. At that time, GHNHSFT employed 9192 staff, with a workforce composition of approximately 78.1% women and 21.9% men.

Key findings from March 2024 are as follows:

- **The average Mean Gender Pay Gap for men is £6.05 or 23.3%, reflecting a 2.4% decrease from 25.7% in 2024.**

- **The Median Gender Pay Gap for men is £3.75 or 17.2% reflecting a 1.9% decrease from 19.1% in 2024.**

When excluding the medical and Dental staff, the mean GPG reduces to 0.62% (£0.11) in favour of men, meaning that, on average, men earn 0.62% more than women, equating to a small difference of 11p earned. This suggests near parity in average earnings.

The median GPG becomes 5.3% in favour of women, meaning that the middle-earning woman earns 5.3% more than men. Showing the data is mainly driven by the medical and dental awards. Therefore, excluding Medical, Dental staff and Clinical Excellence Awards (CEAs), the pay gap shifts significantly.

- **The Mean Gender Pay Gap reduces to 0.62% (£0.11) in favour of men.**
- **The Median Gender Pay Gap becomes 5.3%, (£0.87) in favour of women.**

Nationally, the GPG has been gradually decreasing, falling by about a quarter over the past decade among full-time employees, reaching 7.7% in April 2023.

The GPG has been declining slowly over time; over the last decade it has fallen by approximately a quarter among full-time employees, and in April 2023 it stands at 7.7%

Key Findings Include:

Trust's Gender Pay Gap summary:

- The Trust's Mean Gender Pay Gap is 23.3%
- The Trust's Median Gender Pay Gap is 17.2%
- The Trust's Mean Bonus Gender Pay Gap is 35.9%
- The Trust's Median bonus Gender Pay Gap is 0.00%
- The proportion of Men receiving a Bonus payment is 64%
- The proportion of Women receiving a Bonus payment is 36%

The proportion of men and women for all staff in each quartile (Quartile 1 represents our lowest paid staff and Quartile 4 represents our highest paid staff).

- Quartile 1: 82.67% (1899 Headcount) Women and 17.33% (398Headcount) Men
- Quartile 2: 82.81% (1903 Headcount) Women and 17.19% (395 Headcount) Men
- Quartile 3: 82.33% (1892Headcount) Women and 41.47% (406.00 Headcount) Men
- Quartile 4: 64.72% (1488.00 Headcount) Women and 35.28% (811.00 Headcount) Men

Workforce Overview

Pay data is based on the period including the snapshot date of 31 March 2024, sourced from the national Electronic Staff Record (ESR). As of this date, GHNHSFT data shows a 1.2% decrease in the proportion of women (previously 79.3% in 2023), with a corresponding increase in the proportion of men. The report complies fully with the Equality Act 2010 **r**egulations, including the GPG Information Regulations 2017.

For this report the numbers have all been rounded to 1 decimal place. This may mean that the accumulative figures add up slightly more of less than 100.

Workforce Data	2024 Headcount	2024%	2023 Headcount	2023%	% Difference
Total Workforce	9192		8830		Increase of 4.1% compared to the 2023 data.
Men	2010	21.9%	1831	20.7%	Increase of 1.2% compared to 2023
Women	7182	78.1%	6999	79.3%	Decrease of 1.2% compared to the 2023 data.

The total workforce increased by 4.1% from 2023 to 2024, growing from 8,830 to 9,192 employees. Men rose by 1.2%, from 20.7% to 21.9% of the total workforce, while the number of women employees grew slightly in absolute terms, from 6,999 to 7,182. However, due to the overall workforce increase, the percentage of women decreased by 1.2%, from 79.3% to 78.1%.

Gender Pay Gap – All Staff

Difference in Pay	Gender Pay Gap	Compared to 2023

Mean hourly pay for men **£6.05** higher than Women	Gender Pay Gap of 23.3%	Decrease of 2.4% *(25.7% in 2023)*
Median hourly pay for men **£3.75** higher than Women	Gender Pay Gap of 17.2%	Decrease of 1.9% *(19.1% in 2023)*

- Mean (Average) Gender Pay Gap: Men earn an average of £26.00 per hour, while women earn £19.94 per hour—a difference of £6.05 or 23.3%. This represents a 2.4% improvement from 2023.
- Median Gender Pay Gap: Men earn £3.75 more per hour than women, resulting in a median pay gap of 17.2%. This reflects a 1.9% improvement from 2023.

Gender Pay Gap – Excluding Medical and Dental Staff

Difference in Pay	Gender Pay Gap	Compared to 2023
Mean hourly pay for men **£0.11** higher than women	Gender Pay Gap of 0.62%	Decrease of 1.3% (1.90% in 2023)
Median hourly pay for men -**£0.87** higher than women	Gender Pay Gap of -5.3%	Decrease of 0.5% *(-4.85% in 2023)*

When medical and dental staff are excluded:

- Mean (Average) Gender Pay Gap: Men earn an average of £18.30 per hour, while women earn £18.19 per hour—a difference of £0.11 or 0.62%. This marks a 1.3% improvement from 2023.
- Median Gender Pay Gap: Women earn more on average, with men earning £16.30 per hour and women earning £17.17 per hour, resulting in a gender pay gap of -5.3% in favour of women.

Medical Staff Only

Difference in Pay	Gender Pay Gap	Compared to 2023
Mean hourly pay for men **£40.34** higher than women	Gender Pay Gap of 17.3%	Decrease of 0.7% (18.0% in 2023)
Median hourly pay for men **£31.47** higher than women	Gender Pay Gap of 2.6%	Decrease of 4.2% *(6.8% in 2023)*

When this group is analysed in isolation:

- Mean Gender Pay Gap for Medical Staff:
- Median Gender Pay Gap: Men earn £31.47 per hour, whereas women earn £30.65 per hour—a gap of £0.82 or 2.6%.

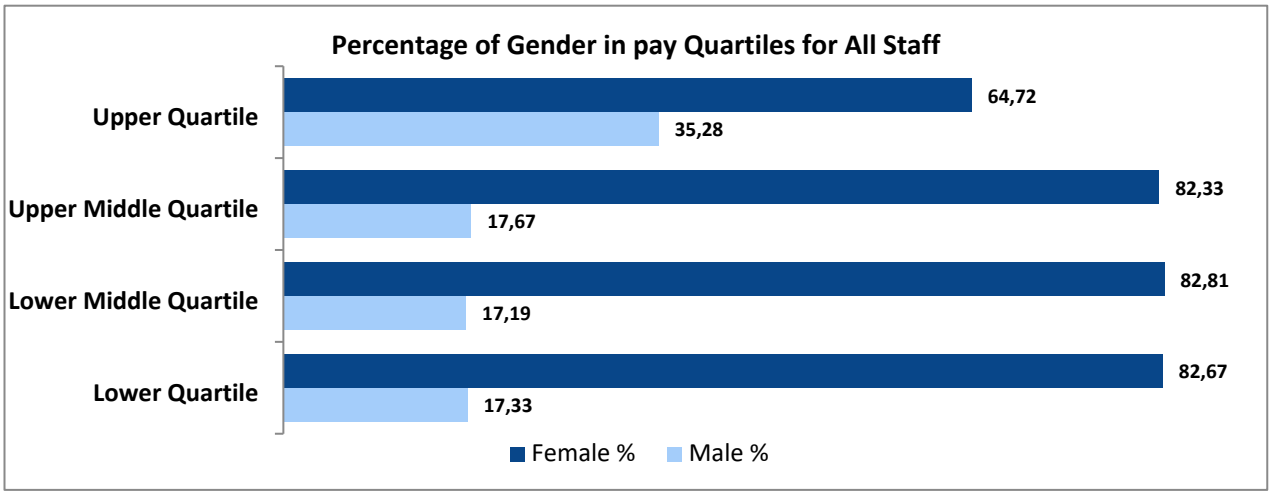
Pay Quartiles

We are required to split the workforce into quartiles (blocks of 25%) split by pay and show proportions of men and women.

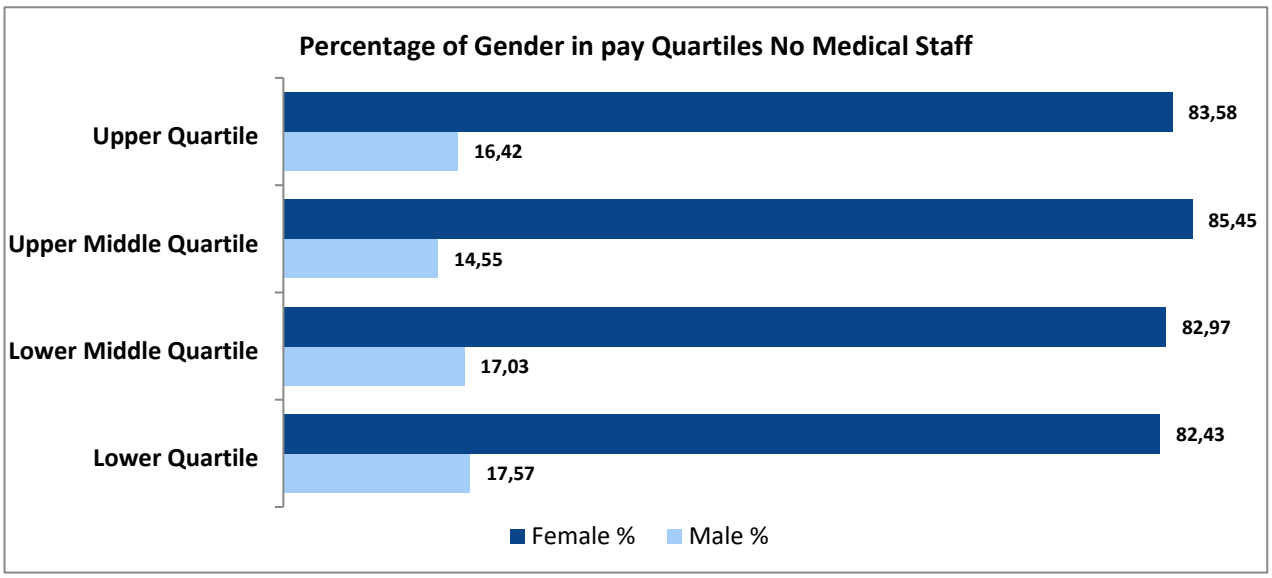
The chart below shows the percentage distribution of men and women across pay quartiles. Women dominate the lower, lower middle, and upper middle quartiles, making up over 82% in each, while men account for around 17% in these categories.

However, in the upper quartile, women representation drops to 64.72%, with men occupying 35.28% of the highest-paid roles. This indicates that men are more concentrated in senior, higher-paying positions, while women are more evenly distributed across lower-paid roles.

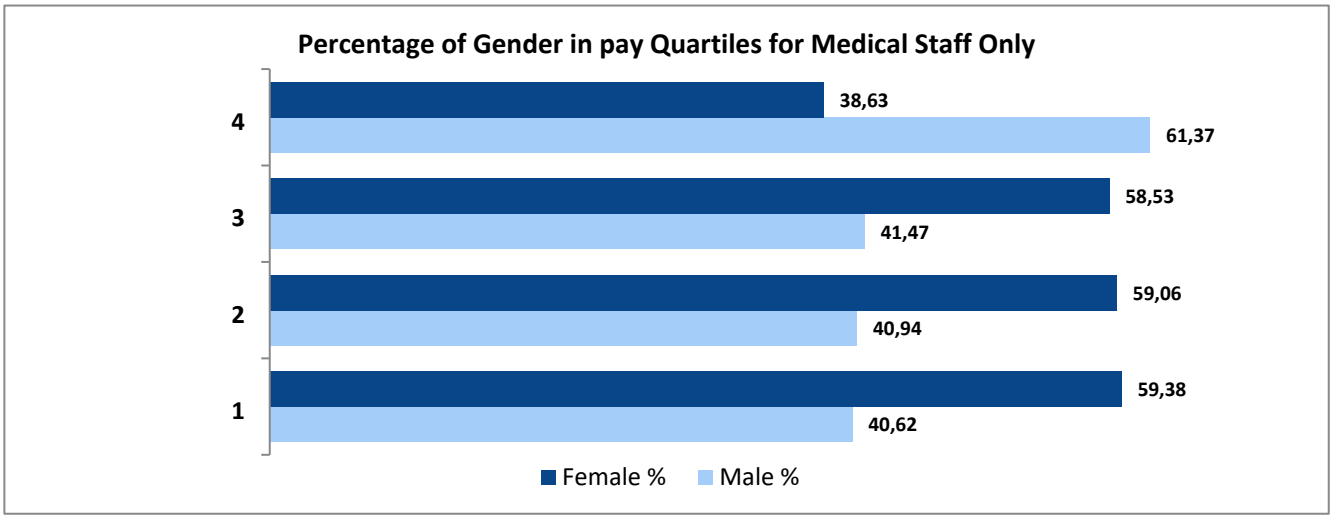
Across all pay quartiles (from lower to upper), women represent a significantly larger proportion compared to men, consistently making up around 82% to 85 of the workforce in each quartile. This suggests that non-medical roles within this organisation are heavily dominated by women, regardless of pay level.



Percentage of Gender in pay quartiles no medical Staff



Medical Staff Only



Across all pay quartiles (from lower to upper), women make up the majority, consistently comprising around **59%** of the workforce in the lower to middle pay levels. However, in the top quartile (highest pay levels), men become the majority, representing 61% of the workforce**.** This indicates that while women dominate the lower and middle pay levels, men are more prevalent in higher pay levels

Bonus Payments

The Trust operated an annual Local Clinical Excellence Award (LCEA) round for eligible consultants. This recognises and rewards individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS. However, this was stopped in 2020 and the budget for CEAs was split equally between substantive consultants. Of note, this was not done pro rata – less than fulltime staff received the same amount as full time staff. Local CEAs were abolished as part of the pay negotiations resulting in a new consultant contract last year. There are fewer than 10 consultants in the Trust who receive a national CEA but these awards are very large and still significantly contribute to the gender pay gap.

In 2024, 399 bonus payments were made to Medical and Dental staff: 64% awarded to men and 36% awarded to women.

- Mean Bonus Pay Gap: Male Consultants earned an average bonus of £8,802.24, compared to £5,644.48 for women – a 35.90% pay gap.
- Median Bonus Pay Gap: No gap using the median calculation.

The tables below detail bonus pay as (LCEA), as with the median hourly rate of pay, this is based on the mid-point of all staff receiving bonus pay.

	Role	Men	Women	Total	% Men	% Women
2024	Consultant	**255**	144	399	63.9%	36.1%
2023	Consultant	131	63	194	67.5%	32.5%
2022	Consultant	125	59	184	67.7%	32.5%

The Trust is committed to reducing the GPG We have outlined key initiatives and will continue to explore further opportunities through local, regional, and national programmes. Whilst we have seen gradual progress, we recognise that addressing the gap will take time.

Women often face additional challenges, such as unpaid caregiving responsibilities, which can result in career breaks, part-time work, and occupational segregation, where men dominate certain roles that are valued differently. Despite these challenges, we remain dedicated to driving change and making continued progress toward gender equality.

Conclusion

In 2024, the Trust's GPG stands at 23.3%, showing a decrease from the previous year's figure of 25.7%. While this reduction is a positive development, it is important to note that the gender pay gap does not equate to unequal pay for equal work. Unequal pay, which involves paying individuals differently for doing the same job based on their gender, would be unlawful. Instead, the gender pay gap arises due to the fact that men are more commonly found in higher-paid roles within the Trust, while women tend to occupy lower-paid positions.

The demographic composition of the Trust reflects broader trends seen across the NHS, with women making up 78.1% of the workforce and men comprising 21.9%. While this gender distribution is relatively in line with national NHS figures, it highlights a significant disparity in the representation of men and women across various job grades. Specifically, there are proportionately more women in lower pay bands and, conversely, more men in higher pay bands. This imbalance contributes to the overall gender pay gap, as men, on average, hold roles that command higher salaries, while women are overrepresented in lower-paying roles.

Efforts to address this GPG must focus not only on closing the disparity in the representation of men and women across different job bands but also on supporting women's advancement into higher-paid roles. This includes ensuring equal access to development opportunities, mentorship, and leadership positions that enable women to progress in their careers.

Recommendations and Actions

1.	**Develop targeted actions:** Integrate findings into the Equality, Diversity, and Inclusion (EDI) priorities for 2023–24. And the coming years
2.	**Track progress:** Monitor initiatives through the EDI Steering Group, reporting to the People and Organisational Development Committee.
3.	**Engage staff**: Collaborate with female staff to address barriers to progression and identify opportunities for development.
4.	**Equality Impact Assessment** Use Equality Impact Assessments to monitor and review recruitment and promotion policies and processes to ensure any barriers to recruitment or promotion are identified and removed
5.	**Women's Network;** The Women's Network will officially launch in March 2025, with an executive sponsor and two co-chairs already appointed. This initiative aims to create a supportive community that empowers women within the organisation, encourages networking opportunities, and promotes professional growth. The network will provide a platform for women to connect, share insights, and collaborate on initiatives that drive EDI across all levels of the organisation.
6.	**Sexual Safety Charter:** The Trust is dedicated to tackling sexism and sexual harassment in the workplace by identifying and challenging inappropriate behaviours. A Sexual Behaviour Policy is currently being developed.

7.	**Explore male-focused initiatives:** We will revisit the feasibility of establishing a men's health network. While there has been limited interest in starting a dedicated network so far, we will continue to raise awareness of the importance of having conversations around men's mental health and health.

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Ethnicity Pay Gap Report

2025

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Gloucestershire Hospitals Ethnicity Minority Pay Gap 2024

Data reported as at 31 March 2024, unless otherwise indicated.

Summary

The Ethnicity Pay Gap ((EPG)) is based on a snapshot of all GHFT Ethnic Minority (EM) employees on the 30 March 2024. On that date, GHFT employed 9,192. As the 31st March, GHFT employed 22% of EM staff and 67% of White Staff. Please note 11% ethnicity is unknown.

For the purpose of this report, the term "Ethnic Minority" will be used to refer to our Black and Asian staff. This terminology has been chosen for consistency within the report; however, we acknowledge the evolving discussions around language and inclusivity.

Gloucestershire Demographics (Census 2021)

- 6.9% of the population of Gloucestershire is ethnically diverse.
- 15.1% of the population of Gloucester is ethnically diverse.
- 8.6% of the population of Cheltenham is ethnically diverse

Introduction

Unlike the Gender Pay Gap, there is no legal requirement in the UK to conduct an ethnicity pay gap (EPG) report. The Government did however, publish the first report in 2017 to examine the barriers EM face in employment in its 'Race in the Workplace report.

The Trust sees this as an opportunity to build stronger relationships with our workforce and beyond through openness and transparency, as well as demonstrating our commitment to consistently improve.

Reporting our EPG aims to support analysis and use of the resulting information to produce effective action plans. These will be used to address any gaps in pay within the ethnic group's EPG

What is the Ethnicity Pay Gap

The ethnicity pay gap is different to equal pay. Ethnic pay disparities are not primarily about those from a white background and other ethnic groups being paid differently for the same job. The Equality Act 2010 make it unlawful to discriminate (both directly and indirectly) against employees because of their race. Analysing the EPG will help the Trust to better understand the extent of the pay gap amongst staff to raise awareness and focus on actions to close the gap and monitor improvement.

As of March 2024, 22% of staff at GHNHSFT identified as being from an EM background, 66.84% of the workforce is White, and 11% had their ethnicity recorded as unknown

The table below shows the average and median hourly rates for different ethnic origins groups as follows.

Please note: **NULL** - indicates no data was entered.
Not Stated - indicates that the person chose not to disclose the information.

Ethnic Origin Grouping Summary	Avg. Hourly Rate	Median Hourly Rate
EM	£22.18	£19.48
NULL	£18.85	£16.11
Not Stated	£20.76	£18.98
Other	£24.32	£21.80
White	£21.49	£18.50

The mean pay gap between EM and White staff shows that EM employees earn an average hourly rate of £22.17, while White staff earn £21.49. This results in a difference of £0.68, representing a gap of 3.2%.

The median pay gap reveals that EM staff earn £19.48 per hour, compared to £18.50 for White staff. The difference is £0.98, equating to a gap of 5.25%.

- The mean average for NULL is £18.85 and median of £16.11.

- The mean average for Not Stated is £20.76 and median £18.98.
- The mean average for Other is £24.32 and median £21.80

Staff who did not declare or have an unspecified ethnicity tend to have higher earnings, while White staff earn the least on average.

Pay Quartiles

This data shows the distribution of individuals in different ethnic groups across four pay quartiles (1 to 4). These quartiles represent salary bands, with Quartile 1 being the lowest and Quartile 4 being the highest. The numbers show how many individuals from each ethnic group are in each quartile.

Quartile	Asian	Black	Mixed	NULL	Not Stated	Other	White British	White Other
1	196	81	44	98	122	28	1,649	104
2	372	113	41	167	202	36	1,266	126
3	385	125	32	58	213	48	1,356	106
4	313	102	58	61	139	47	1,457	146

Quartile 1 - White British individuals make up a large portion of the lowest-paid employees (1,649 individuals). However, there are also a notable number of individuals who have not stated their ethnicity (122), as well as a significant number of Asian employees (196).

Quartile 2 - White British staff are still the largest group, but the number has decreased (1,266). The number of Asian employees increases here (372), and there are also more Black staff (113) compared to Quartile 1.

Quartile 3 - White British employees still make up the largest group, but the number is slightly less than in the previous quartiles (1,356). Asian (385) and Black (125) staff make up a substantial part of this quartile as well.

Quartile 4 - White British staff are still the largest group (1,457). There are fewer Asian (313) and Black (102) staff in the highest salary range compared to the lower quartiles

White British staff are the largest ethnic group across all pay quartiles, with Asian individuals following. Black and Mixed groups have smaller representation, peaking in **Quartile 2**. A

significant number of staff haven't stated their ethnicity, particularly in **Quartiles 2 and 3.** There are fewer people in the "Other" category, with their numbers remaining consistent across the quartiles.

Ethnicity Local Clinical Excellence Awards Bonus Payments 2024

Average LCEA Bonus Gender Pay Gap as a mean and median average Consultants

399 bonus payments were made to medical and dental staff: in 2024. There are **295 (74%)** white consultants, compared to **89 (23%)** EM Consultants and **14 (4%)** of those not stated their ethnicity.

Year	Role	Total	White	EM	% White	% EM
2025	**Consultant**	**399**	**295**	**89**	**74%**	**23%**

Conclusion

The Gloucestershire Hospitals NHS Foundation Trust EPG pay gap **at March 2024** is reported at:

- **Mean Ethnicity Pay Gap, 3.2% in favour of EM Staff**
- **Median Ethnicity Pay Gap, 5.3% in favour of EM Staff**

These figures reflect the **combined** Ethnicity Pay Gap of all staff.

Based on the current data, EM staff are paid slightly more than white staff. There could be several reasons for this. EM staff may remain longer within a pay band, progressing through the band's incremental points. EM staff are more likely to undertake more unsocial shifts, such as Bank, lates, nights or weekends.

In contrast, white staff are more likely to be promoted to higher bands, although they may start at lower incremental points. Additionally, EM staff are more likely to work unsocial hours—such as late shifts, nights, weekends, or Bank work—which typically attract higher rates of pay. These combined factors may contribute to the higher average pay observed for EM staff at this particular point in time.

With regards to the Ethnicity Bonus Pay Gap. The data shows that among 399 consultants, 74% identify as White, while 23% identify as EM. This indicates that White Consultants continue to make up the majority of the Consultant roles, though there is representation from EM.

Further analysis may be needed to understand factors influencing this distribution, such as recruitment, progression opportunities, and retention within these roles.

Recommendations and Actions

1.	**Inclusion Network:** Invited members of staff to safely have conversations about race through the Inclusion Network
2.	**Knowledge Sharing:** A pilot knowledge-sharing session was held, providing colleagues with a safe space to learn about different religions and topics of interest, while confidently asking questions. The first session in November 2024 focused on learning about Islam, with a session on Sikh beliefs scheduled for April. Plans are in place to host additional sessions on topics of interest throughout 2025.
3.	**Equality Impact Assessment:** A Task and Finish group has been established to revise the outdated EIA form. The updated form will support staff in effectively assessing the impact of policies, projects, and decisions on different groups, promoting inclusivity, equality, and informed decision-making across the organisation.
4.	**Training: Interviewing with Impact:** low attendance for the Pilot Interviewing with Impact workshop in August 2024. However, there is now renewed interest in holding another workshop in April. **Managers Development Programme. (MDP):** MDP training programme is currently being developed to support both new and existing managers. As part of this initiative, an important component will focus on EDI training. This EDI element will be designed to equip managers with the knowledge and tools to best understand best practice in promoting fairness and diversity within their teams. The training will help managers to enhance their leadership skills by addressing potential biases, improving team dynamics, and supporting a culture of inclusion and respect. The Inclusive Culture workshop has been successfully launched as part of the Developing Leaders Programme.
5.	**EDI/Recruitment:** Both teams are collaborating to develop a more equitable and unbiased recruitment process.

	Inclusion champion training is currently being developed for both existing champions and those new to interviewing.
6.	**Electronic Staff Record:** Collecting and updating staff demographic information, such as ethnicity and disability status, is vital for maintaining a fair, inclusive, and supportive workplace. It also plays a key role in identifying and addressing pay gaps, ensuring greater pay equity across the Trust Staff are encouraged to update their ESR when applying to join the network. A video with step-by-step instructions on updating ESR is being shared through the Inclusion Network.

Freedom to Speak Up Annual Report 2024-25 Report to People and Organisational Development Committee				
Date	10 April 2025			
Title	Freedom to Speak Up Annual Report 2024-25			
Author /Sponsoring Director/Presenter	Author: Louisa Hopkins - Lead Freedom to Speak Up Guardian Sponsor: Dr Claire Radley- Executive Lead for Freedom to Speak Up			
Purpose of Report		Tick all that apply ✓		
To provide assurance		**To obtain approval**		
Regulatory requirement		**To highlight an emerging risk or issue**		
To canvas opinion		**For information**		✓
To provide advice		**To highlight patient or staff experience**		

Summary of Report

This report provides an update on the progress the Trust continues to make.

Including-

- Review and update on matters raised in 2023/ 24 Annual Report
- Freedom to Speak up Guardian assessment of the current position
- Review of concerns raised to Freedom to Speak Up

Impact on Corporate Risks:

Board Assurance Frameworks: 3 & 16

Regulatory and/or legal implications:

Freedom to Speak Up arrangements and learning are reviewed as part of the Well Led domain in CQC inspections.

The Trust is required to meet the following legal/regulatory requirements in relation to raising concerns:

- NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian.
- National NHS Freedom to Speak Up raising concerns policy (2022)
- NHS Constitution: The Francis Report emphasises the role of the NHS Constitution in helping to create a more open and transparent reporting culture in the NHS which focuses on driving up the quality and safety of patient care.

Sustainability Impact:

No impact on sustainability

Equality Impact:

Staff have spoken up about concerns regarding discrimination.

Staff disclose to the Freedom to Speak up service protected characteristics of disability,

pregnancy, maternity, religion, LGBTQ+ race and age.

Patient Impact:

Staff share patient safety concerns, and they are responded to on a case-to-case basis.

Concerns with elements of patient safety or quality are reported nationally to the National Guardians Office on a quarterly basis.

Recommendation

- Discuss and note the Freedom to Speak Up update and
- Support on going work to ensure an open and transparent culture of speaking up is achieved in the organisation

Supporting the organisational work on compassionate culture and just culture

Enclosures

Purpose

This is an update report of the Lead Freedom to Speak up Guardian capturing a year of activity, bench marking where possible against National data.

Background

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report 'The Freedom To Speak Up' (2015 www.freedomtospeakup.org.uk/the-report/). In this report, Sir Robert found that the culture in the NHS did not always encourage or support workers to raise concerns that they might have about quality and safety of care provided, potentially resulting in poor experiences and outcomes for patients and colleagues.

Concerns can be raised about anything that gets in the way of providing good care. When things go wrong, it is important to ensure that lessons are learnt and improvements made. Where there is the potential for something to go wrong, it is important that staff feel able to speak up so that potential harm is avoided.

Freedom to Speak up Guardians (FTSUG) are employed to promote an open and transparent culture of speaking up and raising concerns. FTSUG provide impartial support to speaking up matters, monitoring and supporting any concerns of detriment or disadvantages behaviour toward staff as a result of speaking up. The Freedom to Speak Up (FTSU) Guardian values are Impartiality, Empathy, Courage and Learning.

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a

regulator, but is sponsored by the CQC and NHSE.

Review and update on matters raised in 2023/24 FTSU annual report:

The FTSU 2023/24 report committed to continue to review the FTSU function and service. Further review initiated the following improvements over the last year:

The recruitment of the additional 0.4 WTE Band 7 FTSU Guardian has improved the service function and supported important work such as building the Champion network and aligning the FTSU element of education into the Trust.

Improvements have been made to the data holding and recording of cases.

The champion network is a growing network of 20+ champions who are supporting speaking up matters in the organisation. Champions are supported in monthly meetings, where visiting speakers promote speaking up matters.

The FTSU policy has been updated to include recommendations from National Guardians Office and actions from an external audit (June 2024) to include advice on detriment. The policy has passed through GHFT HR policy group and will go live during Q1 2025/26.

Further updates on improving speak up culture:

A training needs analysis project is underway to address the speaking up training needs in the organisation. FTSU listen up, speak up, follow up training is available for all staff to access on ESR but additional elements are being reviewed to ensure FTSU agenda is present in all leadership and managerial systems and training.

FTSU continues to have a live communications plan and support to promote the service.

FTSU continues to actively support Maternity Services in Gloucestershire Hospitals, noting the Panorama programme in January 2024. This has included regular and out of hours visits to advertise the FTSU service and speak with staff. FTSU attended their first PROMPT training on April 2nd, a monthly slot to educate and advertise the FTSU function. Safe speaking up continues to be explored by staff in Maternity with staff raising a range of issues, some relating to barriers to speaking up. Staff are being supported with escalation routes and support from the FTSU team and senior leaders in the organisation.

Report, Support and Learn system is a reporting system being introduced to the organisation. It is anticipated that Report, Support and Learn will support the FTSU function and increase organisational accountability on speaking up matters with a likely impact of reducing FTSU contacts as the organisation takes accountability for concerns/ issues raised. The FTSU service remains the contact for staff experiencing barriers to speaking up matters and fully supports and welcomes the initiation of this programme.

The FTSU service has implemented weekly managerial drop in sessions to respond to the 151 out of 230 cases where staff reported their line manager as a barrier to speaking up. Reasons for those barriers are themed as; actual detriment or discouragement to speak up; perceived

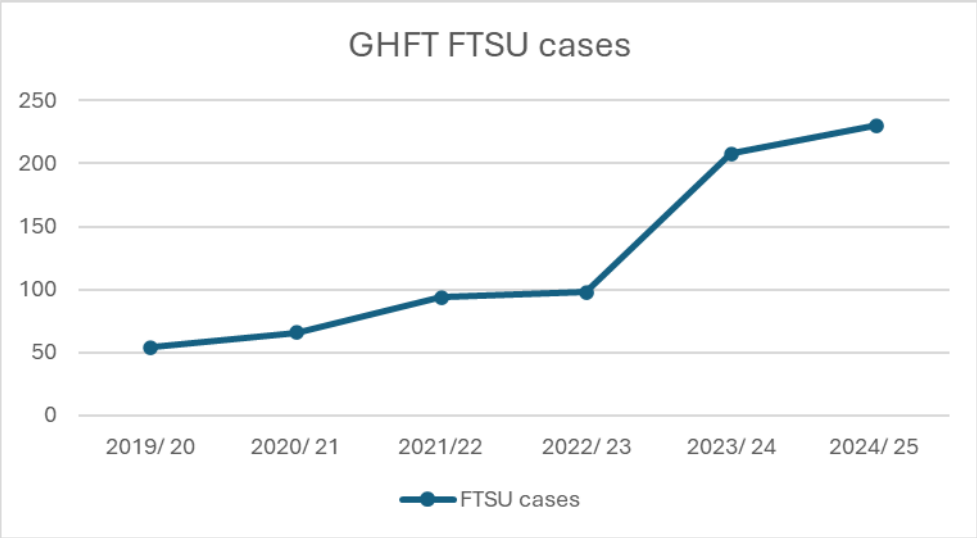
favourable relationships with other managers; lack of trust; fear of detriment; unsatisfactory experience of speaking up and occasions where staff have seen their manager upset over other speaking up issues which leads them to avoid approaching their line manager.

The FTSU manager drop ins have a restorative ethos, to ensure managers are supported in speaking up matters, and have the training required to support staff who are speaking up.

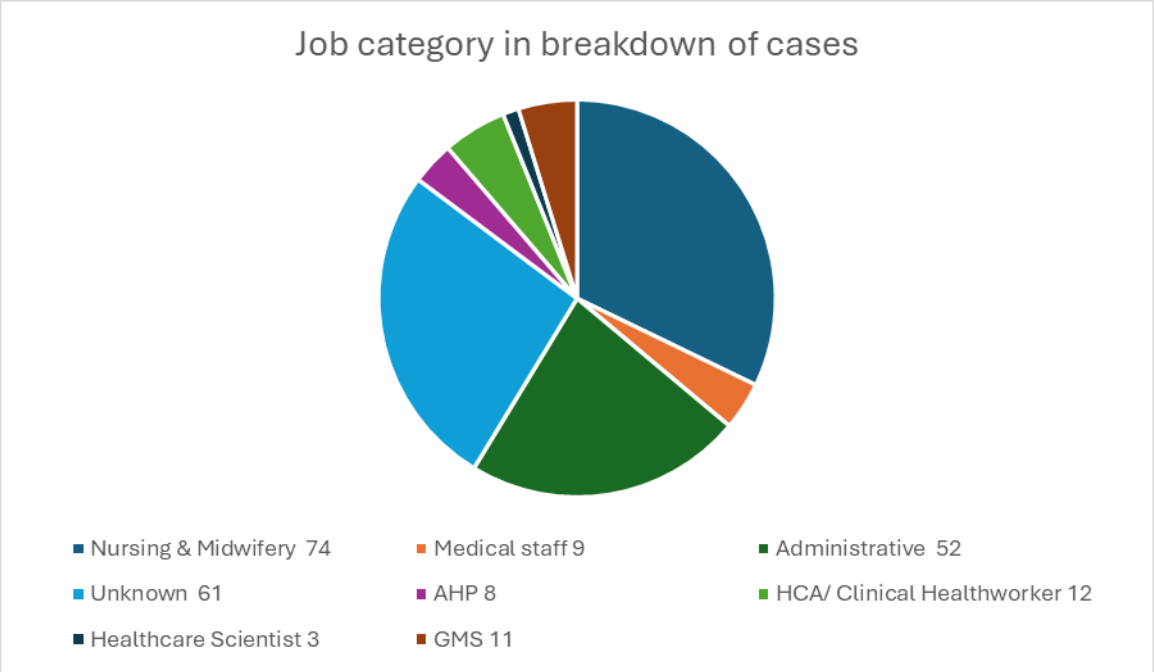
The National Guardians Office released detriment guidance in January 2025 and this has been made available to staff and utilised within the service.

2024- 2025 FTSU data and activity:

In 2023- 24, 208 staff accessed FTSU to raise concerns, more than doubling the activity of the previous year. At the end of last year, it was expected that cases would continue to rise, and 230 cases have been raised in 2024/25. Staff accessing FTSU this year are voicing barriers, indicating that the correct cases are now reaching the FTSU service.



The types of cases that staff raise remain broad with staff accessing the service from all staff groups. It is reassuring that the reach of the service continues to be established in the organisation.

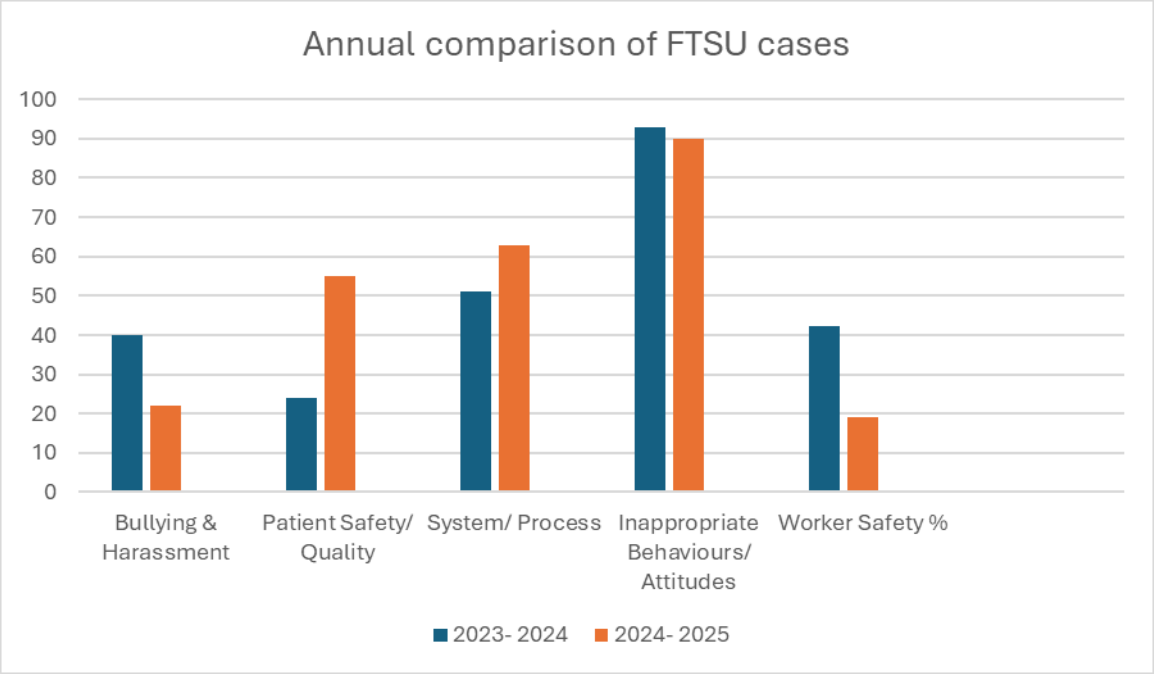


All concerns are addressed and escalated appropriately in the Trust and any barriers are reported to the Lead FTSU Executive Dr Claire Radley for action with regular contact with the Chief Executive and Non Executive Director for FTSU.

Inappropriate behaviours and attitudes remain the highest reason with 39.1% of all speaking up cases in 2024/25. This mirrors National NGO 2023/ 24 reported data of 38.5%.

There is a marked increase in patient safety concerns being raised as staff are more open about concerns from 11.5% of all cases last year to 23.9% of all cases this year. The most recent data to bench mark against is National Data 2023/ 24 18.7% Staff are raising issues

When staff access the FTSU service, staff express concerns about repercussions and are at times fearful of trusting the organisation in speaking up matters. The National Guardians Office new detriment guidance https://nationalguardian.org.uk/2025/01/30/detriment-guidance/ is supporting the FTSU service address these issues. The new FTSU policy refers to detriment and expresses support of all staff speaking up. National detriment was last reported as 4% where as GHFT is currently 1.7%. This is expected to increase as the service and staff understand more about detriment and report the incidence of it.



Examples of live anonymised staff concerns are captured here and show the complexities of some of the issues staff are raising:

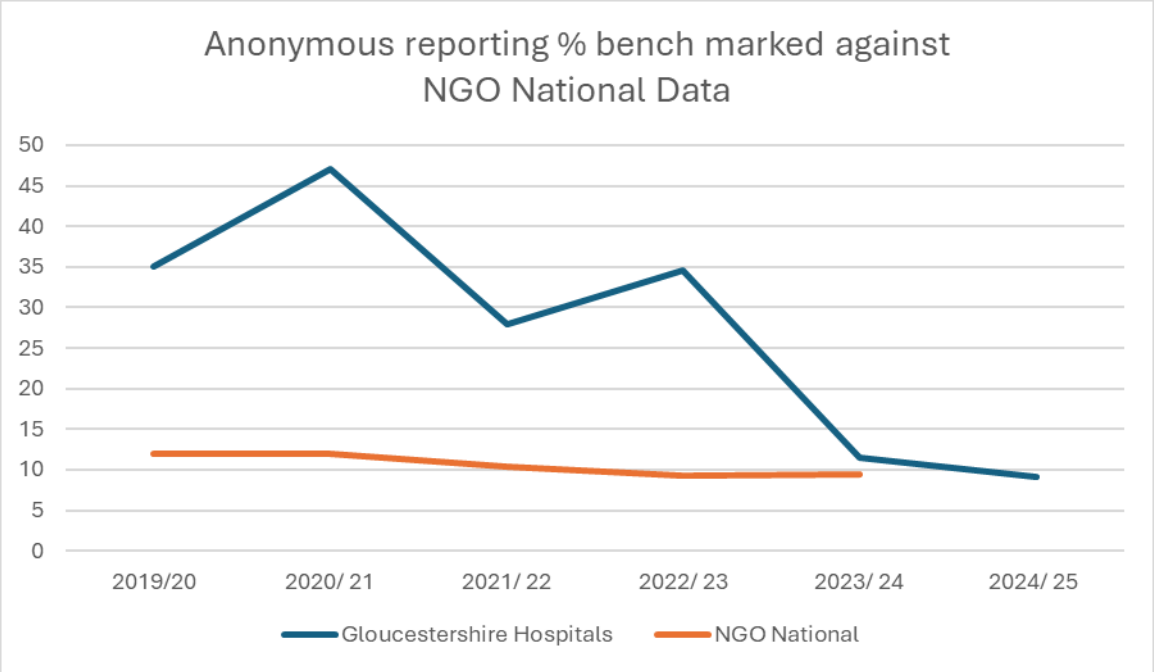
Cases with an element of worker safety	• Staff reporting going through an HR process after speaking up • Staff voicing safety concerns connected to sexual safety
Examples of patient safety concerns	• Feeling discouraged to speak up about a patient safety issue
Examples of bullying and harassment concerns	• Staff experiencing racist behaviour • Staff reporting harassment
Examples of a system and process concerns	• Staff expressing concerns about the bank worker booking system • Staff speaking up about their HR process being passed to multiple HR staff leading to a poor collective experience
Examples of cases with inappropriate attitudes or behaviour	• Staff observing a staff member shout at others • Staff reporting gaslighting behaviours from a colleague

Themes have been captured in the FTSU service as voicing concerns about speaking up due to staff experience; poor experience connected to a process; poor behaviours witnessed or experienced in the organisation.

A stark change in the FTSU service has been the reduction of anonymous reporting. It was noted in the last report that anonymous reporting at Gloucestershire Hospitals has been higher than the national average peaking in 2020/21 at 47%.

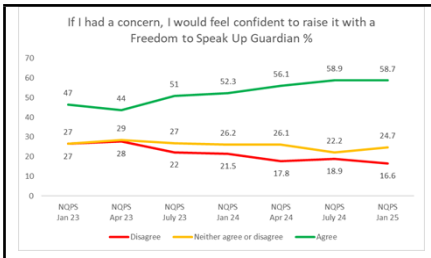
Anonymous reporting is highlighted by the National Guardians Office as an indicator of staff potentially feeling a lack of trust and fear of detriment. As expected, the stability of a Lead Guardian and FTSU team has decreased anonymous reporting to more open concerns and less anonymised concerns.

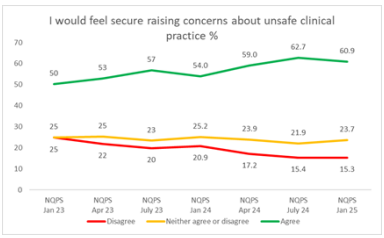
The graph below shows the anonymous reporting trends bench marked with National Data over the last 5 years showing the reduction to 9.1%

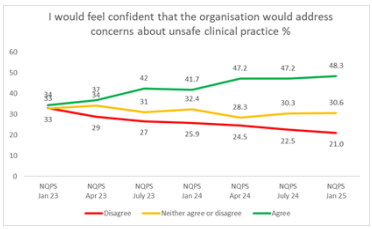


Staff survey results:

Quarterly pulse survey results can be seen below showing overall improvement since April 2023.







The most recent staff survey also shows improvements in the FTSU data with one of the Speaking Up questions as one of the top 5 most improved questions in the recent staff survey.

5 Most Improved Questions: Trust 2024 vs. Trust 2023 (and 2022)	Trust 2024	Trust 2023	Trust 2022
q3i. Enough staff at organisation to do my job properly (top 5 most improved in 2023)	34%	28%	19%
q25c. Would recommend organisation as place to work	51%	47%	43%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours (top 5 most improved in 2023 & 2022)	51%	47%	41%
q25b. Organisation acts on concerns raised by patients/service users	58%	54%	52%
q25f. Feel organisation would address any concerns I raised	40%	36%	33%

Staff experience and feedback:

As previously reported, an anonymised feedback reporting system has been introduced. This data is not available in its entirety for this report, however here is some of the collated feedback that staff have provided:

'I didn't know where else to go. As I say, this wasn't person specific, this was process driven issue I wanted to raise. I needed someone neutral who could address this as a system which is where Freedom to Speak up were so important'
'It was the best decision I ever made to speak to one of the guardians, they offered me sympathy and helped resolved the most stressful problems at work'
'I had a telephone conversation seeking for advice on someone who had reported a breach of confidentiality to me. It was very helpful'
'I felt listened to, I was able to speak without any interruptions, it was a safe space. I have had follow up calls and emails regarding my disclosure'
'No help at all- they should be able to do something when an employee is upset. They did nothing'

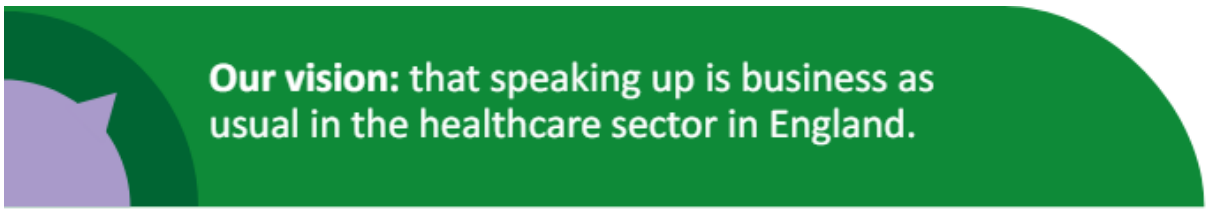
'I would like to see them bolder in the organisation'
'I think an improvement could be perhaps clarity of pathways and responsibilities'
'I was able to talk to someone neutral who was able to reassure me that I was right to be concerned about this'

The data captured in the anonymous feedback system will be collated to drive improvements in the service alongside qualitative data from the NQPS survey.

To date regarding 2024- 2025 cases, 69 cases remain open and 161 cases have been closed. The FTSU service frequently experiences barriers to resolving concerns in the organisation, resulting in delays and at times, an unsatisfactory outcome for staff. In this instance, it is the FTSUG role to escalate to more senior leaders to restore trust to the staff involved and ensure the concern is responded to. To date, concerns are resolved more effectively if addressed at Executive or senior leadership level. Reasons for escalation are; the staff members lack of trust in the person they have spoken to, escalation due to a lack of engagement from the leader/ manager, escalation due to the staff member not being listened to.

Noted guidance from the National Guardians Office is that FTSU Guardians should not need to attend meetings with managers and leaders when staff are speaking up. The FTSUG can support the contact and will be supportive to staff and leaders/ managers before and after the meeting, holding the organisation to account for the issue raised. This approach is to ensure impartiality for all staff who may wish to speak up. The FTSU service will support as staff need dictates to ensure promotion of open and transparent speaking up and will endeavour at all times to align practice with the National Guardians Office guidance.

Local, Regional and National Work:



The NGO shared on 3rd April 2025 that The Dash Review of patient safety across the health and care landscape will be published after Easter, although no date has been given. The National Guardian's Office is one of six organisations the review is considering.

The National Guardian Office 2023/ 24 reports a 27.6% increase in concerns raised leading to a national total of over 30,000 cases.

In response to the publication of Too Hot to Handle: why concerns about racism are not heard or

acted upon, Response to Too Hot to Handle - National Guardian's Office the NGO has incorporated equity, diversity and belonging into the mandatory refresher training for all FTSU Guardians to give all guardians an understanding of discrimination. The report promotes the better use of FTSU Guardians, who as part of their role have a focus on encouraging their organisations to remove the barriers which workers face in speaking up, particularly black and minoritized workers. In the year ahead, the FTSU has committed to widening the data collected to include a deeper dive into discrimination and the learning that can be shared Trust wide as a result.

In April 2025, GHFT will host the quarterly South West National Guardians Office meeting.

Hosting a range of board members and regional FTSU guardians to discuss and support speaking up matters, the event is supported by GHFT Lead Executive Dr Claire Radley speaking on 'Freedom to Speak Up as a Barometer of Organisational Culture'.

Gloucestershire Hospitals Lead FTSU Guardian continues to actively engage with the National Guardian's Office, seeking support for the organisation on speaking up matters and providing support to peers and mentorship for newly registered guardians nationally.

Learning:

Learning is promoted by the National Guardian Office as one of the key FTSU values. The majority of concerns continue to provide local opportunities for learning and reflection. As data from 2024/25 is collated, learning will be captured and disseminated to divisions to support improvement in the organisation.

Report, Support and Learn will provide an avenue to triangulate data. Restorative Just and Learning culture is also an enabler of FTSU in supporting learning in the organisation. The progress of these functions and the improvements will continue to be reported on.

Conclusion:

The Freedom to Speak Up function is designed to support staff to have a voice in the organisation where there are barriers to speaking up. The FTSU service continues to focus on case management and restorative support to provide staff with an excellent speaking up experience, challenge the organisation and ensure speak up, listen up and follow up is supported by the organisation.

Despite some of the challenges that staff express around speaking up, there is evidence to suggest trust has been gained in the service and the organisation is being increasingly trusted by staff to respond to their concerns.

Over the next year, the FTSU service will continue to capture data on the barriers staff are experiencing in relation to speaking up and commits to widening the data collected to support a deeper dive into discrimination and the learning that can be shared Trust wide as a result.

There is genuine support from senior leaders to respond to cases and support staff speaking up, the FTSU Service is committed to seeing this multiplied across all levels of leadership. Looking ahead, the FTSU service will engage with all divisions every quarter to support this approach.

The FTSU service has an ambition to operate restoratively, and develop into a trusted service that improves organisational speak up culture, impacting patient safety/ quality by supporting the speaking up concerns of all staff who meet barriers.

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) 20 March 2025	
Committee Deep Dive	**Complaints Report** - The committee received a planned deep dive on the work in progress to improve complaint response rates with a current focus on complaints received after 31 December 2024. Assurance was given that a backlog reduction would be delivered enabling a shift to focus on current cases managed through surge processes. - Assurance was given that action plans including learning from PHSO feedback were actively developed, monitored, and assured through to closure, with future plans to implement a new QI framework. Feedback from complaints was integrated into consultant appraisals and nurse revalidation. - Training needs were currently being assessed for those who investigate complaints to support improved responses. - The committee supported the direction of travel proposed with the merging complaints and Patient Advice and Liaison Service functions, supported by a monthly patient experience meeting involving division representatives and complaints and Patient Advice and Liaison Service leads. - An accessibility review of services, involving input from service users and Healthwatch, was planned for completion by September 2025. - The Trust Chair acknowledged that there is still progress to be made and commended improvements in complaint handling so far, emphasising the importance of plain English, avoiding jargon, and incorporating health literacy into training. It was suggested that sampling feedback from service users on response quality to truly understand the quality of our responses. - Vareta Bryan raised concerns about recurring communication issues and timelines for complex complaints. It was confirmed that the 35-day target applied universally and emphasised the need for collaboration with divisions to address emerging trends and hotspots - The Trust CEO stressed the need to prevent future backlogs. He advocated for an earlier rollout of the new framework and better integration of complaint insights with Human Resources processes which the CEO proposed to action with colleagues. **FFT/PALS Update** - The committee received a planned deep dive into the FFT/PALs function. The committee discussed the National Quality Board for Safety's goal to improve both functional (processes) and relational (staff-patient interaction) aspects of care. noting that stronger staff-patient relationships could reduce complaints raised through Patient Advice and Liaison Service.

	- A new framework for care improvement, which covered leadership, culture, feedback collection and analysis, and learning, was introduced expected to be in use by April. - It was noted that the organisation is strong at gathering feedback but noted challenges in effectively analysing and acting upon it. A benchmarking exercise was planned to develop a clearer improvement strategy. - The focus on empowering divisions to lead improvement work, was noted. more effective use of data was needed, along with alternative feedback methods to ensure that all patient groups were reached. Thematic analysis using Artificial Intelligence was suggested to deepen understanding of feedback, enabling more targeted actions. - The staff survey showed positive responses, particularly regarding staff feeling their roles made a difference. However, there was room for improvement in prioritising patient care. The results also showed that the organisation's previous struggles with acting on concerns had improved. Triangulating staff feedback with complaints and Patient Advice and Liaison Service was considered key to gaining a full picture of patient experience. The Friends and Family Test results indicated 50% of staff would recommend the organisation, suggesting an area for improvement. - It was acknowledged ongoing concerns regarding Emergency Department waiting times, which were reflected in Friends and Family Test responses. It was proposed to add more questions to the Friends and Family Test about the waiting experience, especially improving communication. The success of the Surgical Assessment Unit in managing patient expectations and improving experience scores was noted, with a suggestion this approach could be expanded to other areas to improve patient experience. - Sam Foster requested further insights into the Emergency Department's score improvements.
	Operational Plan - The Trust COO outlined the national priorities, focusing on improving elective care productivity, ambulance response times, GP access, and mental health crisis flow which was an area where Gloucester excelled. It was emphasised that prevention as a key focus, supported by digital transformation, robotic process automation, and Artificial Intelligence, with quality, safety, and performance central to the plan. - The 2024-25 forecast excluded non-recurrent funding, the plan did not account for elective recovery funding or high-cost investments due to uncertainty, but it was anticipated that there would be more clarity in the next few months. - Business planning followed last year's divisional approach, with a submission deadline of 27 March 2025. Some areas were flagged as non-compliant, including the 18-week Referral to Treatment target, which was unachievable

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	without additional funding despite a focus on high-volume specialties like Ears, Nose and Throat. - For the 52-week target, the aim was to reduce patients waiting over 52 weeks to below 1% by March 2026. With flat cash and a 3% productivity increase, the forecast stood at 1.7%, though elective recovery funding could improve this to 0.6%, with a system-wide stretch goal of zero. - The Trust CEO raised concerns about the trust receiving a smaller share of elective recovery funding than other providers, highlighting its impact on meeting targets. - The Trust Chair questioned the use of £30 million allocated to the system's bottom line to cover deficits, which limited elective care funding. AI explained that £1.5 million in costs had been incurred in relation to community hospitals, as ongoing discussions continued with Gloucestershire Health and Care Foundation Trust. The Trust COO also raised the need to consolidate services at fewer sites due to financial constraints. - The Trust CEO noted ongoing system-wide conversations to align funding with national targets. Sam Foster asked whether risks associated with service rationalisation were included in the Integrated Care Board risk register, and AI confirmed they would be if non-compliance was reached. - Updates on waiting lists showed a reduction from 74,000 in November to 72,000 in December; further productivity improvements were needed. Progress in cancer care diagnostics was noted, despite challenges in echocardiography; a recovery plan was in place. - The Trust COO reported that the Integrated Care Board had allocated £1 million for endoscopy services, though £5 million was required, necessitating a long-term funding strategy. - The Trust COO outlined urgent care improvements, including reduced ambulance delays and efforts to address 12-hour Accident and Emergency waits. A new discharge ready date metric and Same Day Emergency Care model aimed to enhance flow. - The Trust Chair raised concerns about balancing bed reductions with effective discharge processes; the Committee agreed that these should align with patient flow improvements. - The Trust CEO stressed the importance of clarifying funding to improve 18-week Referral to Treatment performance. Orthopaedics were highlighted as a capacity risk and suggested collaboration with the Nuffield group and private providers to manage demand in Ears, Nose and Throat and dermatology services. - Theatre capacity issues were highlighted; the Committee noted an annual £1 million loss due to inefficiencies and stretched capital plans. The Trust CEO confirmed a previous theatre plan had been withdrawn due to cost overruns, but a revised approach would be explored. The Chair emphasised the need for strategic investment in theatres at Cheltenham and Gloucester. It was

	reported that the plan was nearly ready for submission, with £1.7 million left to finalise. The committee noted the report.		
Items rated Red			
Item	**Rationale for rating**	**Actions/Outcome**	
Items rated Amber			
Item	**Rationale for rating**		**Actions/Outcome**
Patient Safety and Risk Assurance Report	- The Committee were provided with an assurance update on the daily executive-led harm review meetings which had been in place since November 2023, focussed on high-concern incidents and duty of candour cases. An evaluation is now in progress. - The Nutrition and Hydration project remained in the improvement phase, with plans to establish a dedicated group before closure. The Care Quality Summit had completed two workshops, with the next focused on defining project aims; a new summit on histopathology results reporting was being launched, with discussions underway to extend it Trust-wide. - Action being put in place to improve results acknowledgement were noted. - A reduction in open incidents, from 340 in January to 148 was noted, usability issues were being addressed by the Datix Development Group. A slight decline in incident reporting, was noted linked to the complexity of the Datix system, but feedback from the Datix Development Group was being used to improve usability. - Progress was made on two overdue alerts: the update for medical beds and the transition to Neuraxial Fit		

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	Connectors, with procurement discussions ongoing. Risks continued to be monitored through the Risk Management and Development process. - The Trust Chair raised concerns about recognising and escalating deteriorating patients, particularly those requiring urgent transfers. The Trust CMO confirmed this was no longer a formal safety priority but remained under routine monitoring, with Early Warning Scores and the Acute Care Response Team having reduced related incidents. - The Trust Chair highlighted a disconnect between documented risks and management actions in the Department of Critical Care. The Trust CMO acknowledged this and committed to updating the risk register, adding that a plan to address bed capacity was being developed.	
Patient Safety Investigation and Learning Report	- The report highlighted the focus on patient safety investigations, with all Serious Incident investigations now completed and action plans for ongoing cases in place. - Workforce challenges remained a concern and were added to the corporate department risk register, with methods address these noted. - A new Governance and Morbidities and Mortality forum had been launched to increase understanding of roles and improve knowledge of the Patient Safety Framework. - The Trust CNO provided an update on the quality governance proposals. These were being implemented in three stages, with the first stage ongoing. Job descriptions and	

	banding for senior roles, had been finalised, and recruitment was due to begin shortly. - Vareta Bryan highlighted the need to extract and share learning from safety incidents, particularly within maternity services, as recommended by the Care Quality Commission. She requested that ongoing support be given to divisions to help them demonstrate tangible improvements as a result of this learning.		
Item	**Rationale for rating**	**Actions/Outcome**	
Items not Rated			
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.			
Governor Observations: Helen Brown praised the quality of reports highlighting the value of in-depth reviews during the meeting. She commended the trust's quick response to challenges, strong inter-organisational relationships, and progress on a collaborative plan. Helen acknowledged advances in learning, coaching, integrating safety and governance processes, and aligning PALS with complaints. She welcomed the trust's focus on Equality, Diversity, and Inclusion and emphasised the importance of staff feedback during challenging times. Fiona Hodder, raised concerns about cultural issues affecting Emergency Department delays, and stressed the need to support staff handling complaints to ensure wellbeing and avoid blame.			
Impact on Board Assurance Framework (BAF)			
Key strategic risks discussed as planned agenda			

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

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KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee (QPC) March 24 2025		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Maternity Services	• The Trust CNO reported an improving postion regading closure of older risks, incident reporting and ATTAIN cases – however shared concnerns that there was still further improvements to be made. **Q3 PQS Report** • Safeguarding Training compliance requires improvement • Emerging safety concerns were highlighted and included triage challenges related to preterm birth advice, foetal movements, and access to information leaflets. • The Trust CMO highlighted staffing challenges among consultant obstetricians due to retirements, sick leave, and departures, • There was a closed session to consider maternity related papers.	Ongoing strengthening of assurance reporting was noted to continue to be required and progress to be shared with QPC following further updates at MDG in May. A plan with a trajectory will be shared at the next QPC. National plans for regional training passport initiative is being implemented to smooth trainee transitions. A task-and-finish group has commenced to delivery improvements. 3 additional training posts have been secured. Solutions include reviewing job plans, prioritising essential services, and developing a recruitment programme with obstetric improvement advisors. Ongoing improvement work was noted and plans to track improvments disucussed.

Regulatory Report	• Challenges with Level 3 safeguarding training were discussed. The complexity of the current delivery method is a barrier. • The need for a timeline for achieving Section 31 compliance which has been in place for 12 months was disucssed.	A/A Alignement of delivery tiescales was reported as under review – The Trust CNO shared his expectation that he expects full compliance by July
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Integrated Performance report	• No ambulances had been delayed over four hours since 11th April, and year-end progress was noted. ED wait times reduced, but efforts to cut waits over 12 hours by 50% continued. • Elective care's 62-day performance remained a challenge, though full compliance was expected. • Diagnostics made progress, except for echocardiograms, where staffing and demand issues persisted. • Non-recurrent funding was provided for ECHO services recovery. • Histopathology saw improvement in March, but further work was required. • The Trust CNO updated on patient feedback, noting a decrease in concerns resolved within five working days to 68%, below the 75% target. • The CMO update VTE compliance, noting that the trust was nearing compliance with the national standard for assessments across all areas. The focus was now on improving documentation and prophylaxis, which still required attention. • Assurance was sought over the management of waiting lists and clinical risk assessments for patients waiting	Continued deep dives to be presented to QPC for assurance along with IPR

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	longer than expected. The COO gave assurance describing the clinical harm review process	
QDG	• Our Pharmacy Manufacturing Unit , has been temporarily closed due to a contamination traced in the water supply. The CMO confirmed that patient appointments were rescheduled, and mutual aid had been sourced.	
DM01 Performance and Improvement Deep Dive	• The comitee received an update on DM01 performance, comparing the current year to last financial year. • Improvements in cystoscopy performance, though progress had plateaued due to delays in estate handover, impacting capacity. • Planned improvements regarding process redesign, validation and workforce shortages were shared. • An emerging issue with MRI performance was highlighted, noting that one of the two MRI scanners at Cheltenham General was out of action, leading to an increase in breaches, particularly for urology. Recovery plans were in place, with a replacement MRI scanner scheduled for July 2025. • Improvements in histopathology turnaround times for urgent urology cases, with a significant reduction in turnaround time since October was reported - The trust was noted as one of the first in the UK to be asked to consider piloting AI technology for histopathology.	
UEC & Flow Improvement Board	• The Trust COO shared the executive led approach to reduce long waits, and overcrowding, this included Trust improvements alongside the need for	The Clinical Vision of Flow improvement methodology is being used to guide improvements, with notable progress made

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	system support to improve discharge flows.	through embedded streaming pilots in the ED. A deep dive into UEC is planned for QPC – This will include system feedback from winter learning.
Learning from Deaths Report	QPC received a presentation focues on four areas: • Patient safety incidents with assurance that improvements were underway. • Medical Examiner (ME) and Bereavement Services, sharing that the ME service now operates in the community • SHMI data, reporting that Cheltenham and Gloucester hospital remain above control limits, particularly in relation to out-of-hospital deaths, due to planned, expected end-of-life care at home. Due to data quality improvements in reviewing primary diagnoses and comorbidities through Charleson scoring, SHMI has improved but remains high. The overall SHMI trend is positive however, with ongoing monthly falls. Ongoing work is continuing to address these concerns. • The hospital mortality (deaths per spell) remain static and in line with national data • Delay-related harm, particularly for patients in the Emergency Department (ED). Data showed that patients waiting more than 8 hours in the ED had higher mortality rates. Although the percentage of patients waiting over 8 hours decreased from 78% (January to June 2022) to 65% (July to December 2024), delays continue to significantly	ICB led NHS Mortality Insight visit planned to review progress and support ongoing improvement work The CEO proposed that an action plan be brought to the committee to address ED delays and improve overall patient flow, highlighting the need for system-wide collaboration and accountability.

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	impact outcomes. A spike in delays in December 2024, attributed to seasonal factors like flu, highlighted the ongoing challenges in patient flow. Despite improvements in patient flow at Cheltenham, Gloucester Royal faced significant challenges in December, requiring further investigation into these issues.	The CEO proposed escalating the issue to the ICB board level for further action.
Upper GI Action Plan	• The CMO provided assurance regarding improvement work led by the GI team	The CEO requested timescales for developing a future strategy for the Upper GI service - The CMO confirmed that the team aims to complete their work within the next three to six months, to determine the best solution for patients in the Three Counties Area.
Child Protection Medical Assessments	• The CNO provided an update on child protection medical assessments (CPMAs), and the work to improve collaboration. And systematic approach to the threshold for triggering CPMAs and the importance of joint commissioning. • A review process, including recommendations, was completed and endorsed by executive leadership. These were shared with community paediatricians. Matt confirmed an effective escalation process is in place for managing risk. • The need for a shared understanding of risk, was emphasied which the CNO assured would be addressed through the recommendations, and though further discussions with key stakeholders.	The committee agreed that a jointly authored report between the trust and ICB colleagues would be beneficial and should be presented at the next meeting.
Items Rated Green		

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

Item	Rationale for rating	Actions/Outcome
Planned presentation to enable QPC Oversight of Children's Services	• Karen Pudge - Presented an excellent report on children's services. • The report covered: - workforce challenges and the Trust response - Local improvement work aimed at addressing mental health crises in young people and wider helath inequalities - transition programme needs for young people moving into adult health services. - tackle health inequalities, particularly in deprived areas.	
Guardian of Safe Working	• Shyam Bhakthavalsala highlighted that the number of exceptions received during the reporting period remained consistent with previous years. • The primary factor contributing to these exceptions was ongoing vacancies across various specialties. • The CMO addressed the flow of junior doctors and training schemes, noting an oversupply of SHO-level adopters and a higher number of applicants for locally employed doctor positions, leading to fewer rota gaps. • The Trust CEO raised awarenss regarding a recent report on exhausted NHS workers and a discussion took place regarding the oversight of doctors in training and our wider staff groups.	
Committee Terms of Reference and Effectiveness Review- The Company Secreatry proposed immediate housekeeping changes to the committee's terms of reference, with broader revisions to be considered in coming months. The committee also aimed to assess its effectiveness, focusing on membership and performance. The committee was asked to support the proposed changes, which were approved with no objections.		
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.		
Governor Observations Andrea Holder appreciated the meeting's focus on streamlining reports and presenting clear, structured information, particularly through the Integrated Performance Report (IPR) format. She		

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noted improvements in the relationship with the CQC, despite some delays in reports, and praised the progress in children's mental health services, especially with the introduction of mental health youth workers. Andrea emphasised the importance of early intervention, collaborating with schools and nurseries to address potential mental health issues early on, and mentioned ongoing discussions about a dedicated children's menu in the Nutrition and Quality Improvement Group. Helen Bown thanked the team for the informative meeting, highlighted the focus on frailty beds and delayed-related harm, and recognised the value of recent deep dives that have led to positive changes. Helen raised the question of a potential link between children's services and young influencers, suggesting it as a topic for further exploration.

Investments			
Case	**Comments**	**Approval**	**Actions**

Impact on Board Assurance Framework (BAF)
All strategic risks discussed. Challenge given on current and target risk scores

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

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Report to Public Board of Directors	
Date	8 May 2025
Title	Integrated Performance Report (IPR)
Author / Sponsoring Director/ Presenter	Chief Operating Officer (COO) Chief Medical Officer (CMO) Chief Nurse (CN) Director of People & OD (DoP&OD) Director of Finance (DoF)

Purpose of Report (Tick all that apply ⚑)			
To provide assurance	⚑	To obtain approval	
Regulatory requirement	⚑	To highlight an emerging risk or issue	⚑
To canvas opinion		For information	⚑
To provide advice		To highlight patient or staff experience	⚑

Summary of Report

URGENT & EMERGENCY CARE PERFORMANCE

Following a difficult Q4, the Trust ended relatively strongly; Daily attendances were slightly up on February with an average of 444 per day (+25). Overall attendance was up by 2041 compared to February. Monday 31st March saw the highest number of attendances in the last 12 months with 504 attendances.

Performance against the 4 hours standard was also very slightly up at 60.7%; Overall duration spend in ED was slightly less for a greater number of patients reflecting the changes to the Acute Medicine and SDEC profile which saw 112 additional attendances in month. The acuity of patients increased with an additional 262 patients requiring admission, which will have contributed to the delays experienced across all areas including an increase (+36) in the number of patients waiting over 12 hours for a bed.

Handover delays from an Ambulance into the Department and the Trust dealt strongly with increased activity and reduced delays, with just 78 additional hours lost compared to February, and yet 3 more days and 282 additional ambulance conveyances to ED.

NB - Timely Handover Process (THP) is set to reduce from 90minutes to 60 minutes by the end of the next month (Apr) and to 45 minutes by the end of Q1.

PLANNED CARE

Referral to Treatment (RTT)

The RTT percentage improved in month, moving from 66.91% in January to 68.68% in February, although
improvements continued to be made in reducing the number of patients waiting 52 weeks or more. In
addition, the Total Incompletes improved reducing from 71,121 in January to 70,586 in February.
The Trusts performance against the rest of the Southwest region remains favourable, particularly in
relation to RTT performance and 52 weeks as a % of incompletes. Many Trusts have remained relatively
static on 52 week waits, where GHT has made reductions. The unsubmitted March month-end position suggests the Trust will finish the year with 125 reportable 52-week breaches, compared to 588 submitted in February.

DM01
The M12 aggregate diagnostic performance is 17.51% breach performance which is a 3.71% deterioration on the previous month. The deterioration of three specialties has contributed 66% of all DM01 breaches in month; MRI, ECHO and Cystoscopy.

CANCER
62 Day reportable backlog is 160 as of 06/04/2025; most of this cohort is held by Urology. Unvalidated 62 Day standard for March is currently 70.1% which is an improvement of 4.2% (although still not compliant).
Unvalidated 28 Day standard for March is currently at 81.6%, which is continued compliance against the national standard.

QUALITY
Patient experience
Friends and Family Test (FFT) – rate the quality of your care
The overall FFT score has decreased from 92.8% in February to 92.1% in March. Focused safety and
quality priorities target the main themes of concern which are around communication, appointment
availability, appointment cancellations and appointment follow-up.

Patient Advice and Liaison Service (PALS)
The PALS team have seen a slight decrease in the number of concerns closed in 5 working days to 68%,
which is below the target of 75%. There are some concerns over data quality regarding the number of
cases received and the number carried over to the next month. This issue will be closely monitored. A
Deep Dive into PALS was taken to QDG in March and presented to March QPC. A review of the KPIs,
workload distribution and triaging are underway to support staff and improve experiences of patients.

Complaints
The collaborative approach of the Complaints Department and Divisional Leads in clearing the backlog of
complaints, alongside the implementation of a new Complaints Response Framework has achieved a 65%
reduction in the backlog of complaints in Medicine, Maternity and Surgery. The Trust-wide backlog
reduction is expected to be reduced to 60% in June, 80% in September and 90% by Jan 26.

Safety incident management
PSII/AERs - 67 Patient Safety Incidents have required review through Patient Safety Incident Investigation, After Event
Review, or Multi Professional Review since the Trust transitioned to PSIRF in March 24; an average of 5.1
per month.

Clinical effectiveness - ICB Quality Improvement Groups (QIGs) (PPH and SHMI) The ICB

has 2 QIGs in place that are supporting our improvement actions.

PPH Overall Massive Obstetric Haemorrhage (MOH) rates have decreased to below national average again this month. This remains one of the Trust safety priorities and is monitored under a CQC S31 enforcement notice. Key actions have been on the commencement of Carbetocin for all caesarean section patients and the implementation of a REDUCE proforma for risk assessment and management plan. Audits of the REDUCE proforma continue to identify areas of focus.

SHMI - The improvement focus for the SHMI QIG is on the primary diagnosis/ Charlson Scoring work on AMU, the correction of inaccurate data and clinical audits of CGH data (CGH increased SHMI relates to post discharge mortality from Oncology/Haematology/Frailty and are expected deaths). SHMI is predicted to be in the normal range in Q4 due to this improved data quality Latest SHMI = 1.15.

WORKFORCE

The workforce section complies with the requirements of the Single Oversight Framework in terms of staff engagement and the demographics of staff in leadership roles. It reflects a number of 'watch' metrics with annual targets where movement monthly will not be seen. However, underpinning these are 'driver' metrics which reflect activities and interventions that aim to move the dial of change and improvement to meet the associated targets.

Workforce performance metrics reflect where there has been deterioration in performance. This being seen in Appraisal and Bank use in this month's reporting. The supportive narrative reflects the areas/services which are contributing to this performance position together with the recovery actions in train to realise improved performance against target.

FINANCE

At the end of month 12 the Trust reported a YTD surplus of £67k against the NHS England control total (which includes adjustments for impairments). This position includes the consolidation of the Trust's subsidiary, GMS. At a system level Gloucestershire ICS is reporting a small surplus of c£0.4m. The Trust has managed in year pressures (linked to financial sustainability delivery, workforce, non-pass-through drugs and costs of clinical supplies and services) through a range of non-recurrent measures.

The Trust is showing delivery against all 3 uses of resources metrics.

Capital expenditure has reported a c£2.5m underspend which is predominantly linked to an underspend on lease costs associated with IFRS16. Without this the Trust has reported an underspend of c£7k against the capital allocation.

Risks or Concerns
There are no immediate concerns to raise that are not covered in other committee or reports.
Financial Implications
Recommendation
The Board are asked to receive the Integrated Performance Report.
Enclosures
Integrated Performance Report (IRP)

Integrated Performance Report (IPR)

March 2025

- Operational Performance
- Quality & Safety
- Use of Resources
- Workforce

SPC Chart Guidance

Variation			Assurance		
					
Common Cause No significant change	Special Cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special Cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates consistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

Operational Performance Metrics

Single Oversight Framework

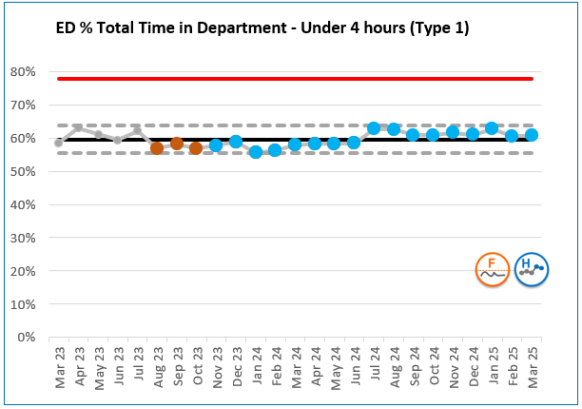
			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality of Care, Access & Outcomes	Elective Care	Total patients waiting more than 52, 65, 78 and 104 weeks to start consultant-led treatment													
		52ww	0 by Sept 24	2738	2883	2816	2626	2509	1737	1614	1479	1256	946	588	124
		65ww	0	379	525	558	512	441	55	8	11	10	12	6	4
		78ww	0	3	3	0	1	0	0	0	0	0	0	1	1
		104ww	0	0	0	0	0	0	0	0	0	0	0	0	0
		Total elective activity undertaken compared with 2019/20 baseline		115%	110%	105%	108%	110%	112%	108%	109%	109%	106%	108%	126%
		Total diagnostic activity undertaken compared with 2019/20 baseline		145%	135%	150%	135%	142%	136%	133%	138%	128%	133%	133%	
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	No Target	159	203	217	201	188	197	191	181	190	185	200	159
		Total patients waiting over 62 days to begin cancer treatment compared with baseline	<=6%	6.93%	8.21%	8.73%	7.64%	7.34%	7.47%	7.69%	7.55%	8.44%	8.36%	8.77%	7.45%
		Proportion of patients meeting the faster cancer diagnosis standard	75%	75.3%	77.9%	75.6%	76.2%	72.3%	70.1%	73.9%	72.6%	72.28%	70.26%	80%	82%
		Total patients treated for cancer compared with the same point in 2019/20	No Target	339	344	323	364	353	312	325	314	341	386	303	282
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		117.2%	111.2%	104.3%	109.1%	110.5%	114.5%	110.8%	109.8%	108.2%	105.8%	105.10%	119.10%
	Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes	0%	58.1%	57.6%	60.2%	50.9%	47.0%	52.8%	60.3%	47.1%	55.3%	54.4%	50.1%	46.9%
		Proportion of patients spending more than 12 hours in an emergency department	0%	13.4%	13.0%	12.8%	11.0%	10.7%	11.0%	11.8%	11.1%	11.4%	11.9%	11.5%	10.8%
	Primary Care	Proportion of patients discharged from hospital to their usual place of residence	No Target	97.47%	97.16%	97.38%	97.22%	97.47%	97.25%	97.25%	97.05%	96.92%	96.92%	97.46%	97.30%
	Safe Care	Summary Hospital -level Mortality Indicator	No Target	1.141	1.146	1.164	1.163	1.158	1.154	No Data	No Data	No Data	No Data	No Data	No Data
		Clostridium difficile infection rate per 100,000 bed days	104	50.3	31.4	44.5	30.8	59.1	46.1	34.9	41.6	45.5	13.4	14.6	35.1
		E. coli bloodstream infection rate per 100,000 bed days	71	36.6	31.4	22.3	26.4	27.3	27.7	26.2	4.6	40.9	13.4	39	26.4

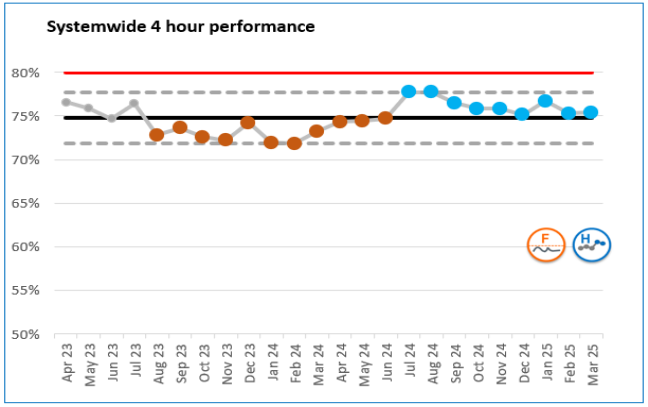
Watch Measures

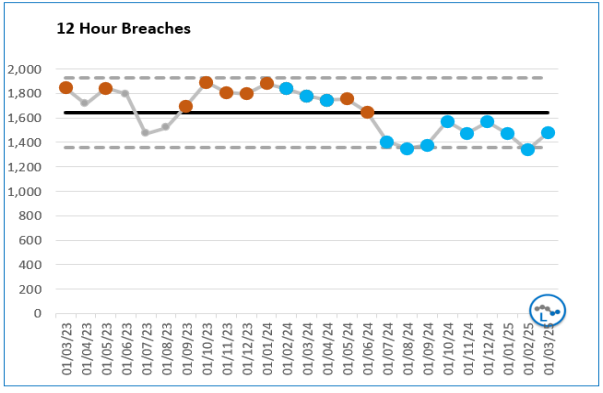
Watch Measures			Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
	Diagnostics	**Compliant Diagnostic Modalities**												
		Audiology	*95%*	84%	82%	82%	91%	98%	87%	98%	99%	99%	99%	99%
		Barium Enema Performance	*95%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	73%	75%
		Computed Tomography Performance	*95%*	100%	99%	100%	100%	100%	100%	100%	100%	99%	97%	97%
		DEXA Scan Performance	*95%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Non-obstetric Ultrasound Performance	*95%*	97%	96%	99%	97%	97%	95%	99%	99%	99%	99%	100%
		Severe Harm from Patient Medication Errors	*0*	0	0	0	1	0	0	0	0	0	0	0
	Elective Care	78ww	*0*	3	3	0	1	0	0	0	0	0	0	1
		65ww	*0*	379	525	558	512	441	55	8	11	10	12	6

UEC: Seen within 4 hours

(Standard: a min of 78% of patients seen within 4 hrs in March 25)





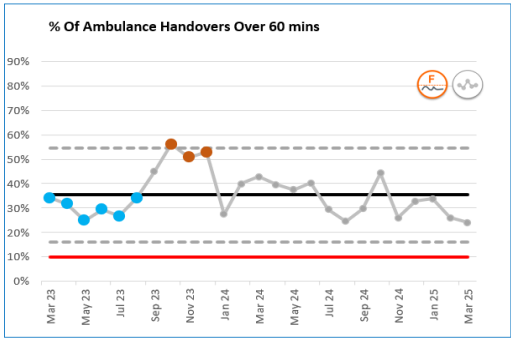


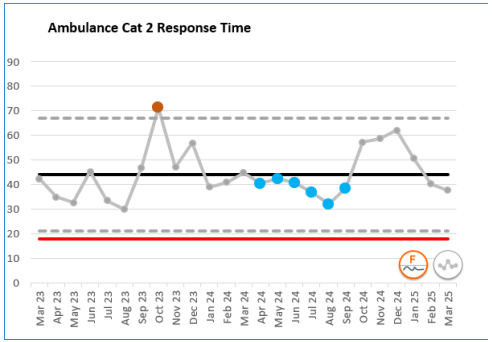
Commentary:
Following the challenges of December, January and February, there was a slight improvement in 4hr performance – notably in Majors (up 0.9%). However there was a deterioration in the number of patients waiting in ED for over 12hours with an additional 139 breaches in month.

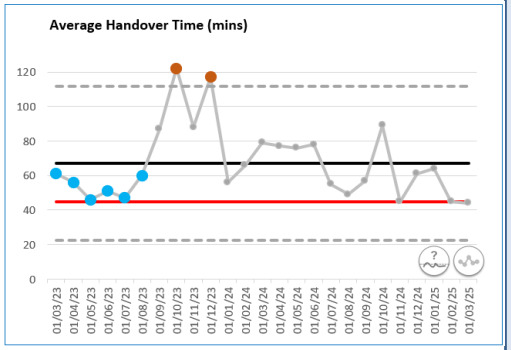
Planned Actions:
UEC improvement plan ongoing, aimed at targeted improvements with minors, pitstop and streaming. There is a requirement for the Department to have 11 fewer breaches each day to meet the reported standard of 78%.

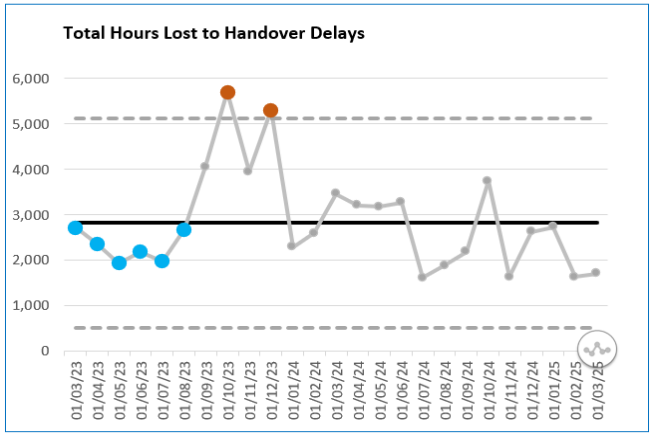
UEC: Average Handover Time

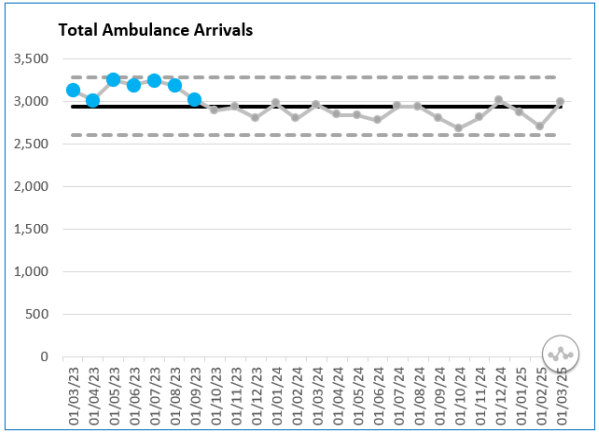
(Standard: Improve Cat 2 ambulance response time to an avg of 30 min across 24/25)











Commentary:
Average Hours lost to ambulance handovers continues to improve (44 minutes on average in March compared to 64 minutes in January). The Trust dealt strongly with increased activity and reduced delays, with just 78 additional hours lost compared to February, and yet 3 more days and 282 additional ambulance conveyances to ED.

Planned Actions:

THPV3 has been formally launched and has been sanctioned by TLT. It will be further revised to reflect 45minutes in the coming weeks. Compliance to this standard is needed by end of Q1 or sooner.

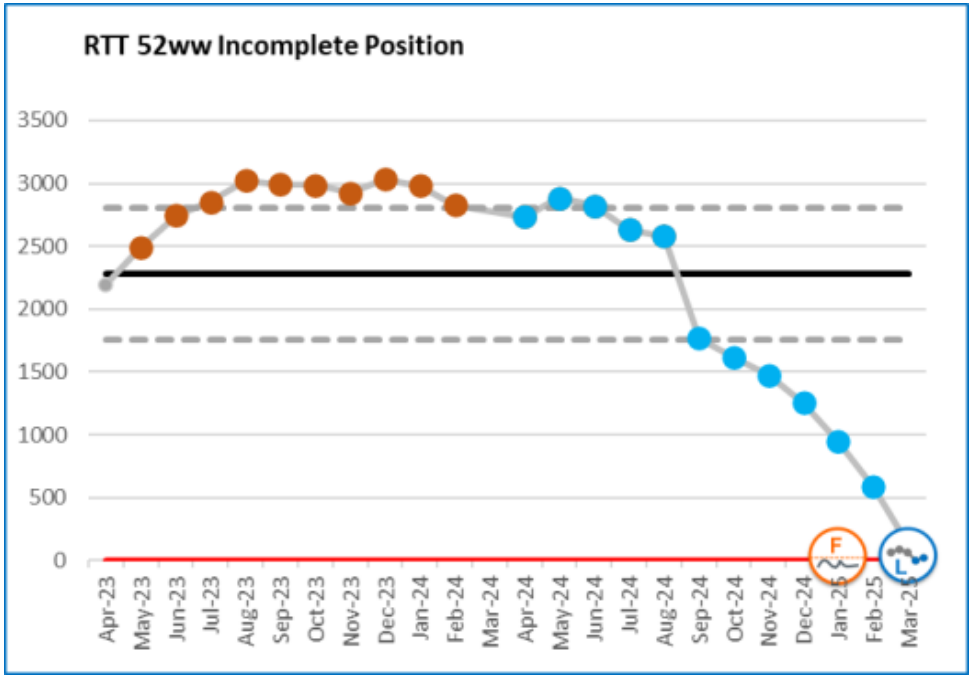
Expected recovery:

NB - Timely Handover Process (THP) is set to reduce from 90minutes to 60 minutes by the end of the next month (Apr) and to 45 minutes by the end of Q1.

There will be periods of challenge which may result in delays being experienced at the front door; however, the whole organisation and wider system plays a part in minimising the impact of these events by maximising flow out of the hospital

Elective: 52 Week Wait

(Standard (Local): *Eliminate all over 52ww by September 2024)*



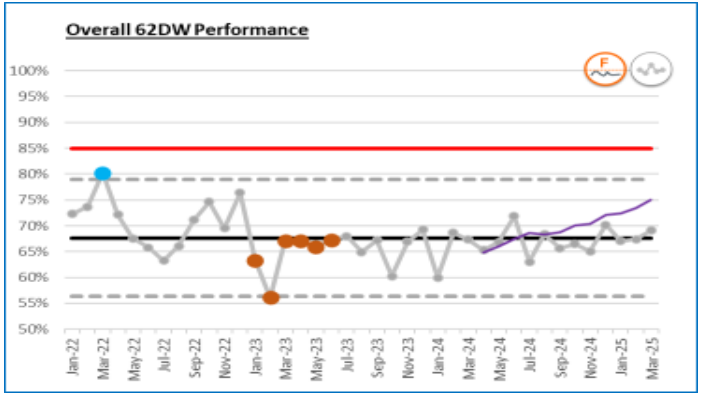
Commentary:
The unsubmitted March month-end position suggests the Trust will finish the year with 125 reportable 52 week breaches, compared to 588 submitted in February. Of the 125, 12 of these breaches directly relate to patients the Trust haven't been able to treat due to national shortages, namely 8 corneal graft and 4 PFJ patients. Effectively the Trust achieved 113 breaches in month. Remarkably, Head & Neck finished the year with zero breaches. The Divisional split was 110 (or 98 excluding national shortages) for Surgery; 13 for Medicine and 2 for W&C.

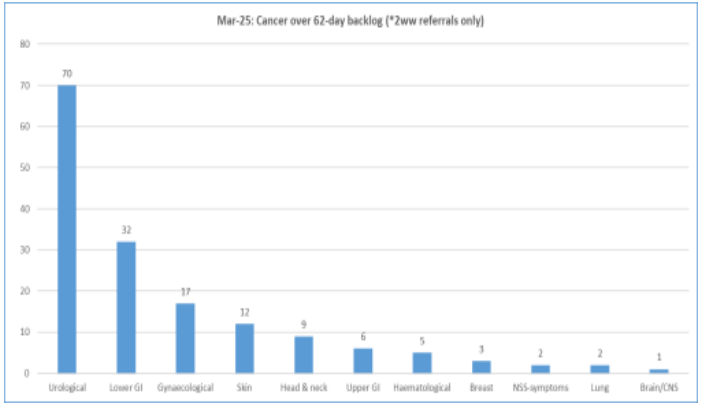
Planned Actions:
Use of ISPs will continue for appropriate patients to be transferred, together with referral avoidance schemes. Scrutiny continues through the various weekly meetings, and support from the validation team/ ECH.

Expected recovery:
Services continue to maintain and improve this position with an ambition of eliminating 52 weeks.

Cancer: % Patients seen within 62 Days (with trajectory)

Standard: 85%



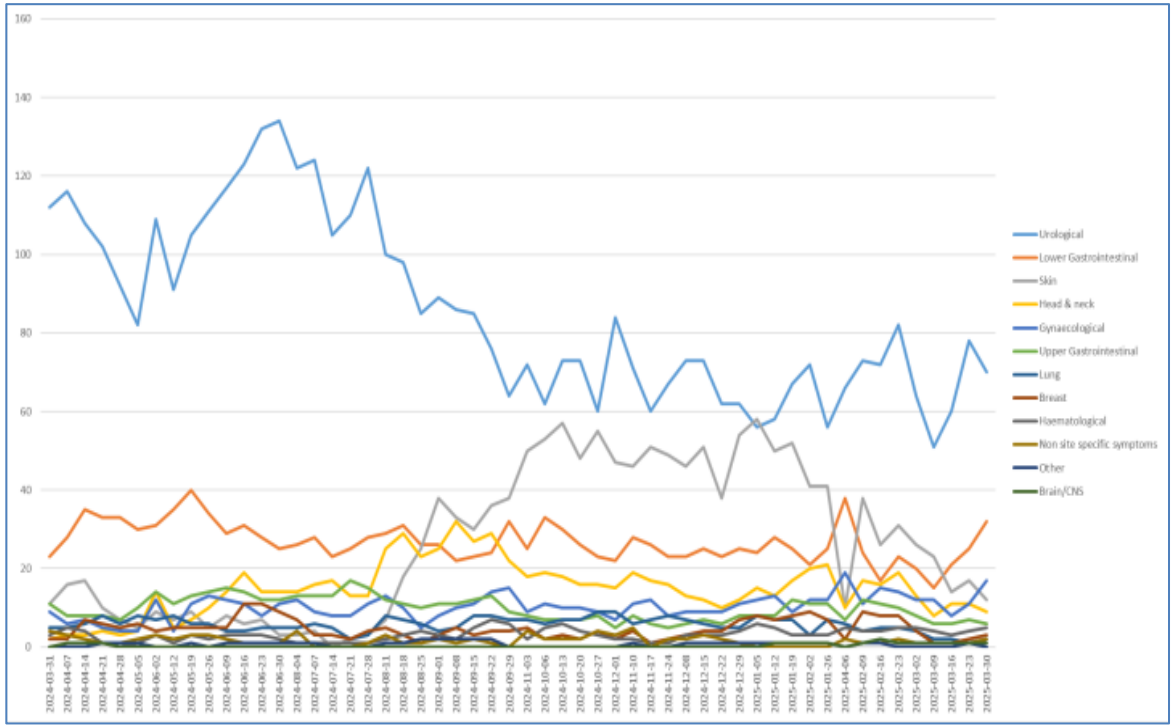


Commentary:
Unvalidated 62 Day standard for March is currently at 69.4% and we will miss this target
This is slightly below our recovery trajectory for 24/25 however we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next few months
Reviewing the diagnostic element of the cancer pathway and focusing on improvements within this will support overall improvement of our 62 day as demonstrated in our 31-Day Performance

Planned Actions:
Focus on specialty level recovery and diagnostic pathways :Urology improvement plan agreed by Trust to support additional LATP and treatment capacity. Local LGI recovery plan being developed with focus on minimising patient delays. Radiology project manager in place to review TATs and improvement plans for diagnostic testing; Review of access policy to support operational decision making and mitigating and performance risk . Review of Cancer Alliance funding for 24/25 with focus on operational delivery against this standard

Expected recovery:
Trajectory has been submitted to ICB for recovery of 62Day at a sustained position of 75% by March-26
Indvidual specialty level trajectories have been developed for 25/26 with breach avoidance targets to ensure individual and Trust compliance with standards by March 2026

Cancer 62 Day Backlog Position



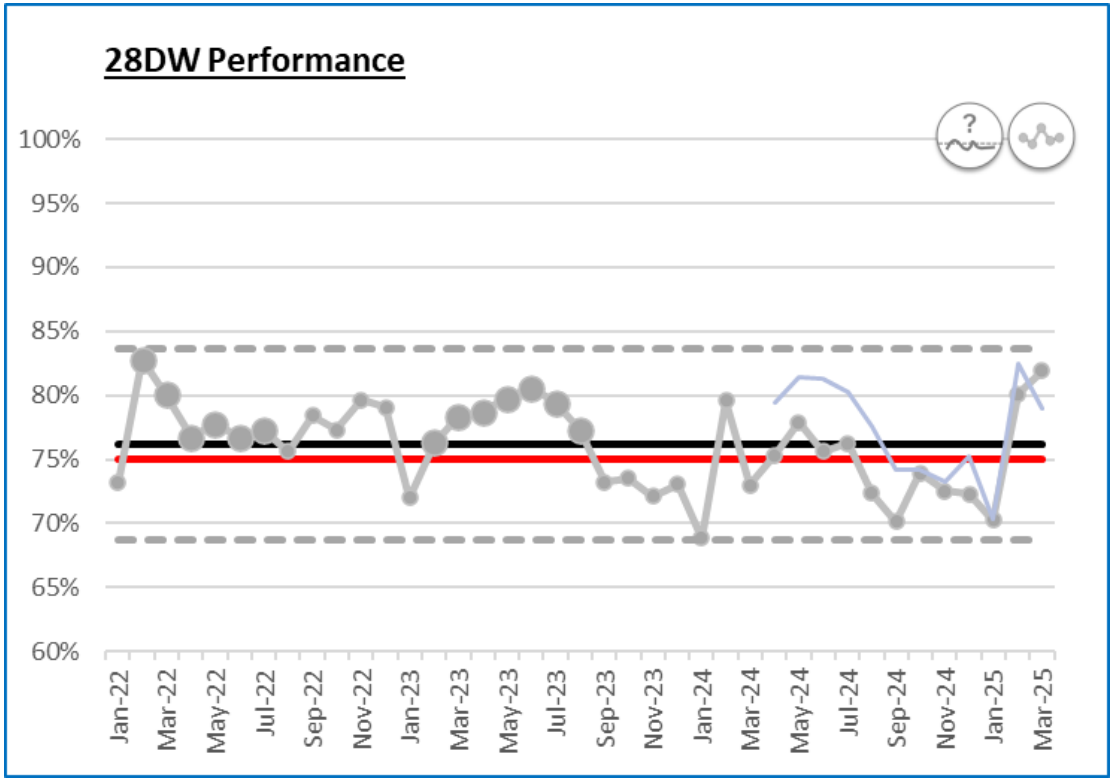
Commentary:
62 Day reportable backlog is 160 as of 06/04/2025
Most of this cohort is held by Urology as demonstrated by the graph however it had decreased significantly over the past few weeks –
The overall delays for Urology are due to the diagnostic phase of this pathway, with many patients waiting after day 62
for diagnostic results or testing, however great improvements have been made to support additional capacity
Due to the delays and constraints within Skin and their Minor Ops Capacity, we have seen a dramatic increase in their backlog and is now the second largest specialty

Planned Actions:
Implementation of "Day 0" pathway analysis and new escalation policy to be devised with timelines supporting treatment or discharge before day 62
Focus on specialty level recovery and diagnostic pathways, especially within Urology

Expected recovery:
Sustained backlog recovery of no more than 6% of our PTL expected March-26
Current backlog of patients waiting longer than 62 days is currently at 6% of our PTL size. As good practice, a manageable backlog size should be no more than 5-6% of the PTL and our aim by (date to be agreed) is to sustain a maximum of 6% backlog moving forward

Cancer: Faster Diagnoses Standard (FDS) % with trajectory

Standard (75%): Improve performance against the 28 day FDS to 77% by March 2025 towards the 80% ambition by March 2026



Commentary:
Unvalidated 28 Day standard for March is currently at 82% and we are expected to meet this target.
Skin FDS recovery trajectory in progress however is dependent on procurement support, additional capacity

Planned Actions:
In order to maintain this standard of 75% and achieve the new target of 80% FDS, some of the planned actions include:
Focus on BTP implementation on key specialties.
New Escalation policy to support earlier identification of bottlenecks and concerns.
Review of 2WW booking date and aim to bring this in line with 7 days or less.

Expected recovery:
Recovery and sustained achievement of the FDS standard is expected by March-25, however, is dependent on all services which support the cancer pathways supporting the actions agreed.

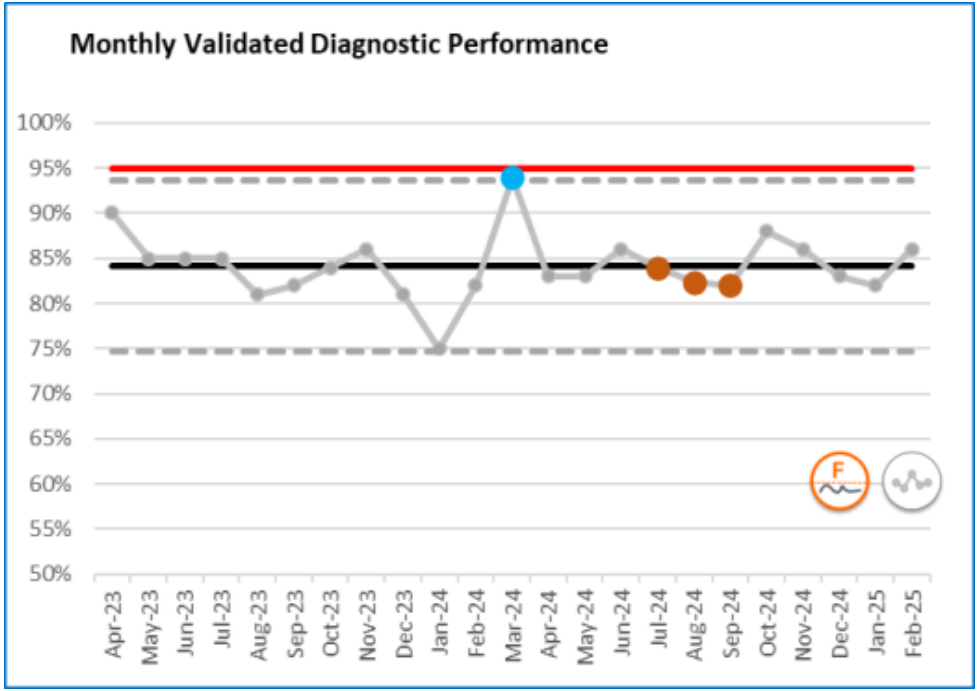
Cancer Waiting Times Performance for the last 3 months

Please Note – March figures are yet to be validated

Excludes Breast Symptomatic referrals

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Jan-25	Feb-25	Mar-25	Jan-25	Feb-25	Mar-25	Jan-25	Feb-25	Mar-25	Jan-25	Feb-25	Mar-25
Acute leukaemia										100.0%		
Brain/CNS	100.0%	100.0%	100.0%	90.0%	90.0%	60.0%	100.0%			0.0%		
Breast	86.5%	98.8%	98.8%	89.2%	97.4%	97.4%	96.4%	94.8%	97.6%	84.6%	87.4%	92.4%
Gynaecological	95.9%	98.7%	97.5%	63.4%	68.2%	76.7%	96.0%	96.7%	84.2%	66.7%	63.6%	82.4%
Haematological	87.5%	92.3%	100.0%	36.0%	60.0%	47.4%	98.5%	100.0%	100.0%	65.4%	60.0%	78.6%
Head & neck	95.8%	97.8%	95.8%	63.4%	77.8%	79.5%	96.6%	97.6%	92.3%	44.4%	53.8%	68.4%
Lower GI	93.4%	96.6%	94.5%	69.8%	83.2%	79.3%	87.2%	90.3%	85.7%	76.5%	65.9%	69.1%
Lung	100.0%	100.0%	93.3%	93.3%	97.1%	96.3%	100.0%	89.7%	96.8%	53.6%	48.0%	85.2%
Other	100.0%			100.0%			100.0%	100.0%	100.0%	33.3%	60.0%	100.0%
Sarcomas							100.0%	100.0%	100.0%	33.3%		80.0%
Skin	75.1%	95.4%	97.1%	55.5%	70.2%	87.8%	83.5%	90.0%	80.6%	66.2%	69.8%	79.2%
Non site specific symptoms	72.7%	83.3%	96.8%	31.3%	31.3%	59.3%						
Testicular	100.0%	100.0%	100.0%	90.9%	90.9%	83.3%				100.0%	100.0%	
Upper GI	97.7%	98.9%	98.5%	82.9%	87.0%	90.1%	98.4%	98.3%	95.9%	78.7%	86.0%	84.7%
Urological	93.9%	96.4%	92.0%	46.0%	54.2%	44.6%	88.8%	90.9%	89.0%	49.7%	46.3%	40.9%
Trust Total	89.8%	97.2%	96.4%	69.0%	79.5%	81.4%	93.2%	93.8%	92.5%	67.1%	67.4%	69.1%

Diagnostics: Performance Trend



Commentary:
The M12 aggregate diagnostic performance is 17.51% breach performance which is a 3.71% deterioration on the previous month. The total waiting list has increased in month, from 13,292 in February to 14,469 in March. The deterioration of three specialties has contributed 66% of all DM01 breaches in month; MRI, ECHO and Cystoscopy.

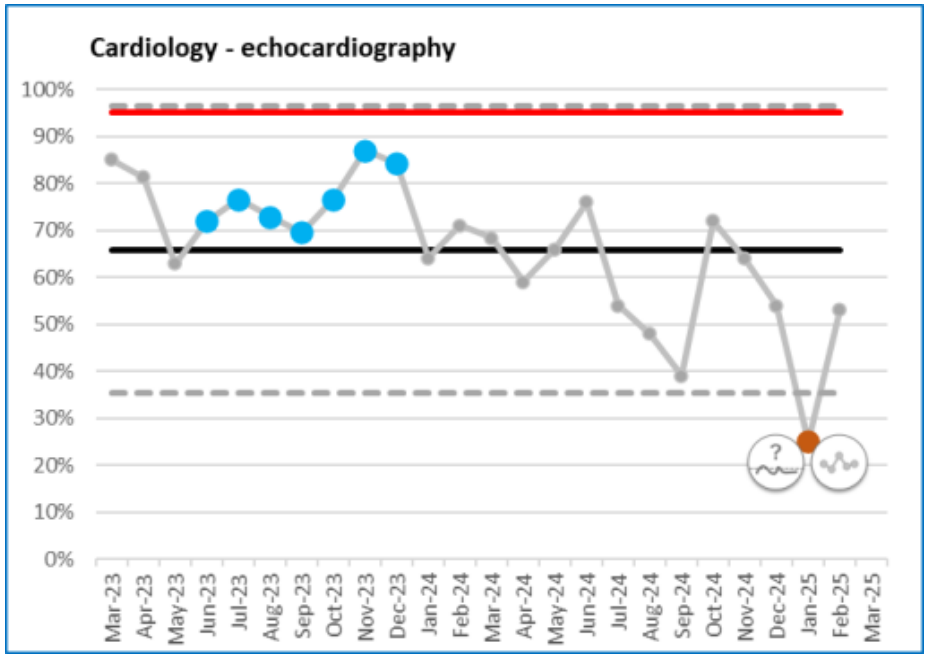
Planned Actions:
The two most challenged specialties remain Neurophysiology and ECHO. MRI has deteriorated by 11.76% in March to 17.09%; rolling average is 2.83%. 469 patients were unable to be dated in month.

Neurophysiology has seen an improvement (4.64%) in month, which an improvement for two months consecutively. Cardiac ECHO has deteriorated by 5.03% which is in keeping with performance trends of massive improvements followed by a month of deterioration.

Expected recovery:
ECHO performance continues to fluctuate in delivery and current recovery actions are difficult to definitively align with either reductions or improvements in performance. Neurophysiology will continue to fluctuate until vacancies are permanently recruited into.

Diagnostics: Echocardiography

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)

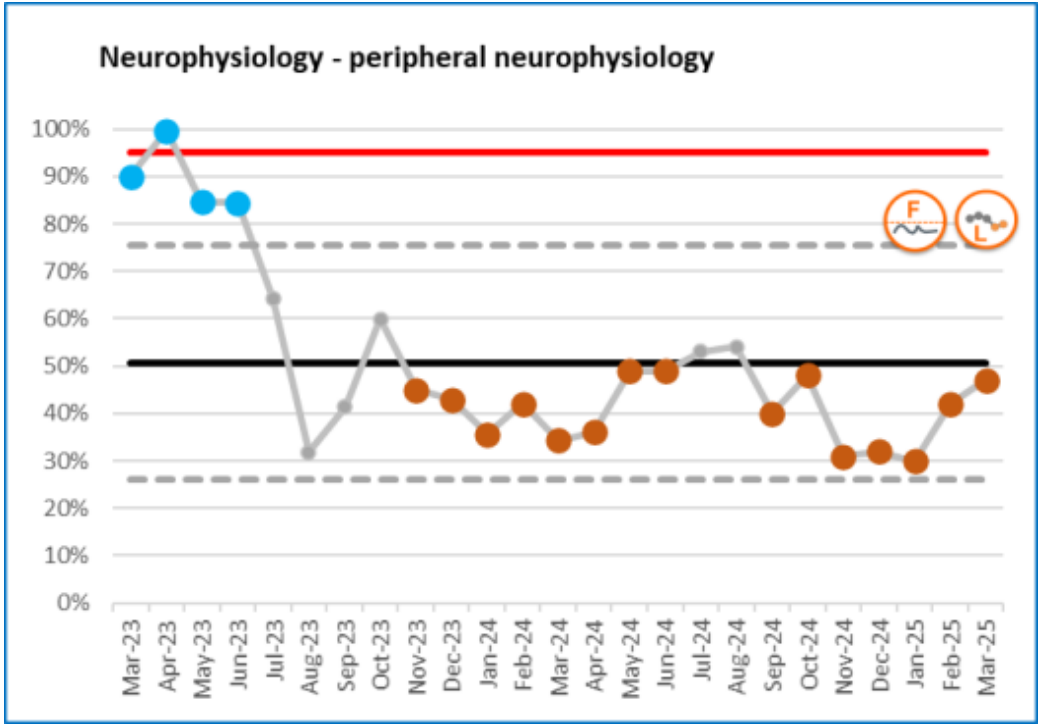


Commentary:
Workforce challenges continue and demands for the service is outstripping available capacity. Demands from inpatient referrals, the community and other services [POAC, Oncology] have a significant impact on delivering the needed activity.
With the removal of the Locum activity at the CDC DMO1 breaches are likely to increase further. The prioritisation of IP activity has impacted the DMO1 recovery plan. NHSE visited on 21st February 2025, formal report is pending.

Planned Actions:
ISCV – dedicated reporting system for the physiology and clinical team. Will support with improving the reporting speed for the physiologists. Launch date of February 2025 has been delayed due to IT issues.
ECHO SUPPORT WORKER– Interview date for 1st week of April. Benchmarking identifies the success of the role in other Trusts.
OPEN ACCESS SERVICE FOR GP's – talks have re-started. At present the service is unable to provide this option due to multifactorial issues. Benchmarking against other Trusts in relation to the value of this service is being undertaken by the service and ICB colleagues. A full understanding of the impact to the service with an open access option needs to be assessed along with roles and responsibilities of both Primary care and the service.
PERFORMANCE – RTT & Performance Manager started in Feb 2025. The post will provide support to the validating of the DMO1 waiting list.
RECRUITMENT
Additional substantive staff have been recruited into staffing gaps. 1 x WTE B7 remains outstanding.
LOCUM SUPPORT
Continuation of locum support is pending approval at TLT. With continued locum support the Open Access pathway could potentially be delivered, reduction in DMO1 and increased activity at the CDC

Diagnostics: Neurophysiology

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)



Commentary:
Improved performance this month with additional capacity provided within the service. This is following a large drop in performance due to the correction of a data issue where a cohort of patients were not being reported on the DM01 breach report (they were still on the WL).

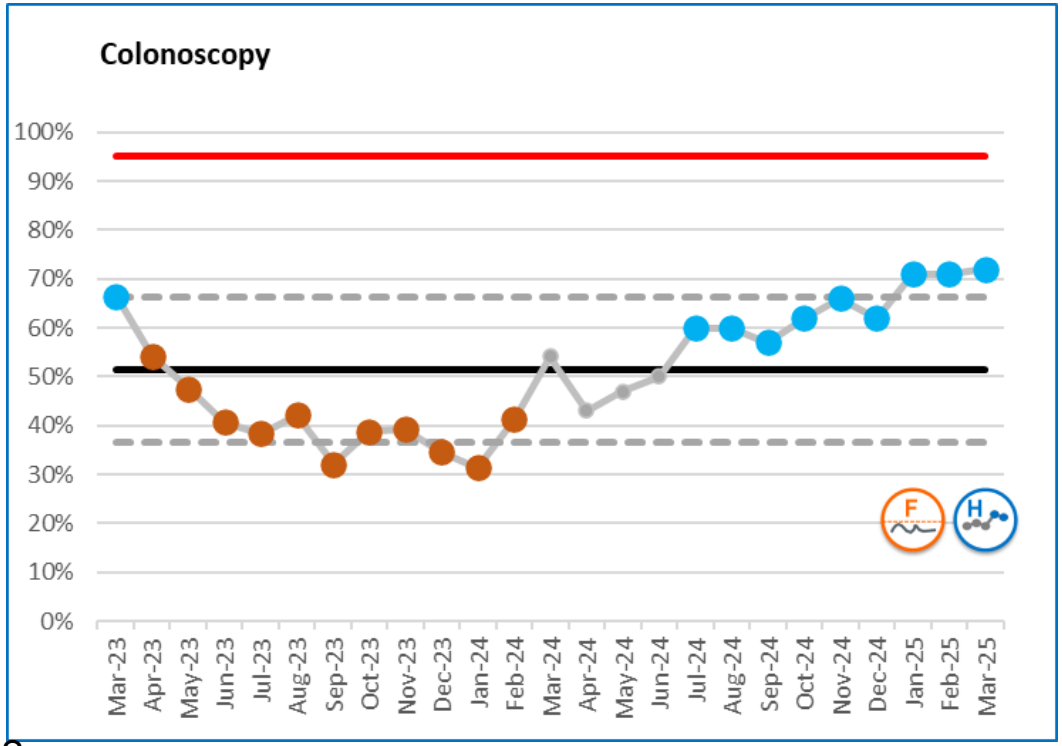
Planned Actions:

- Increase in hours of one B7
- New GP referral form live and embedded
- Aim to develop education programme for GP's and trainees
- Full validation of list now taking place.
- Additional capacity being provided at weekends and evening
- Support from IT to enable remote reporting solution that will increase capacity.

Expected recovery:
Additional 50 tests being provided on average per month against referrals. (More capacity being provided in March using ERF funds) Current waitlist 648 with 430 unbooked.

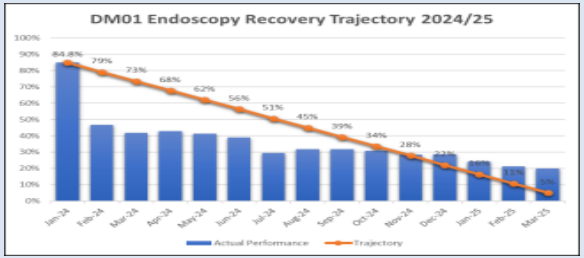
Diagnostics: Colonoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



Commentary:
Colonoscopy DM01 performance saw a slight improvement in March with 28% against the 29% in February.

The service is performing well DM01 overall with 20% in March compared to 21.03% in February, however it remains over the recovery trajectory. Overall improved performance since January has been possible by utilising additional enhanced weekend lists which have now ended.

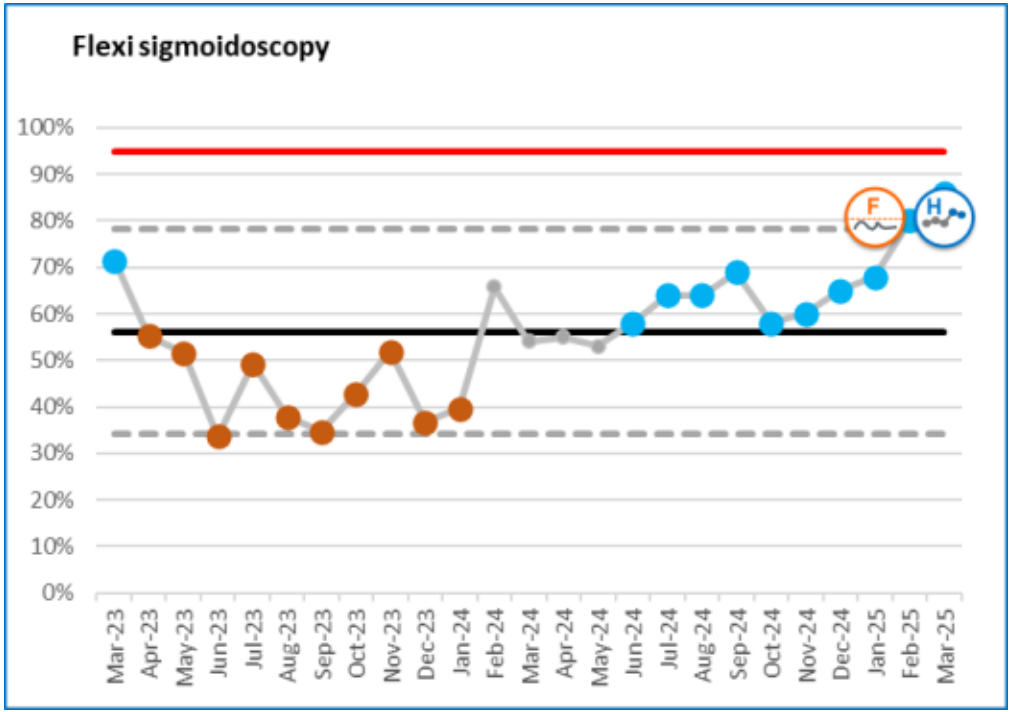


Planned Actions:
-Start scoping 6 day working and consultant recruitment if Business Case is approved
-Backfilling of lists by Clinical Endoscopists.
-Deliver on the Endoscopy Recovery and Improvement Programme Plan

Expected recovery Risk:
Expected DM01 and surveillance recovery is at risk due to the ending of locum ERF scheme at the end of March who has focussed on 2WW/STT. The service will continue with cancer focus but this will come at the detriment of DM01 and surveillance performance.

Diagnostics: Flexi Sigmoidoscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*



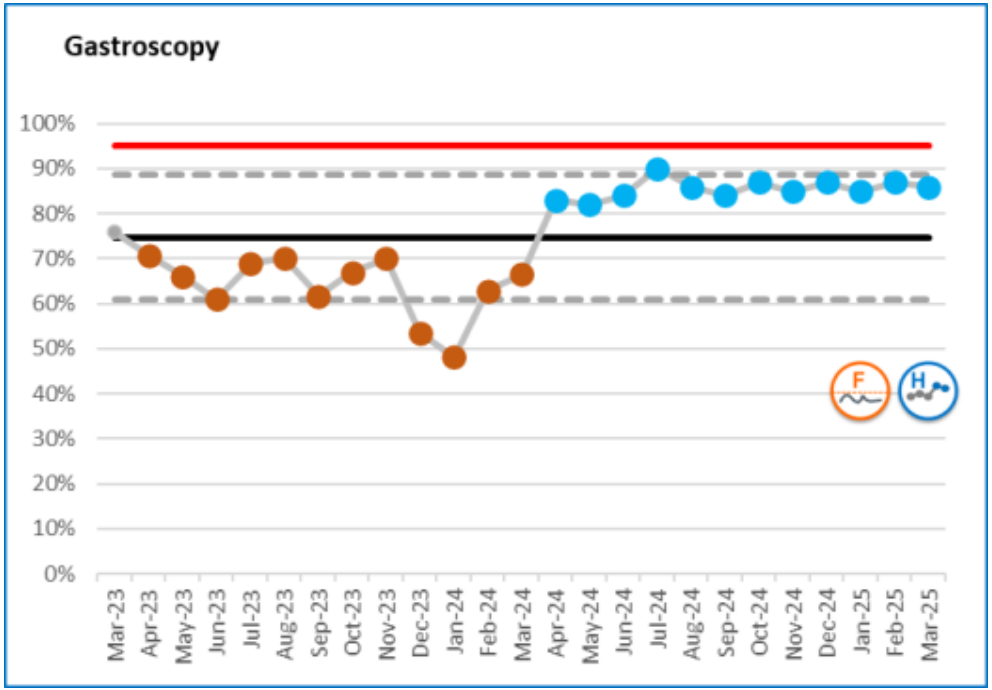
Commentary:
Flexi Sig DM01 performance improved significantly in March with 14% against the 20% in February. This has been enabled by the enhanced weekend lists.

Planned Actions:
-Start scoping 6 day working and consultant recruitment if Business Case is approved
-Backfilling of lists by Clinical Endoscopists.
-Deliver on the Endoscopy Recovery and Improvement Programme Plan

Expected recovery Risk:
Expected DM01 and surveillance recovery is at risk due to the ending of locum ERF scheme at the end of March who has focussed on 2WW/STT. The service will continue with cancer focus but this will come at the detriment of DM01 and surveillance performance

Diagnostics: Gastroscopy

(Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)*

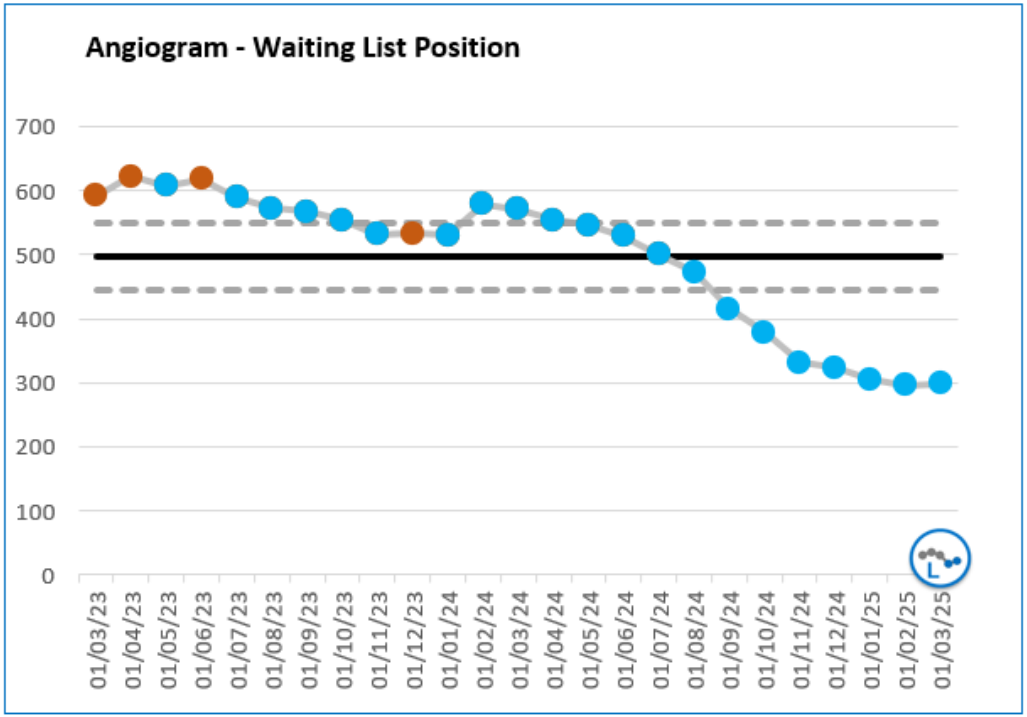


Commentary:
Gastroscopy DM01 performance declined slightly in March with 14% against the 13% in February This has been due to overall capacity.

Planned Actions:
-Start scoping 6 day working and consultant recruitment if Business Case is approved
-Backfilling of lists by Clinical Endoscopists.
-Deliver on the Endoscopy Recovery and Improvement Programme Plan

Expected recovery Risk:
Expected DM01 and surveillance recovery is at risk due to the ending of locum ERF scheme at the end of March who has focussed on 2WW/STT. The service will continue with cancer focus but this will come at the detriment of DM01 and surveillance performance

Angiogram - Waiting List Position



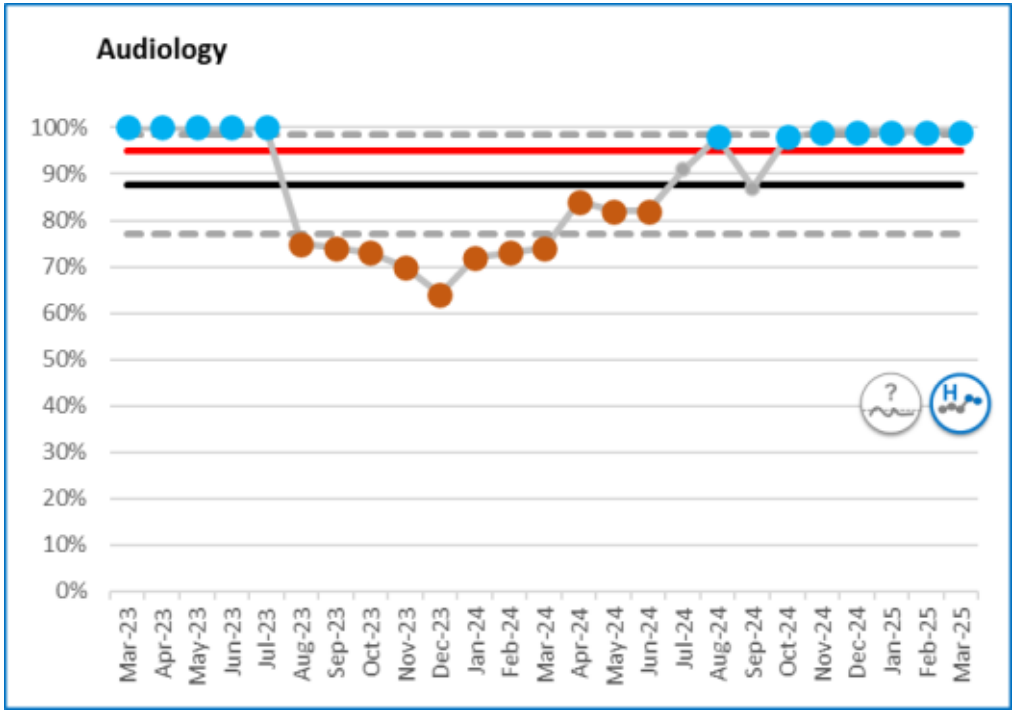
COMMENTRY:
Angiogram waitlist reduction is plateauing as weekend additional lists have reduced. The waitlist is now under 300patients. Cath lab 3 is now fully operational and being utilised when staff available.
Limitations with staffing are from physiology and radiology.

PLANNED ACTIONS:

Funding from HRI business case is £529k which covers pay cost of running 3rd cath lab. The service line are planning how to best utilise cath lab with no non-pay budget

Diagnostics: Audiology

(Standard: *Increase the percentage of patients that receive a diagnostic* test within six weeks in line with the March 2025 ambition of 95%)



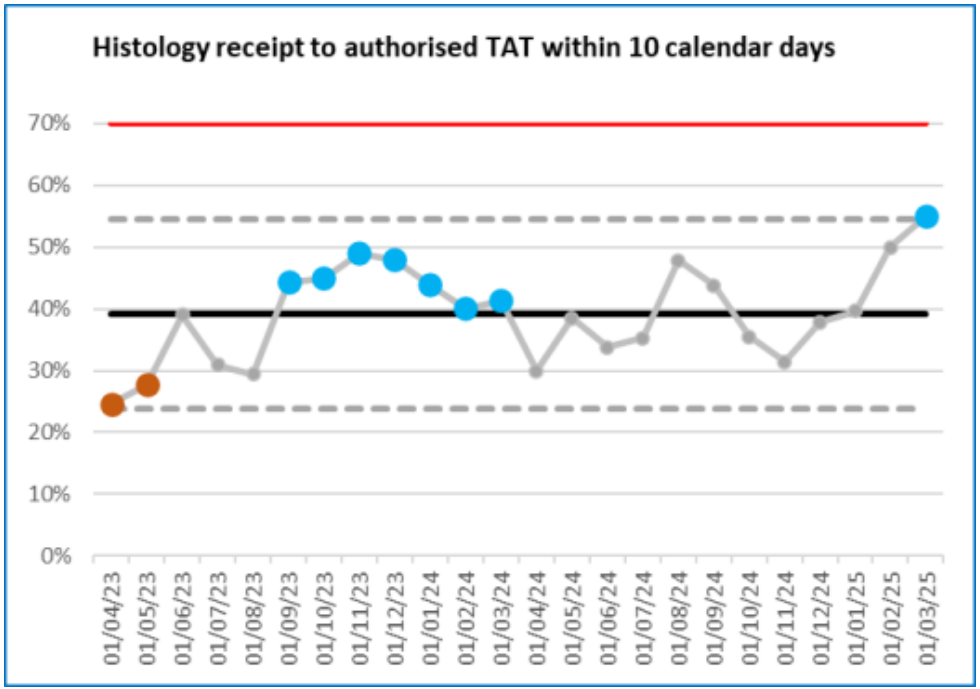
Commentary:
The Change in DM01 Reporting definitions commenced in August 2023 which affected historic 100% performance. DM01 compliant reporting has now been fully applied and reflected.

The service is now demonstrating DM01 compliance since August 2024. The position deteriorated slightly in September due to Audiology delivering an additional 1,000 appointments from Aug-Sept 24 to support ENT 65-week recovery. This has now improved and compliance has been maintained for the last four months.

Planned Actions:
Additional audiology activity continues to DM01 compliance in conjunction with supporting ENT recovery.

Diagnostics: Histopathology 10-day reporting

Standard: Delivering 70% turnaround times

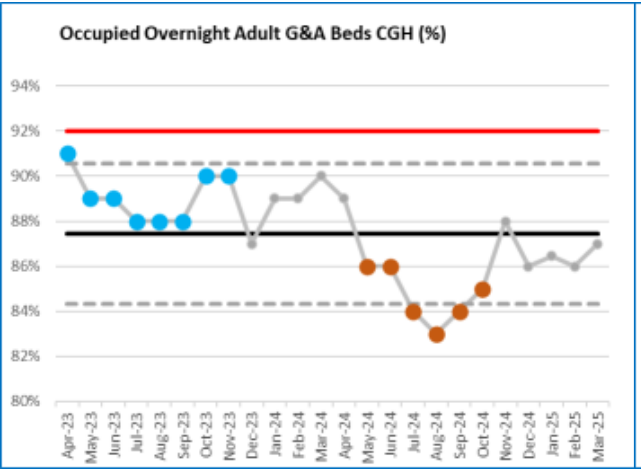


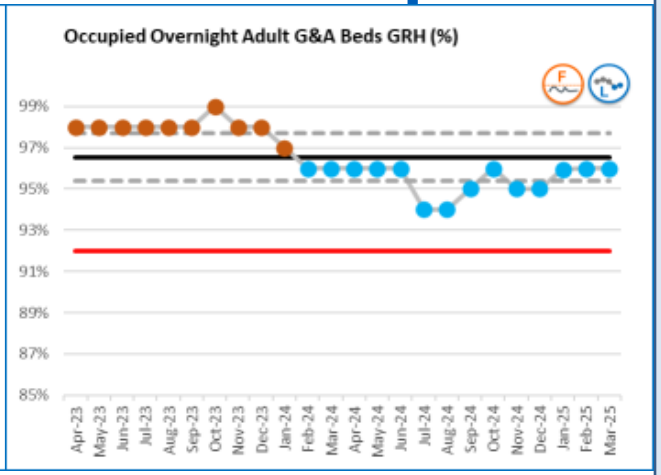
Commentary:
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. There are currently three vacancies within the consultant body. The department has old, end of life equipment which is becoming increasingly unreliable causing delays in processing. The Department is reliant on outsourcing and locum reporting to cover the consultant vacancies. There is a focus on ensuring that specimens contributing to Cancer diagnostics are prioritised.

Planned Actions:
Consultant vacancies are currently out to advert. A short term locum is in place and reporting capacity is being augmented with in-sourcing and out-sourcing. The use of digital outsourcing is being progressed. A procurement for a managed equipment service is underway

Expected recovery:
The use of digital outsourcing and AI will help with improving reporting times and provide capacity and these should be available within this financial year

General & Acute Beds: Occupied



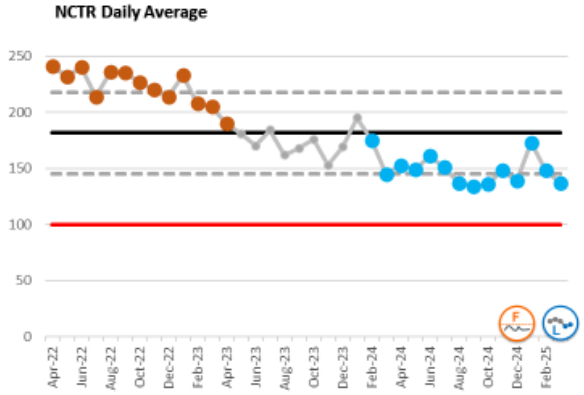


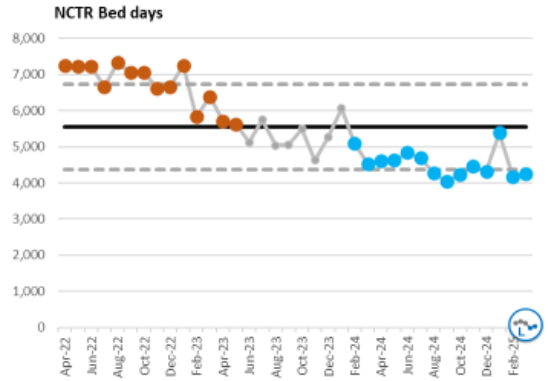
Commentary:
Average bed occupancy has been static over the past month linked to ongoing increased demand and acuity leading to higher conversion to admissions. Main driver of lower occupancy comparatively to the region remains the orthopaedic beds in CGH. Planned changes delayed until the end of April.

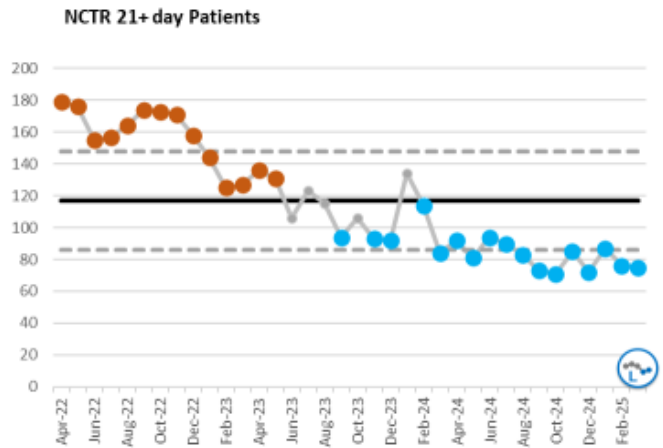
Planned Actions:
Continued pressure to reduce the nCTR numbers will assist in the recovery. Reconfiguration of elective orthopaedic beds will also increase our occupancy as the day case beds are removed from the over bed stock. Further work being undertaken to understand bed stock needs and how they have changed since the SSD work, this is to help consider decant capacity to support essential upgrades to our estate as well as consider the current mix of beds in terms of demand vs capacity.

Expected recovery:
IPC restrictions ongoing but expected to improve throughout April. This will support RCRP and further help reduce LOS.

General & Acute Beds Occupied with NCTR







Commentary:

Generally national language now moved to Discharge Ready Date (DRD) for the number of patients affected with nCTR being the reason for not having been discharged.

DRD numbers have plateaued with a small increase in March linked to delays with discharges through P2. P1 pathway turnover has sustained improvement, but with work internally to drive P1 decisions over P2, the numbers waiting at any 1 time have also seen an increase. The overall DRDs days lost is significantly higher in P2 and P3, although the improved reduction in P1 delay has helped sustain a reduced 21+ day delay picture.

ICS conversations around planning for 25/26 have agreed 87 as the target for DRD numbers, along with an overall reduction of bed days lost towards the national average of 5.7 days post DRD.

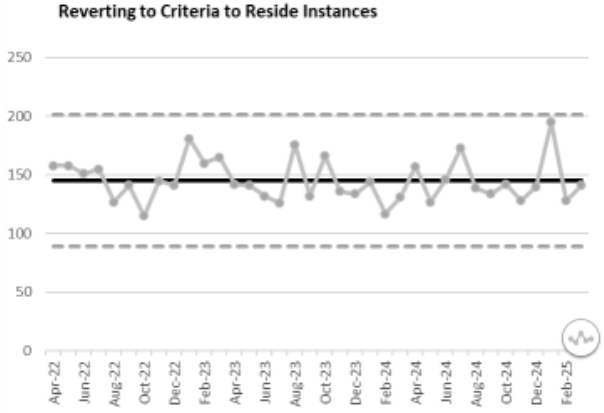
Planned Actions:

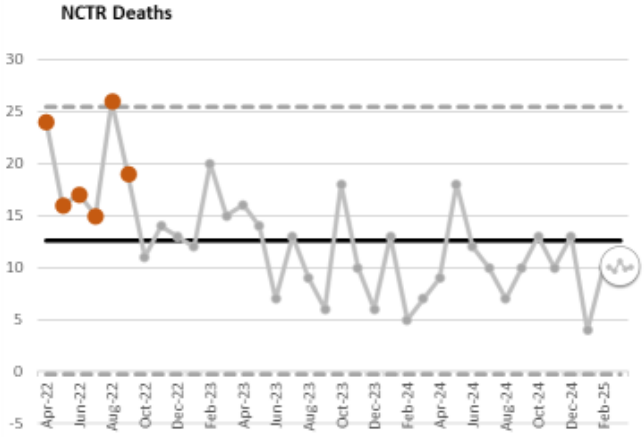
Internal plans around deconditioning and focus on pre DRD referrals and P1 should help reduce overall LOS and LOS post DRD. Pressure placed on our partners to improve the capacity and timeliness of transfers both to P1 and P2 pathways linked to an improved LOS within those pathways.

Expected recovery:

Expected reduction in DRD back to 87 with direct link to timelines required to support estate upgrades and maintenance.

Delay Related Harm NCTR





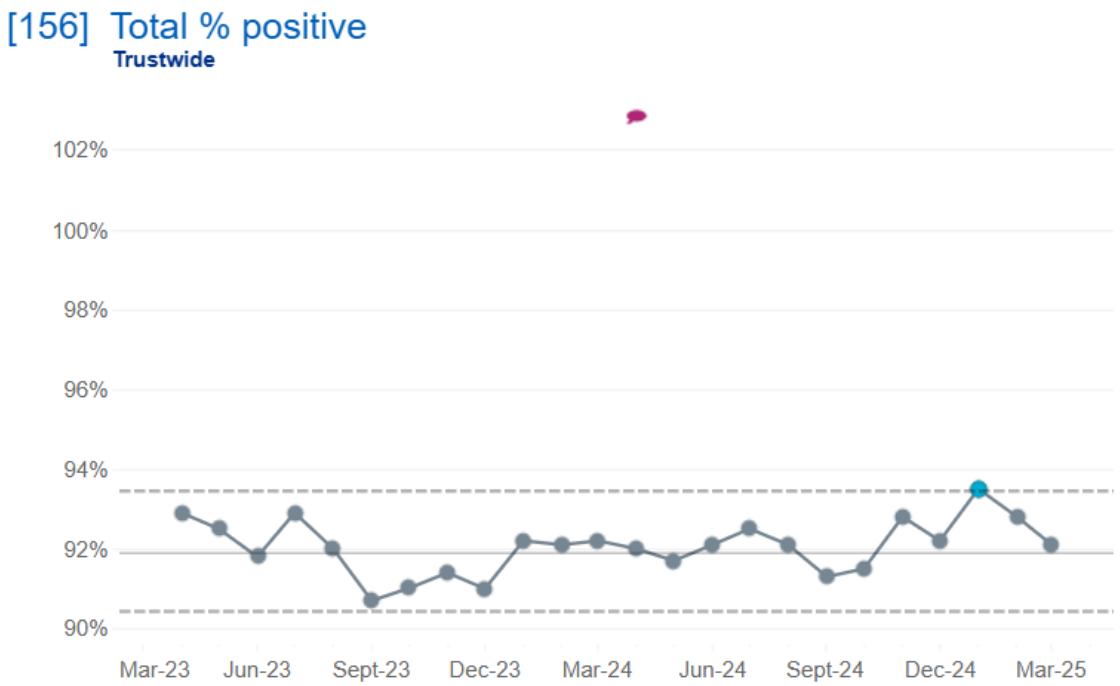
Commentary:
Ongoing occurrences of both patients deteriorating and passing away whilst nCTR. IPC outbreak towards the end of the month did have an impact, with several patients becoming unwell due to active norovirus. Overall, both deteriorations and deaths remain below the average since we started recording in 2022, with deaths still showing an overall downward trend.

Planned Actions:
Linked and picked up as part of the system planning and objectives for 25/26, focus on bringing post DRD bed days lost in line with national average should significantly contribute to both of these measures. Ask for further targeted work around palliative/ EOL patients waiting for onward care through optimisation of the CHC process and timeliness of access to either hospice space or POCs.

Expected recovery:
Hard to predict numbers, but expected reduction in DRD numbers and median wait likely to see a continued reduction in DRH.

Quality & Safety Metrics

Quality of Care: FFT Positive Response



Commentary:
The overall Friends and Family Test (FFT) score has decreased slightly from 92.8% in February to 92.1% for March. This is as a result of a decrease in score for all care types.

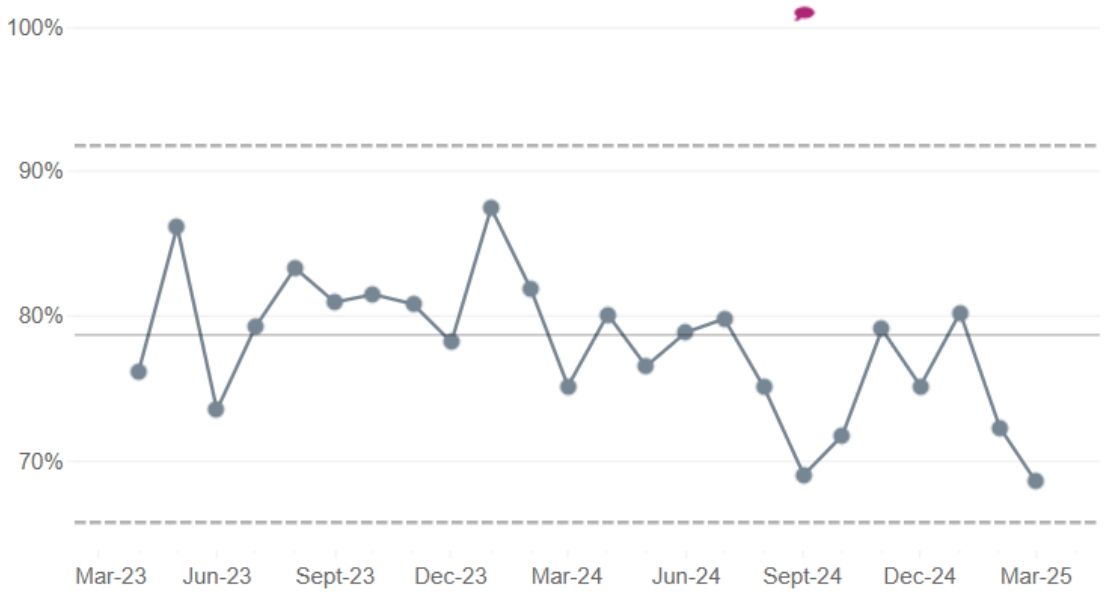
Planned Actions:
To understand how our Trust was working during this month in order for us to look to continue this practice. For divisions to review their data including comments and identify learning and improvement opportunities. We are also planning to increase the fatigue period set between surveys being sent to patients following feedback in some areas from 30 to 60 days.

Expected recovery:
We would hope to see our scores to continue to maintain at the average.

PALS

[569] % of PALS concerns closed in 5 days

Trustwide



Commentary:
The PALS team have seen a slight decrease in concerns closed in 5 working days at 68% which is below the target of 75%. The team have worked hard to close cases more quickly and have been trialling a revised way of triaging cases. Following a deep dive of PALS cases it is also noted that the number of cases received is outpacing the closure due to carry over from each month. It is to be noted that these figures are subject to change following quality checks.

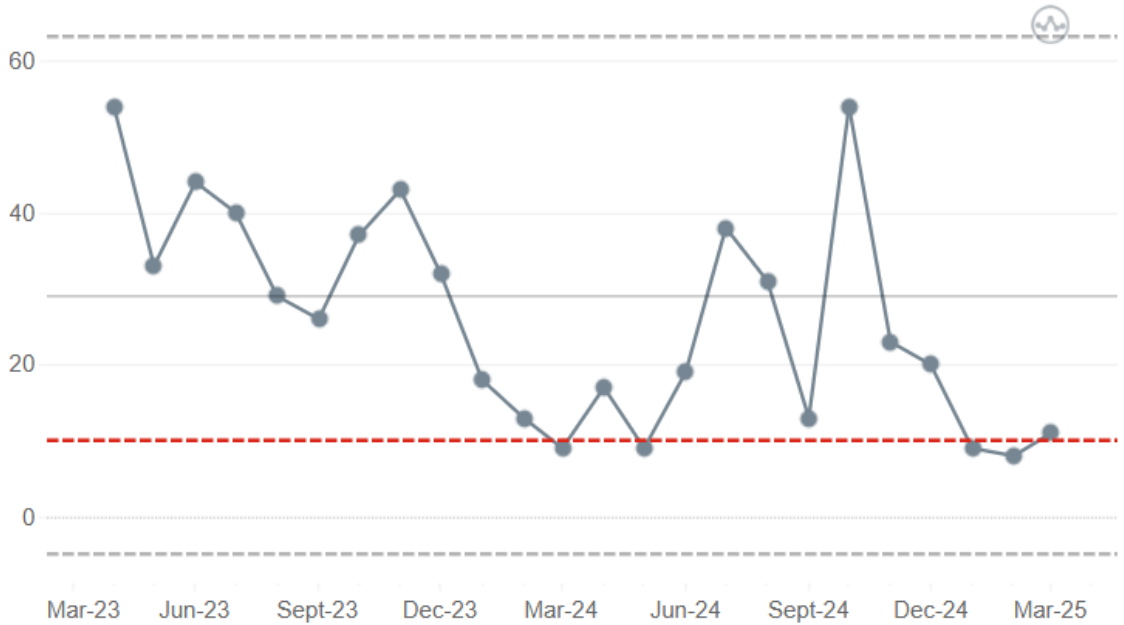
Planned Actions:
PALS team continue to provide a responsive service through email and phone but have suspended their drop in offer in order to manage the workload. An additional PALS advisor post has been recruited to the team and started in March. Deep dive into PALS was taken to QDG in March and went to QPC in March . A review of KPI's in light of deep dive. A review of workload distribution and triaging underway to support staff and improve experiences of patients.

Expected recovery:
Expecting to see improved picture by end of April.

Patient Care: Mixed Sex Breaches

[148] Number of breaches of mixed sex accommodation

Trustwide

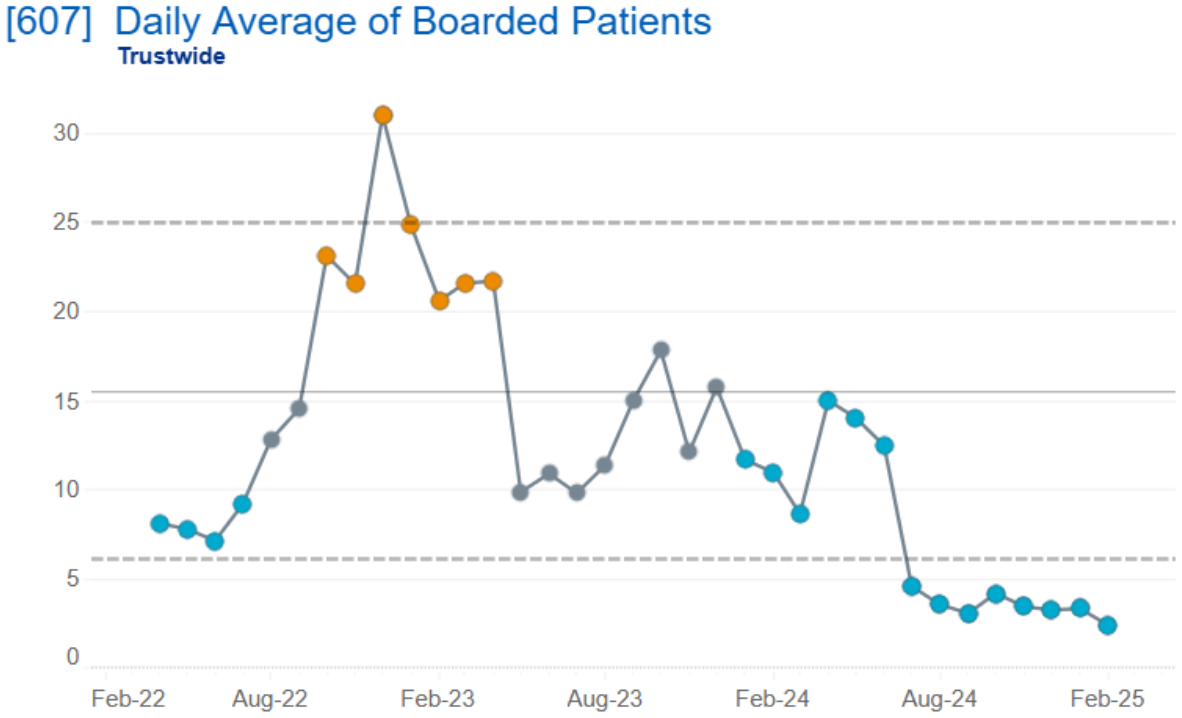


Commentary:
The most recent 3-monhtly periods have been in line with expected performance. Breaches remain minimal and only when no other option is available. Breaches link directly to challenges in flow towards the end of the month, this includes when patients need to transfer out of areas like Critical Care where if not completed within 4 hours a breach is recorded.

Planned Actions:
there is a very low tolerance of breaches, these are discussed on the site call each day if they occur.

Expected recovery:
Expected to remain within limits of expected performance.

Patient Care: Boarded Patients

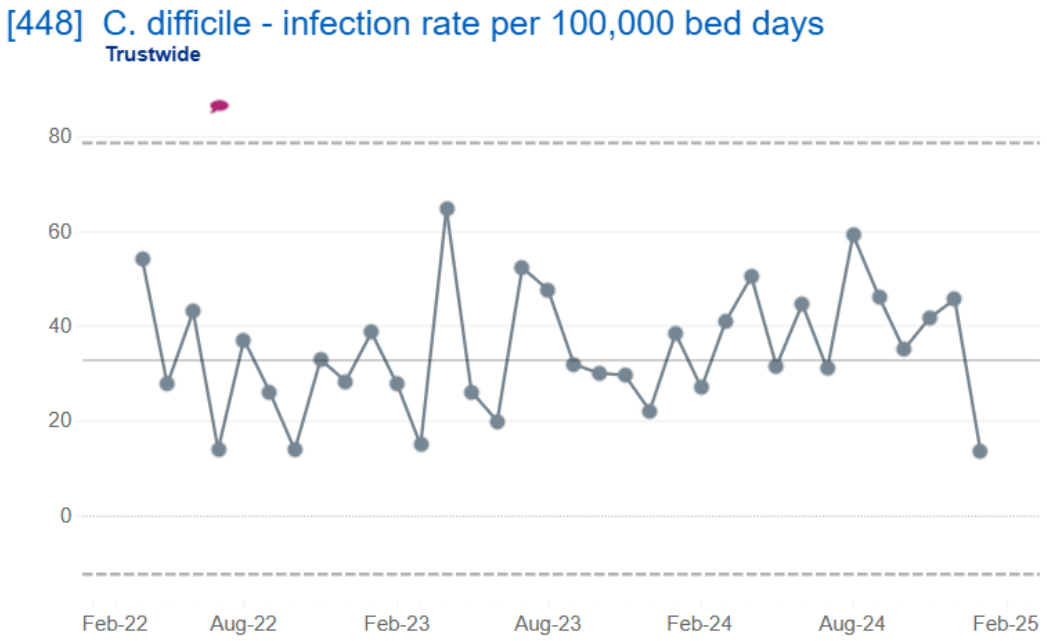


Commentary:
The Trust has not yet had to activate the Plus One Protocol. Despite this patients are regularly waiting in the corridor of AMU at night and occasionally in ED when offloaded by ambulance crews.

Planned Actions:
The Medicine Division are to work up a plan to manage acute medical patients that arrive on AU out of hours, this includes from cinapsis and SDEC.

Expected recovery:
Sustained non-use of corridors to provide care, outside of critical incidents, inline with the revised escalation policy and OPEL framework.

Infection Control: *C. difficile*



Commentary:

The annual CDI threshold for 2024/25 set by NHS England was 104 cases. For 2024-25 we have had **104 trust** apportioned cases of *C. difficile a*nd therefore we have met the nationally set threshold. Nationally and across the South-West region there has been an increase in the number of *C. difficile* cases.

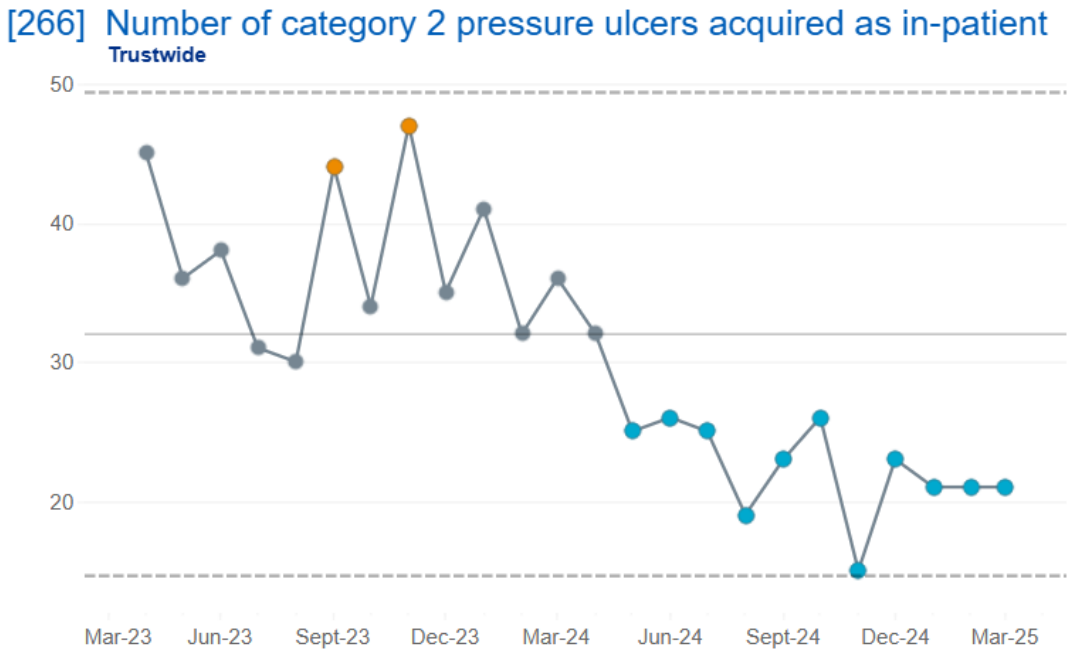
Planned Actions:

The Trust *C. difficile* reduction plan for 2024/2025 focuses on actions to address cleaning; equipment and environment (delivery of National standards of Cleanliness), antimicrobial stewardship, timeliness of stool sampling, prompt isolation of patients and optimising management of patients with *C. difficile.* We have now rolled out enhanced pods across the Trust. Activity against this reduction plan is monitored by the Infection Control Committee. The Trust also chairs and supports a system wide *C. difficile* infection improvement group (CDIIG) which delivers system wide CDI actions to prevent CDI infections and recurrences for all patients across Gloucestershire. This activity is reported and monitored by the ICS IPC and ICS AMS groups which reports to the ICS Infection Prevention Management Group. The Trust also support work in the regional Southwest CDI collaborative led by NHSE. Our deep dive into patients with recurrence of CDI and their care across the system continues. This will support implementation of focused interventions for this risk group including possible increased use of Fidaxomicin.

Expected recovery:

We aim to continue to reduce the burden of CDI on our patients, we are awaiting our new target for 2025/26.

Safety Priority: Pressure Ulcers Cat 2



Commentary:
The Trust has sustained a reduction in Category 2 pressure ulcers for a year now. The challenge going forward is to further reduce the burden.

Planned Actions:
Improvement focus is on specialist review of all hospital acquired category 2 pressure ulcers and above. Specialist equipment for prevention of pressure ulcers has been procured and is available in the equipment library in both hospitals.
The Tissue Viability Team are investigating the significant reduction to provide assurance that this is not a reporting issue.

Expected recovery:
Implementing lessons learned can contribute to the downward trajectory of factors within our control

Safety Priority: Pressure Ulcers Cat 3

Commentary:
These serious pressure ulcers have remained a challenge for the Trust, whilst numbers appear low with an average of 1.25 per month over the previous 12 months our ambition is to have zero cases.

Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of repositioning.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Exacerbated by more patients on a ward than the staffing model accommodates, or gaps in staffing.

Planned Actions:
Improvement focus is on specialist review of all hospital acquired category 3 pressure ulcers. Specialist equipment for prevention of pressure ulcers has been procured by individual wards. The Tissue Viability Team deliver comprehensive simulated training in the prevention of pressure ulcers monthly at a variety of locations.

Expected recovery:
Implementing lessons learned can contribute to the downward trajectory of factors within our control

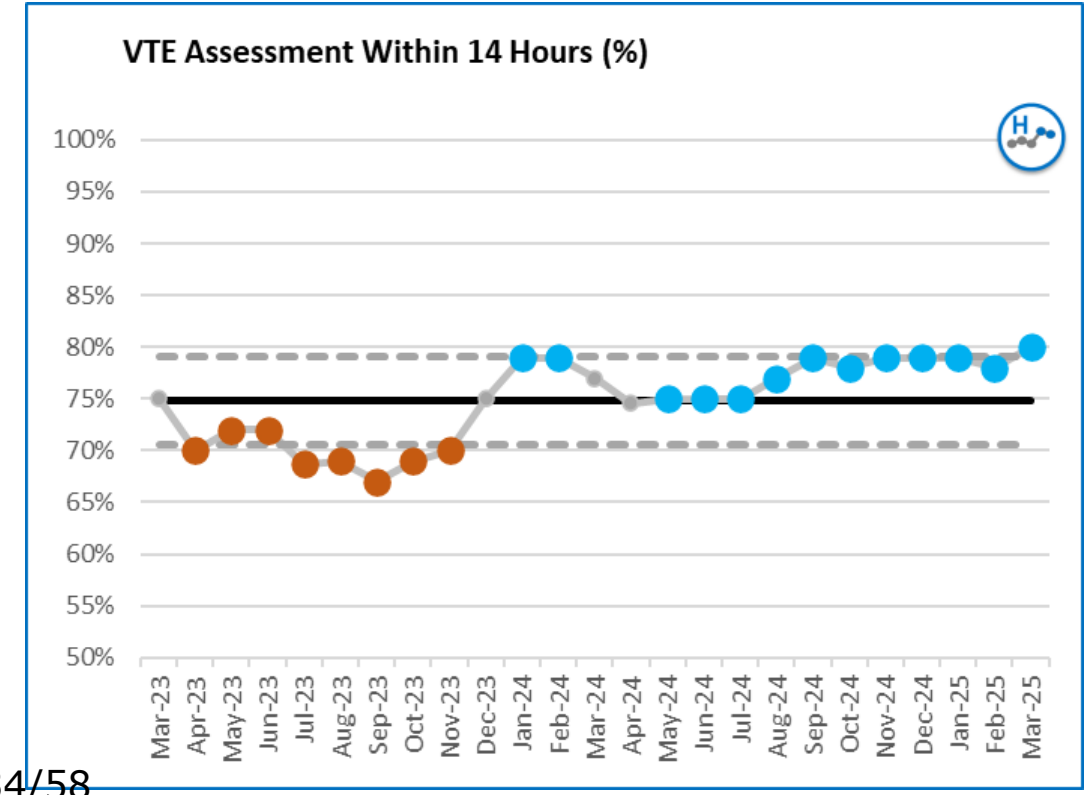
Safety Priority: Patient Falls

Commentary:
The previous 9 reporting periods have demonstrated a period of control in the rate of falls, (note the y axis scale causing a saw-tooth effect in the data). However, the rate remains higher than before the Trust increased controls on the use of enhanced care HCSWs on our wards.

Planned Actions:
A comprehensive training package has been launched by the Falls Team and is being very well attended, this is a key focus for us.
Falls Quality Summit held. Quality Improvement programmes launched in Datix development, Hot Debriefs post falls and Electronic Patient Record Development.

Expected recovery:
The rate of falls we are aiming for is 10% lower.

Patient VTE Risk Assessment Within 14 Hours



Reviewed at VTE Committee on 9/04/25

Data:

- VTE Dashboard has replaced all other data used in the Trust. Confirmed data feeds in to IPR. New metrics agreed.
- Maternity data still managed separately as link to Badgernet in progress

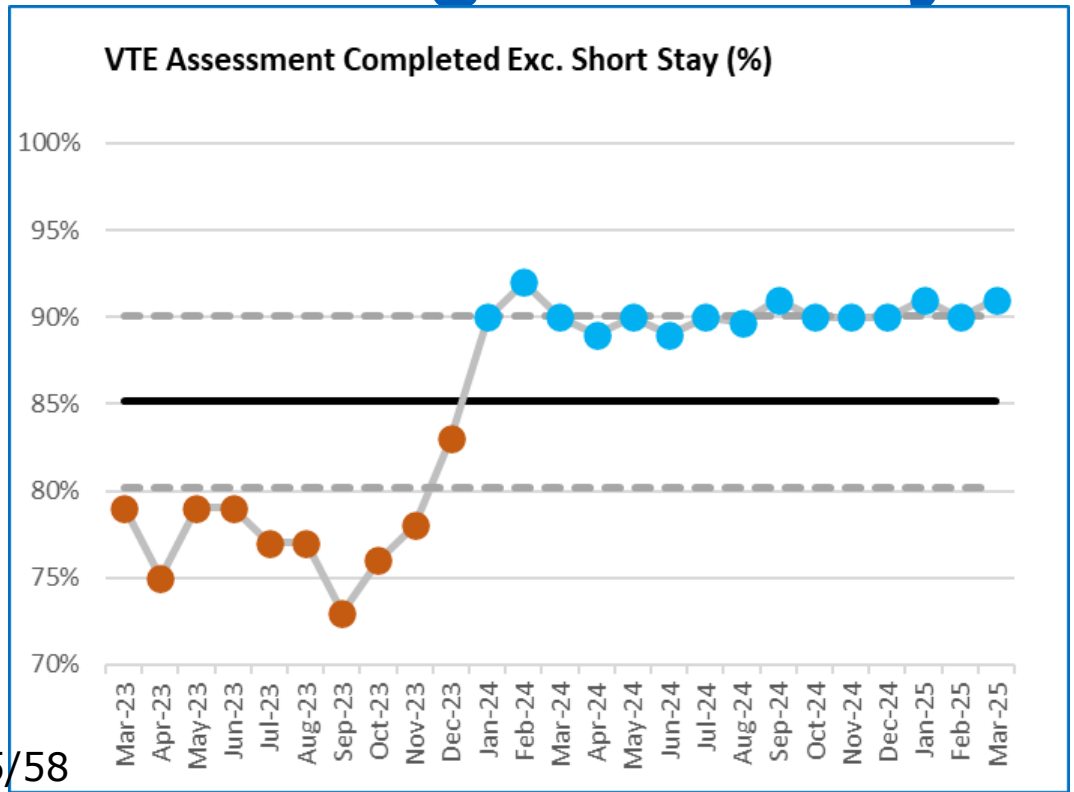
Trust:

- Mandated VTE Assessment in EPR now live
- Data shows significant improvement is assessment within 14 hours – now over 90%

Maternity:

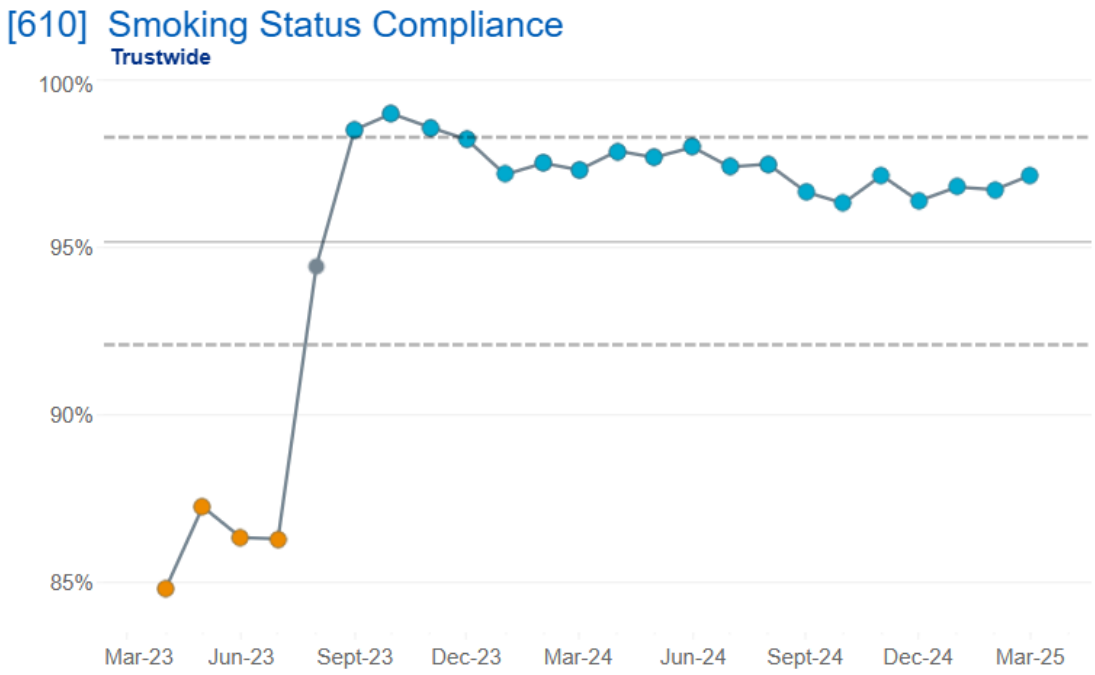
- Aligned targets to the rest of the Trust
- Achieving 100% assessment within 14 hrs (from 60%)
- Focus is now on prescribing of LMWH
- Reporting bi-weekly via CQC/QIG process

Patient VTE Risk Assessment Excluding Short Stay



As previous slide

Patient Smoking Cessation

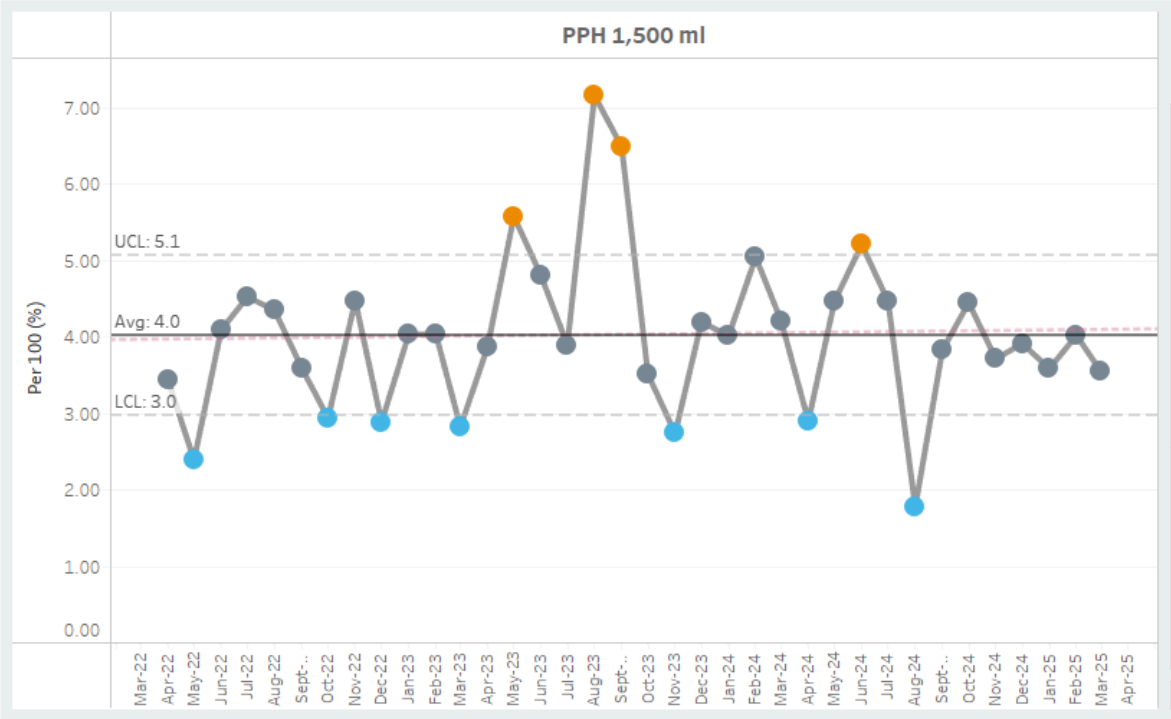


Commentary:
All patients admitted to hospital should be asked about their smoking status by the clinical and admitting teams; this should be recorded on their clinical notes and referred to the Tobacco Free Team.
Smoking should be treated like any other addiction, patients should be offered NRT upon admission.

Planned Actions:
Trust wide communications reminder to record smoking status.
Tobacco Treatment Advisors providing interventions on the ward.
VBA sessions to commenced on wards including paediatrics.

Expected recovery:
The tobacco free team will continue to deliver interventions on the wards.

Maternity Care: Postpartum Haemorrhage >= 1,500 ml



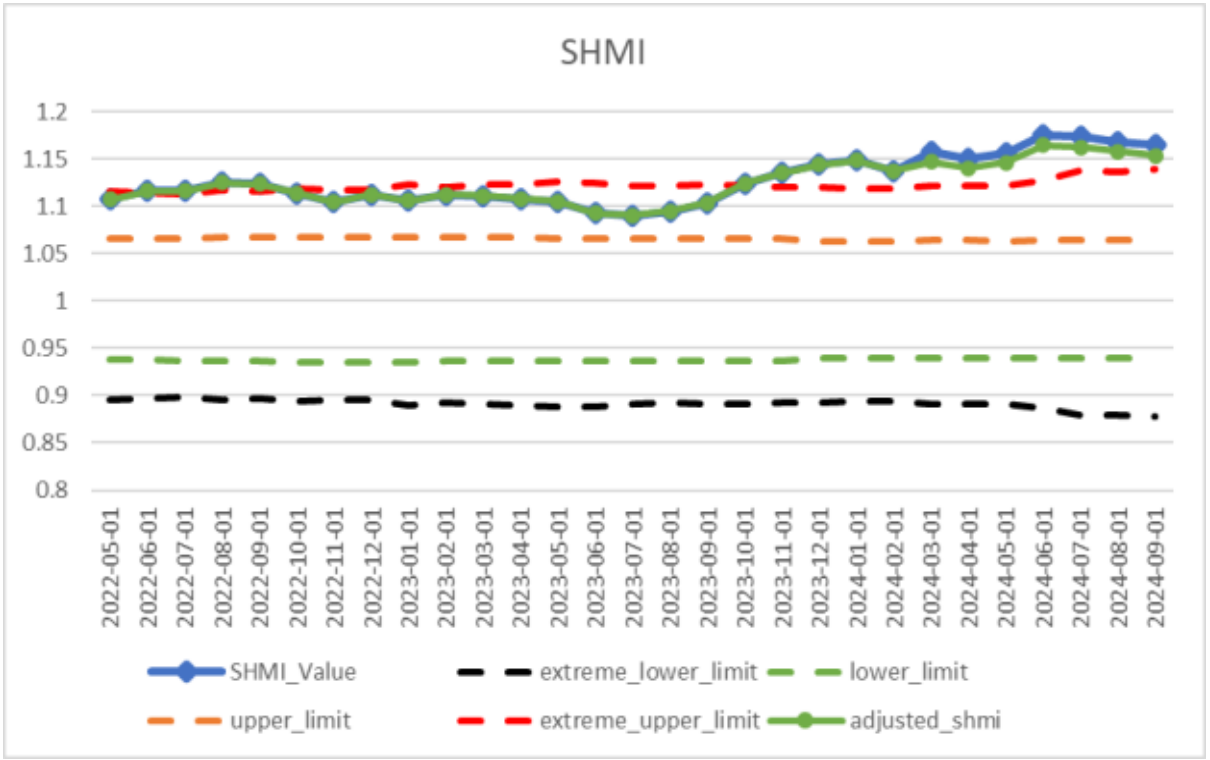
Commentary:
Detection and escalation of maternal and fetal deterioration is one of the areas of improvement for the Trust and this has been identified as one of the Trust Safety **Priorities.** Overall Massive Obstetric Haemorrhage (MOH) rates have decreased. We have a **CQC S31 enforcement notice** that requires us to enable improvement for the management of haemorrhage.

The MOH/PPH improvement team analyse safety incidents on a weekly basis and continue to target their improvement actions using the SEIPS analysis. Key actions have been on the commencement of Carbetocin for all C/S and the implementation of a REDUCE proforma for risk assessment and management plan. Audits of the REDUCE proforma continue to identify areas of focus.

Planned Actions: The next steps are that the QI team are focusing the improvement work in the maternity theatres and also for women who have an instrumental delivery.

Expected recovery: The QI work continues with oversight reported to the **Maternity Delivery Group**.

Mortality – SHMI National Data



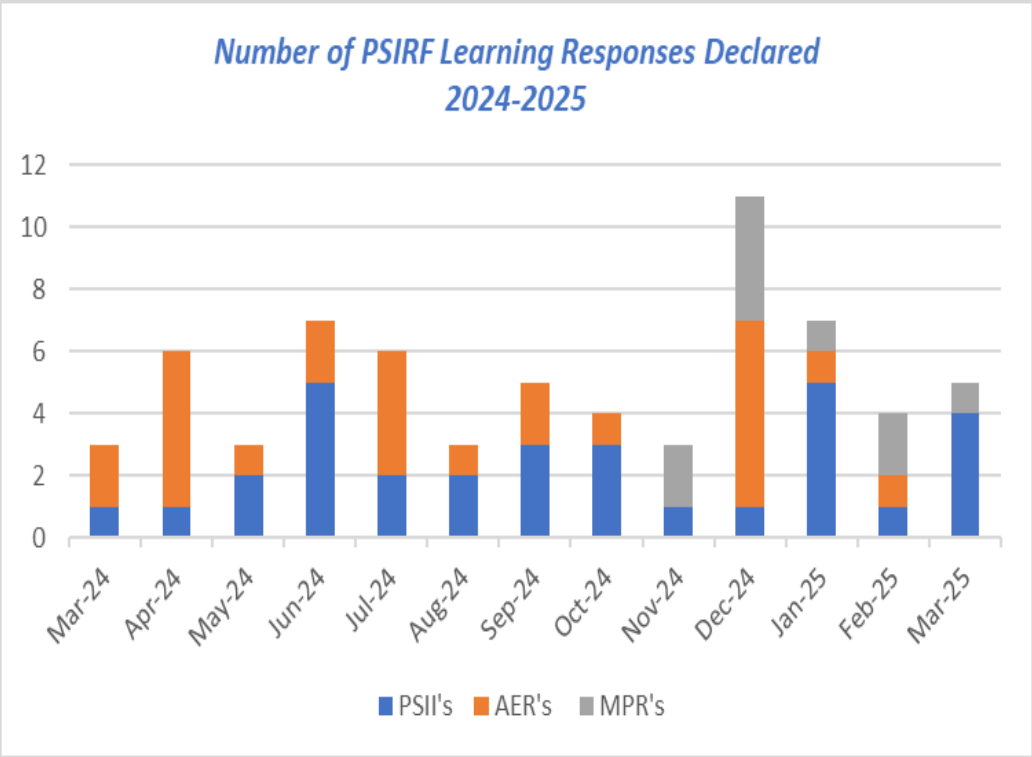
Commentary:
Latest SHMI (NHS Digital) = 1.15, continuing to fall

Actions:
Quality Improvement Group meeting monthly chaired by ICB CMO with Regional NHSE involvement:

- Primary Diagnosis/Charlson scoring significantly improved
- Correction of incorrect data upload (leading to fewer expected deaths for GHT, therefore increasing SHMI due to additional "R" codes)
- CGH increased SHMI relates to post discharge mortality from Oncology/Haematology/Frailty, and are expected deaths.

Expected recovery:
SHMI is predicted to be in the normal range in Q4 due to this improved data quality.

PSIRF Learning Responses



Commentary:

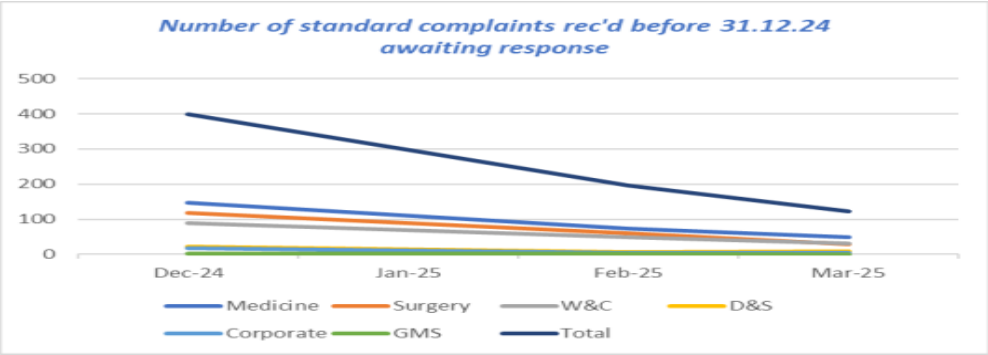
PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

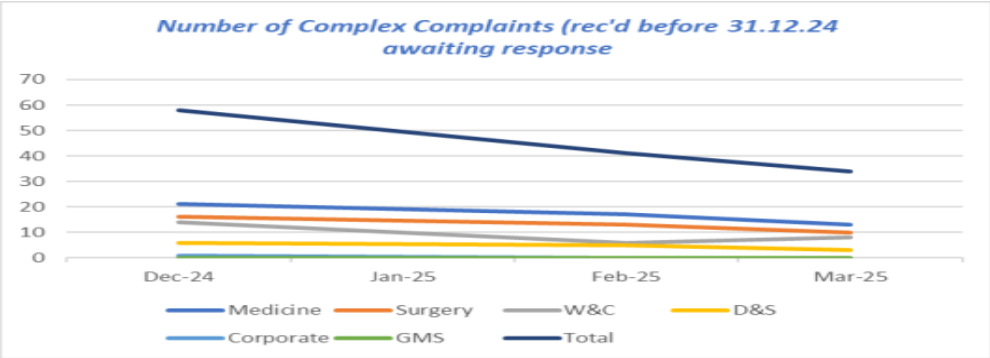
AER – After Event Review. Declared when there is a need for further information to inform action/learning to reduce the risk of recurrence

MPR – Multi Professional Review - Retrospective review of care by relevant specialists; documentation in a summary form

67 Patient Safety Incidents have required review through PSII, AER, or MPR since the Trust transitioned to PSIRF in March 24; an average of 5.1 per month.

Complaints Backlog Recovery





Commentary: The collaborative approach of the Complaint Department and Divisional leads in clearing the backlog of complaints, alongside implementation of the new Complaint Response Framework is firmly anticipated to become business as usual and will drive the sustained improvement required.

Actions:

- Piloting of new Framework began in April in D&S, Paeds and Gynae.
- Collaboration between the Complaint Department and Divisional Leadership teams in Medicine, Maternity and Surgery has significantly reduced the number of responses due (65% in backlog have had a response)
- Divisions assigned individual Complaint Managers
- Weekly meetings with MD and Complaint Dept

Expected recovery:

Initial target of 60% by June 2025, interim of 80% by September 25, increasing to 90% in January 26.

Use of Resources Metrics

Financial Metrics

	Metric		Month 9			Month 10			Month 11			Month 12		
			Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	Ytd £'000s	-4,906	-3,790	1,116	-2,428	-2,157	271	-2,342	-2,133	209	0	67	67
		Forecast £'000s	0	0	0	0	0	0	0	0	0	0	0	0
	Agency spend as % of pay		3.2%	2.7%	-0.5%	3.2%	2.6%	-0.6%	3.2%	2.6%	-0.6%	3.2%	2.5%	-0.7%
	FSP	Ytd £'000s	24,296	24,848	552	28,358	29,960	1,602	32,243	32,398	155	37,389	37,389	0
		Forecast £'000s	37,389	37,389	0	37,389	37,389	0	37,389	37,389	0	37,389	37,389	0
	Capital vs budget plan	Ytd £'000s	32,386	20,382	-12,004	38,033	23,129	-14,904	41,652	27,156	-14,496	45,972	43,458	-2,514
		Forecast £'000s	45,972	43,588	-2,384	45,972	43,588	-2,384	45,972	43,486	-2,486	45,972	43,458	-2,514
	Nos days operating cash		5	19	14	5	14	9	5	20	15	5	20	15
	BPP - nos invoices paid in 30 days		95%	99%	4%	95%	94%	-1%	95%	99%	4%	95%	99%	4%
	Bank spend (incl locum) spend as % of pay		-	8.7%	-	-	8.3%	-	-	8.7%	-	-	8.2%	-

Key Messages

NHS England measure the Trust for FSP delivery, variance from breakeven (revenue I&E position) and agency spend as a % of paybill. Internally we are including other metrics for review.

- Revenue I&E position is £67k surplus against a breakeven plan. This is £67k favourable to plan.
- FSP delivery is £37.4m YTD against a plan of £37.4m. Delivery is in line with plan.
- Agency spend is 2.5% of total pay bill which is 0.6% better than the NHSE target of 3.2%. This is 0.1% better than prior month.
- Bank (including locum) spend has reduced to 8.2% of total pay bill. This is an improvement from prior month which was 8.8%.
- Capital outturn £2.5m under planned CDEL; An overall net underspend on System capital of £35k, an underspend of £2.6m on IFRS16 (£10k less than what had been reported at Month 11), net of £0.1m additional national programme received in year.

M12 Financial Position

Summary I&E Position (Group)	YTD Plan £000	YTD Actual £000	YTD Variance £000
Income	(793,175)	(752,982)	40,193
Pay	545,876	468,107	(77,769)
Non Pay	247,299	313,875	66,576
Total	**0**	**29,000**	**29,000**
Donated Assets/Grants/IFRIC 12 Adj	0	(29,067)	(29,067)
Adjusted (surplus)/deficit	**0**	**(67)**	**(67)**

Summary I&E Position (Trust only)	YTD Budget £000	YTD Actual £000	YTD Variance £000	Variance excluding pension adj and impairment £000
Income	(803,298)	(857,619)	(54,321)	(20,544)
Pay	486,834	516,661	29,827	(3,950)
Non Pay	316,463	369,957	53,494	24,453
Total	**0**	**29,000**	**29,000**	**(41)**
Donated Assets/Grants/IFRIC 12 Adj	0	(29,067)	(29,067)	(26)
Adjusted (surplus)/deficit	**0**	**(67)**	**(67)**	**(67)**

Headlines

The 2024/25 financial position is £67k surplus against a breakeven plan. This is £67k favourable to plan. This is driven by one-off benefits.

The Group position includes GMS and is compared to the original plan submitted in June 24, updated for the 24/25 pay awards. This is what is reported to NHSE. There are large variances against income, pay and non pay due to the various funding received (and associated costs) since the plan was submitted. These include year end pension adjustments, depreciation funding, prior year overperformance and ERF.

The Trust position reflects performance against working budgets which have been adjusted for service changes, funding changes, year end pension adjustments and year end impairments. It is the Trust position that we monitor ourselves against internally. The headline drivers are:

Income overperformance of £20.5m.

Pay underspend of £3.95m.

Non pay overspend of £24m.

M12 Pay

	YTD Budget	YTD Actual	YTD Variance
Pay M12 YTD (excluding year end pension adjustment)	£000	£000	**£000**
Infrastructure	78,549	75,953	(2,597)
Medical & Dental	150,366	151,291	925
Nursing	186,978	186,593	(385)
Other Clinical Staff	72,309	68,562	(3,748)
Total (excl reserves)	488,203	482,398	**(5,804)**
Reserves (FSP & other staff)	2,481	169	(2,312)
Divisions (FSP target & vacancy factor)	(3,850)	317	4,166
TOTAL	486,834	482,884	**(3,950)**

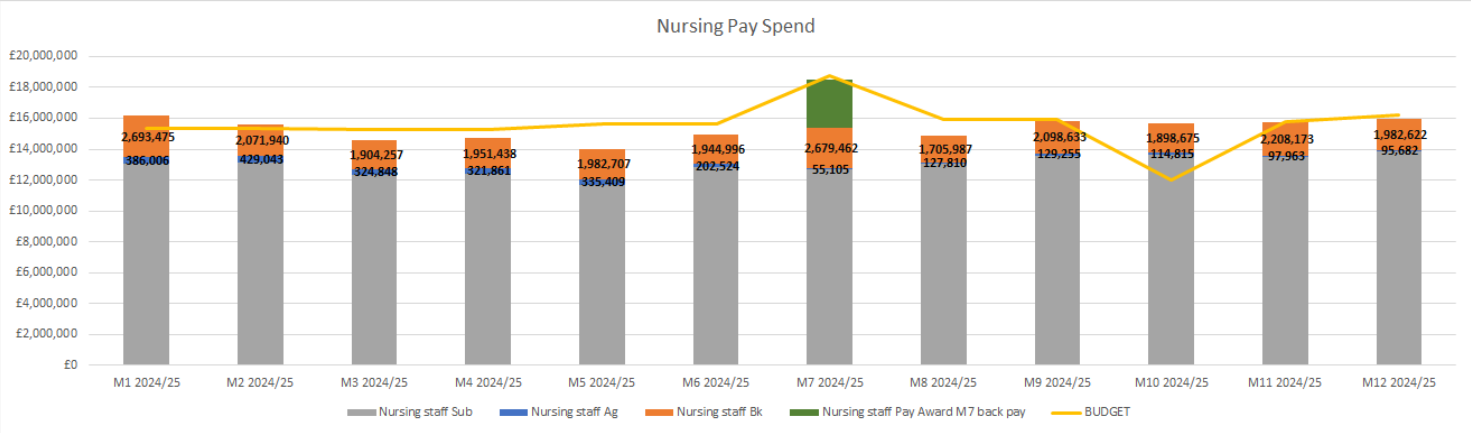
Pay M12 YTD (excluding year end pension adjustment)	Corporate	CoVid-19L4	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Pay YTD Variance including HCSW NR benefit
	£000	£000	£000	£000	£000	£000	£000	£000
Infrastructure	(2,349)	0	254	162	(859)	65	130	**(2,597)**
Medical	92	0	(44)	2,527	(32)	(1,361)	(258)	**925**
Nursing	309	0	(242)	5,126	(1,171)	(2,562)	(1,844)	**(385)**
Other Clinical Staff	30	0	(3,386)	(35)	194	(570)	19	**(3,748)**
Other Staff Sub	481	0	1,523	(7)	(2,312)	1,876	293	**1,854**
Pay YTD Variance including HCSW NR benefit	(1,437)	0	(1,896)	7,774	(4,180)	(2,552)	(1,659)	**(3,950)**
Less HCSW NR benefit					(3,395)			**(3,395)**
Pay YTD Variance excluding HCSW NR benefit	(1,437)	0	(1,896)	7,774	(785)	(2,552)	(1,659)	**(555)**

Headlines

Pay is £3.95m YTD underspent. This includes the benefit of £1m HCSW rebanding underspend relating to M1 to M5. It also include the release of HCSW accrual of £2.4m. Without these non recurrent benefits, pay would be £0.56m underspent.

- Medical staffing overspend of £0.9m. Vacancies within Surgery are offsetting pressures within Medicine.
- Nursing underspend of £0.4m. The YTD position includes £1m underspend on RMN and agency premium budget held in reserves.
- Infrastructure £2.6m underspent, mainly within corporate areas.
- Other clinical staff £3.7m underspent due to vacancies of which £3.4m is in D&S and £0.5m is in Surgery.
- Other staff £1.8m overspent. This is where £4m FSP negative budget and NR vacancy factor is held, offset by £2.4m reserves underspends.

M12 Nursing Pay

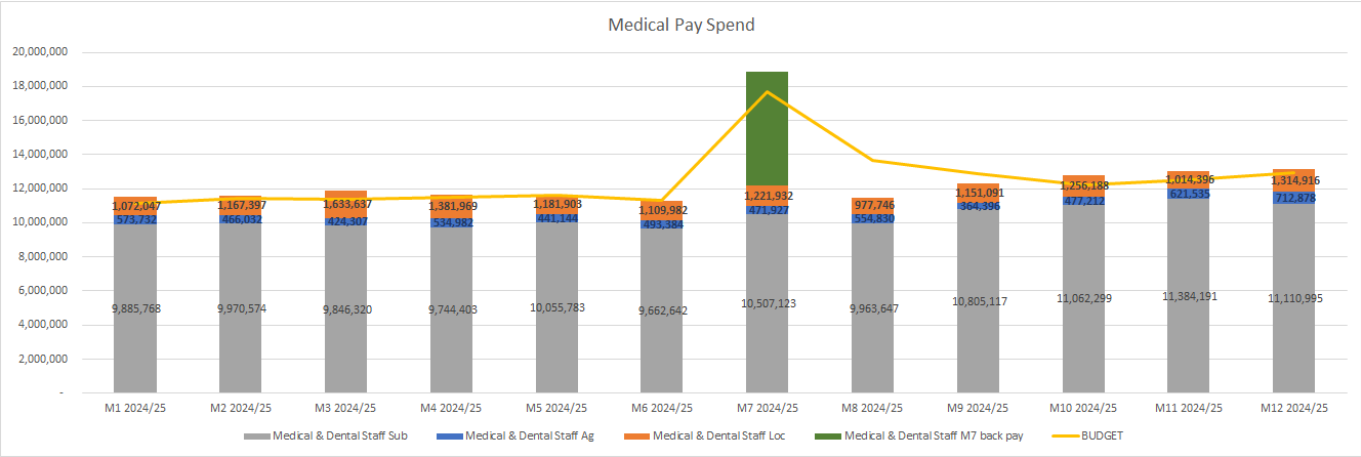


Headlines

- Nursing budgets are £0.4m underspent YTD
- M12 spend is £153k higher than prior month with the largest increase (£114k) in the Medicine Division.
- Across the Trust:
  - Nursing agency spend has reduced by £2k
  - Bank spend has increased by £77k (excluding central adj)
  - Substantive spend has increased by £34k (excluding central adj)

Last month FSP target was allocated to match the NR HCSW FSP. This is illustrated in the budget reduction in the chart above.

M12 Medical Pay



Headlines

Medical staffing budgets are £0.9m overspent YTD.
Spend has increased by £119k from prior month.

- Agency spend has increased by £91k from M11 to M12 (£622k to £713k). Of the increase, £72k is within Medicine.
- Locum costs have increased by £301k (£1,014k to £1,315k). Of the increase, £179k is within Surgery.
- Substantive costs have reduced by £273k, of which £566k is due to Education Supervisors back payments made last month.

M12 Non Pay

Non Pay	YTD Variance £000			
	Divisions	Corporate	Reserves/ Central	Total
YTD Variance (excluding impairement)	30,802	4,259	-10,608	24,453
Drivers of variance				
Pass through drugs and devices	12,302		-5,726	6,576
Bad debt provision		1,321		1,321
FSP gap on non pay but delivered in pay or income	4,961	453	2,816	8,230
Bad debt provision			1,300	1,300
Release of reserves			-9,124	-9,124
Clinical supplies in divisions	8,055			8,055
Non Passthrough drugs	2,994			2,994
Other	2,491	2,486	126	5,103
Total YTD Variance (excluding impairment)	30,802	4,260	-10,608	24,454

Headlines

M12 YTD non pay position is overspent by £24m excluding impairments.

This is driven by:

- £6.6m costs of passthrough drugs & devices that are matched by income
- £8.2m FSP target that is held in non pay but being delivered by pay and income efficiencies.
- £1.3m bad debt provision
- £8m clinical supplies in divisions, including additional endoscopy activity, inflation, theatre supplies and pathology. This includes year end related approved spend on £1m within theatres.
- £3m non pass through drugs across all divisions.

These pressures are offset by £9m non recurrent benefits e.g. pharmacy stock and balance sheet releases.

M12 Income

Income (excluding pension adj)	YTD Budget £000	YTD Actual £000	YTD Variance £000
HEE Income	(18,652)	(22,964)	(4,312)
Other Income from Patient Activities	(11,971)	(22,543)	(10,572)
Other operating income	(31,698)	(28,630)	3,068
PP Overseas and RTA Income	(6,747)	(6,451)	296
SLA & Commissioning Income	(734,230)	(743,251)	(9,023)
Total Income	(803,298)	(823,841)	(20,544)

Headlines

M12 YTD income position is £21m favourable to plan. This is driven by:

- HEE income £4.3m which offsets costs within divisions
- Non Recurrent income & balance sheet releases including:
  - Funding repayment £0.8m
  - Depreciation funding £4.8m
  - Spec comm bowel scope £0.5m
- SLA, Commissioning and other income from patient activities:
  - Pass through drugs overperformance £4m.
  - Underperformance on out of area elective activity which is an API contract. This is £1.5m of which H&W is c.£1m.
  - Prior year income from commissioners £1.6m
  - CDC, endoscopy, virtual ward, cancer funding and other activity related income £4.5m above budget and funding pay & non pay.

M12 Capital Position

	Actual @M12 *(Reported in PFR)*	*£28k System Capital Allocations held within ICB	Actual @M12 *(incl. allocation held with ICB)*	Forecast @M11 *(incl. allocation held with ICB)*	Movement from Forecast @M11
System Operational Capital	7	28	35	(3)	38
IFRS16	2,639	0	2,639	2,649	(10)
Total Charge against Capital Allocation (incl. IFRS 16)	**2,646**	**28**	**2,674**	**2,646**	**28**
Nat Programme, Grants, Donations & Other	(132)	0	(132)	(132)	0
Total CDEL	**2,514**	**28**	**2,542**	**2,514**	**28**

Commentary:
The Trust submitted a gross capital expenditure plan for the 24/25 financial year of £47.7m. National Programme and Grant funding increased by £0.3m during the year whilst Donations via Charitable Funds were £0.2m less than plan. The resulting final allocation for the year was £47.8m.

After taking into account £28k of agreed System Capital allocation that was held by the ICB, the provisionally reported capital outturn position ended up at £45.1m, representing an underspend position of £2.7m against capital allocation. This is broken down into:

- an overall net underspend on System capital of £35k versus plan
- an underspend of £2,639k on IFRS16 (£10k less than what had been reported at Month 11)

The CDEL position reported a £2,542k underspend, which is the net underspend on system capital and IFRS16 less £132k due to the net additional PDC capital received during the year. A breakeven position was reported against national programme, grants and donations.

The Trust delivered £16.6m in the month.

in £000's	Outturn		
	Allocation	Outturn	Variance
DIGITAL	8,230	7,737	493
MEDICAL EQUIPMENT	11,376	10,364	1,012
ESTATES	18,017	18,087	(70)
OVERCOMMITTED PROGRAMME - REQUIRES SLIPPAGE	(1,465)	0	(1,465)
NBV OF ASSET DISPOSALS	(77)	(142)	65
Total Charge against Capital Allocation (excl. IFRS 16)	**36,080**	**36,045**	**35**
RIGHT OF USE ASSET	7,412	4,773	2,639
Total Charge against Capital Allocation (incl. IFRS 16)	**43,492**	**40,818**	**2,674**
NAT PROGRAMME, GRANTS, DONATIONS & OTHER	4,293	4,293	0
Gross Capital Spend Total	**47,785**	**45,111**	**2,674**

Note: The actual forecast system capital allocation is £36,052k but is showing in the table as £36,080k as £28k of the allocation is sitting with the ICB.

Cash Flow

	Apr 24 £'000	May 24 £'000	Jun 24 £'000	Jul 24 £'000	Aug 24 £'000	Sep 24 £'000	Oct 24 £'000	Nov 24 £'000	Dec 24 £'000	Jan 25 £'000	Feb 25 £'000	Mar 25 £'000	Apr 25 £'000	May 25 £'000	Jun 25 £'000	Jul 25 £'000	Aug 25 £'000	Sep 25 £'000	Oct 25 £'000	Nov 25 £'000	Dec 25 £'000	Jan 26 £'000	Feb 26 £'000	Mar 26 £'000
Opening Balance	55,176	59,364	39,309	32,237	40,838	46,441	42,939	67,710	50,590	40,710	29,392	41,594	42,357	46,974	35,725	29,991	53,682	47,737	41,866	49,089	42,565	41,902	31,813	39,702
Receipts																								
SLA Income	56,603	56,604	53,597	58,941	70,953	62,151	71,929	62,915	60,648	62,805	65,504	64,830	60,139	63,766	63,766	63,766	63,766	63,766	63,766	63,766	63,766	63,766	63,766	63,766
Other NHS	17,271	2,650	3,025	14,209	4,254	1,963	27,187	5,074	2,197	4,321	19,997	7,414	17,662	2,400	3,125	15,283	2,215	2,015	21,883	2,155	2,371	4,321	17,757	7,316
Other Non-NHS	2,924	1,941	1,723	1,677	1,487	2,366	2,210	1,819	2,208	2,606	2,027	4,236	2,437	1,906	1,548	2,317	1,896	1,787	2,260	2,720	2,527	3,970	4,470	8,233
VAT	1,051	3,358	2,455	4,210	2,709	3,080	1,863	2,063	2,634	2,989	1,688	3,094	2,628	2,358	2,444	2,841	3,218	2,166	1,935	2,479	2,095	2,989	1,688	2,214
Total Receipts	77,849	64,554	60,801	79,036	79,403	69,963	103,445	71,871	67,826	72,722	89,282	81,037	82,866	70,429	70,883	84,207	71,094	69,734	89,843	71,119	70,758	75,045	87,680	81,529
Payments																								
Payroll - Direct payments	(23,625)	(23,934)	(25,273)	(24,715)	(24,750)	(23,999)	(29,887)	(29,591)	(25,053)	(25,442)	(25,455)	(25,161)	(25,901)	(25,888)	(27,418)	(25,894)	(26,248)	(25,931)	(26,235)	(25,880)	(25,891)	(27,214)	(26,977)	(26,895)
Payroll - On costs	(18,111)	(16,960)	(17,234)	(18,108)	(17,474)	(17,195)	(16,990)	(23,610)	(23,341)	(18,415)	(18,606)	(18,809)	(19,571)	(19,570)	(19,605)	(19,670)	(19,566)	(19,566)	(19,606)	(19,586)	(19,585)	(19,583)	(19,570)	(19,572)
Payables	(31,926)	(43,714)	(25,366)	(27,612)	(31,576)	(26,753)	(31,797)	(35,790)	(29,311)	(40,183)	(32,992)	(31,328)	(32,776)	(36,222)	(29,594)	(14,952)	(31,225)	(25,151)	(36,779)	(32,177)	(25,946)	(38,338)	(33,244)	(27,527)
Loan Principle & Interest	0	0	0	0	0	(1,215)	0	0	0	0	0	(1,186)	0	0	0	0	0	(1,167)	0	0	0	0	0	(1,142)
PDC Payments	0	0	0	0	0	(4,304)	0	0	0	0	(27)	(3,790)	0	0	0	0	0	(3,790)	0	0	0	0	0	(3,790)
Total Payments	(73,661)	(84,609)	(67,873)	(70,435)	(73,801)	(73,466)	(78,674)	(88,991)	(77,706)	(84,040)	(77,079)	(80,274)	(78,249)	(81,679)	(76,617)	(60,516)	(77,039)	(75,605)	(82,620)	(77,643)	(71,421)	(85,134)	(79,791)	(78,926)
Net Cashflow	4,188	(20,055)	(7,072)	8,601	5,603	(3,502)	24,771	(17,120)	(9,880)	(11,318)	12,202	763	4,617	(11,250)	(5,734)	23,691	(5,945)	(5,871)	7,223	(6,524)	(663)	(10,089)	7,889	2,603
Closing Balance	59,364	39,309	32,237	40,838	46,441	42,939	67,710	50,590	40,710	29,392	41,594	42,357	46,974	35,725	29,991	53,682	47,737	41,866	49,089	42,565	41,902	31,813	39,702	42,305
Number of days operating cash held	28	19	15	19	22	20	32	24	19	14	20	20	22	17	14	26	23	20	23	20	20	15	19	20

Headlines

- The cashflow reflects the Trust position.
- The table is for an 18 month period and is based on the assumption that income and expenditure will be at similar levels from April 2025 onwards.
- It is currently assumed that financial sustainability target identified in the plan is achieved
- Trust holds 28 days operating cash (c£2.1m per day) at the end of April – at the end of March 2025 this would be equivalent to 20 days.

Workforce

Thank you!

New slide to be added?

STAFF SURVEY 2024

People Promise scores

65%
Response rate Trust wide

2023 68%

49% Median for acute Trusts

I would recommend my organisation as a place to work

51%
2023 46%
2022 43%

61% National average

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

49%
2023 46%
2022 44%

62% National average

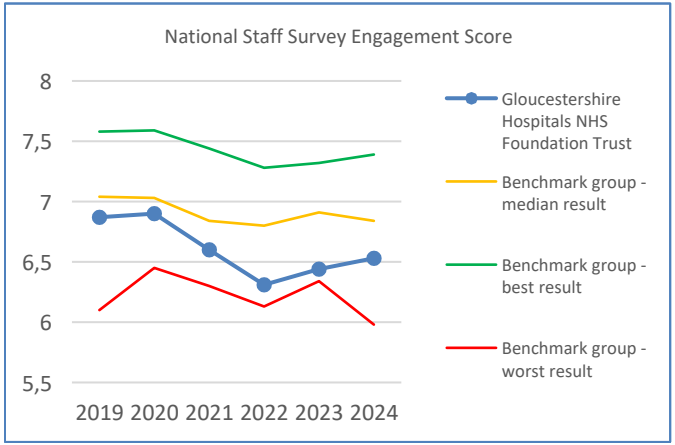
Care of patients/service users is organisation's top priority

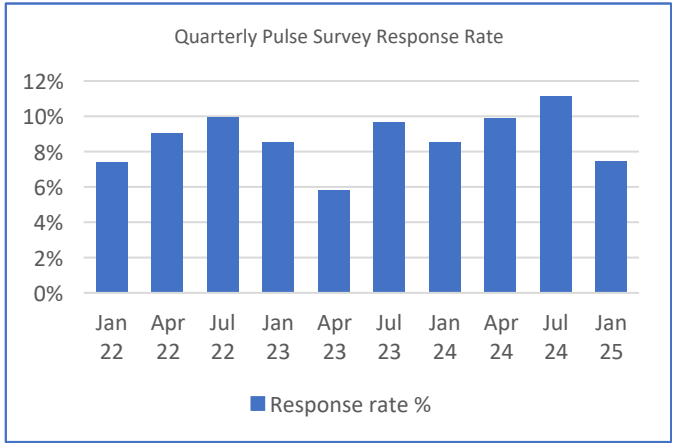
65%
2023 63%
2022 63%

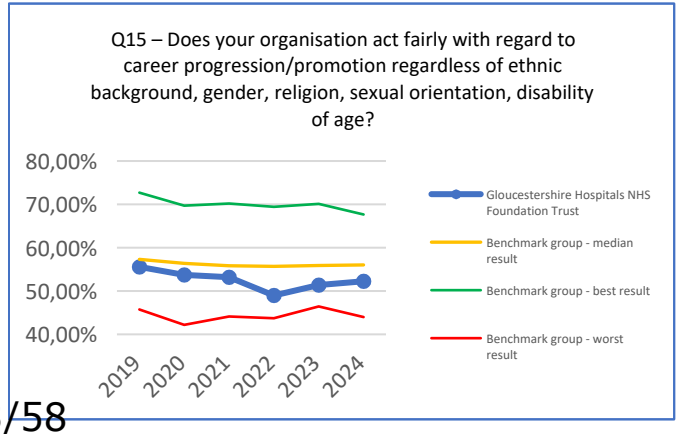
74% National average

Amended to current from the Dec 24 IPR update

Staff Engagement - National Staff Survey watch metric







Commentary:
The 2024 Staff Survey results are now live and improvements can be seen across the organisation.

The independent analysis by NHS England has noted a number of statistically significant improvements in each of the seven People Promise themes and the overall positive score.

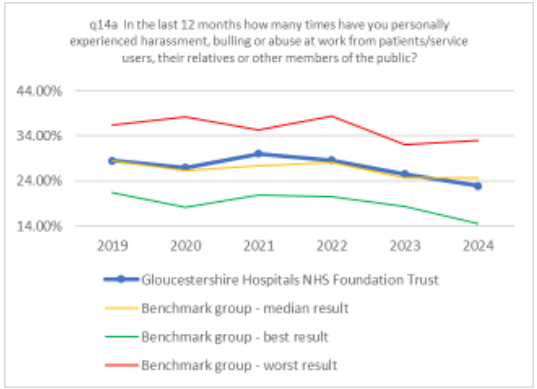
Although there have been improvements, including modest increases in the Net Promoter Scores, the Trust continues to trail behind national averages for the People Promise and staff engagement metrics.

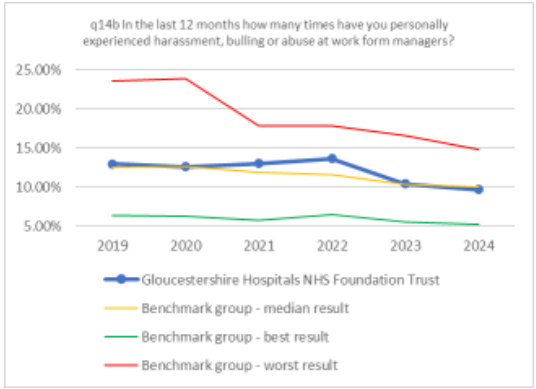
January 2025 NQPS has seen a drop in response rate across the organisation and all divisions.

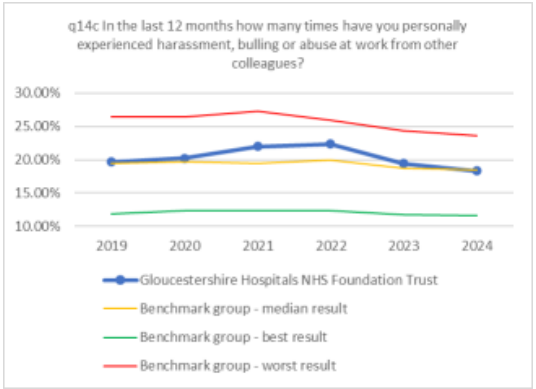
Planned Actions:
Results have already and will continue to be distributed across the organisation with departments focusing on SEIP priorities and questions which have deteriorated when compared to 2023.

Amended to current from the Dec 24 IPR update

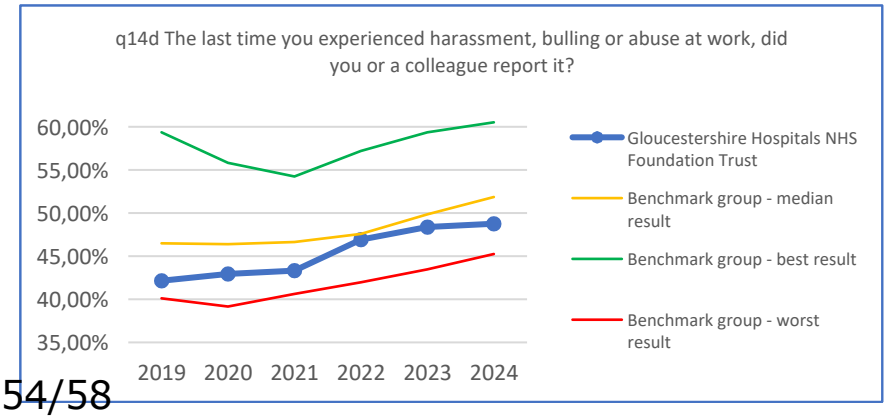
Staff Engagement - National Staff Survey watch metric







% of staff saying they experienced at least one incident of harassment, bullying or abuse



% of staff saying they, or a colleague, reported it, out of those who answered the question excluding those who selected "Don't know" or "Not applicable"

Commentary:

The Trust has seen a positive reduction in the number of staff reporting at least one incident of harassment, bullying, or abuse since the 2023 Staff Survey. Our results now align with, or are better than, national averages in these areas. We recognise there is still progress to be made in increasing the percentage of staff who report such experiences.

Planned Actions:

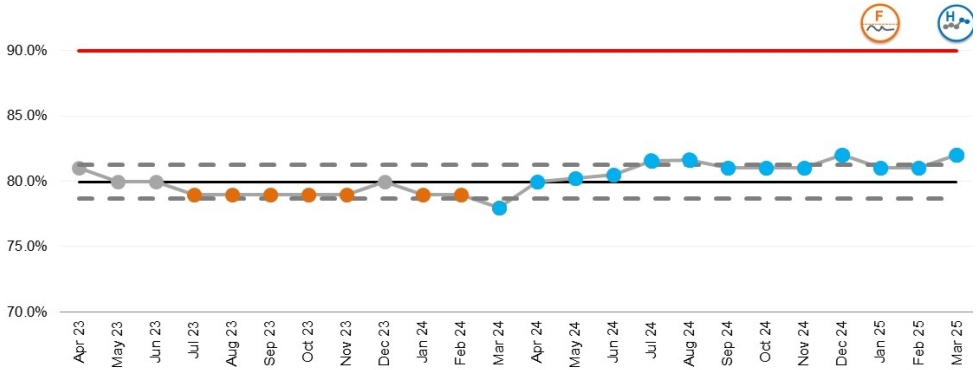
Report Support and Learn platform and process will be launched imminently. Work continues to progress with the onboarding of the reporting software ('Report and Support'), to streamline reporting of staff to staff discrimination, bullying, harassment, sexual misconduct and incivility. This will be in conjunction with an inappropriate behaviours comms campaign.

Workforce Performance Indicators

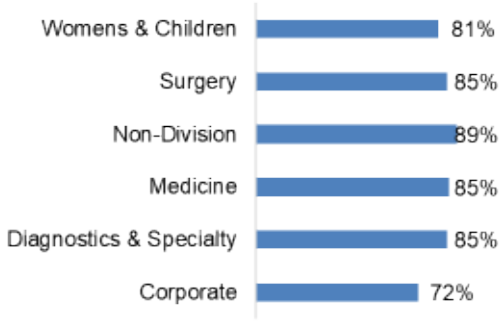
Performance Indicator	Target	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Turnover	**13%**	10.93%	10.58%	10.35%	10.55%	9.95%	9.94%	10.03%	9.41%	9.36%	9.30%	9.04%	8.78%	8.95%
Vacancy	**8%**	6.59%	6.11%	6%	6.82%	7.24%	7.43%	7.48%	7.51%	7.37%	7.67%	7.25%	7.41%	7.21%
Sickness	**5%**	4.29%	4.28%	4.31%	4.32%	4.35%	4.34%	4.34%	4.28%	4.29%	4.57%	4.85%	4.32%	Too early for data
Appraisal	**90%**	78%	80%	80%	80%	82%	82%	81%	81%	81%	82%	81%	81%	82%
Essential Training	**90%**	85%	86%	86%	87%	87%	88%	88%	88%	89%	89%	89%	90%	90%
Agency (FTE & % of establishment)	**2%**	132 (1.7%)	98 (1.2%)	94 (1.2%)	97 (1.2%)	84 (1.1%)	93 (1.12%)	72 (0.9%)	91 (1.1%)	82 (1.0%)	66 (0.9%)	61 (0.8%)	62 (0.8%)	72 (0.9%)
Bank (FTE & % of establishment)	**6.5%**	736 (9.3%)	686 (8.7%)	599 (7.6%)	592 (7.4%)	604 (7.6%)	597 (7.4%)	587 (7.3%)	586 (7.2%)	575 (7.1%)	584 (7.8%)	555 (6.8%)	652 (8.0%)	652 (8.1%)

Workforce - Appraisal

Appraisal % -Trust starting 01/04/23



Appraisal % by Division - Mar 2025



Appraisal % by Staff Group	Mar 25 %
Add Prof Scientific and Technical	78%
Additional Clinical Services	85%
Administrative and Clerical	74%
Allied Health Professionals	83%
Estates and Ancillary	80%
Healthcare Scientists	79%
Medical Staff - Consultants	88%
Medical Staff - SAS	69%
Nursing and Midwifery Registered	87%

Commentary:

Organisational target is **90% for appraisal compliance**. Despite some divisions and professional groups dipping below a 70% compliance in the last year, January and February saw all divisions and professional groups above this threshold and general upward trajectory in compliance. In March Medical Staff – SAS is the only metric to have decreased and subsequently dip below the 70% threshold. Significant improvement is seen in the **Non-division workforce** that have improved their February compliance of 72% to become organisational leader with 89% compliance in March. Corporate Division has seen a modest improvement from 70% in February to **72% in March**, which reflects the need for targeted local action plans as outlined below.

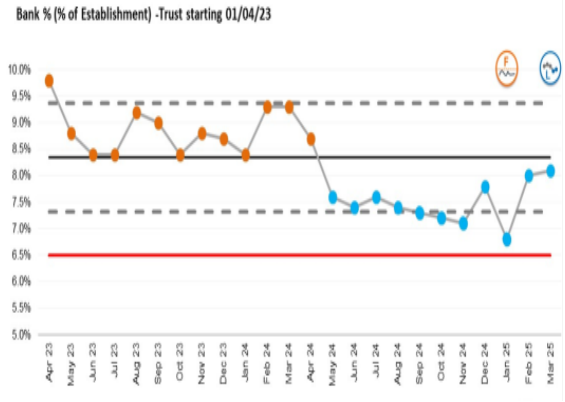
Planned Actions Updates:

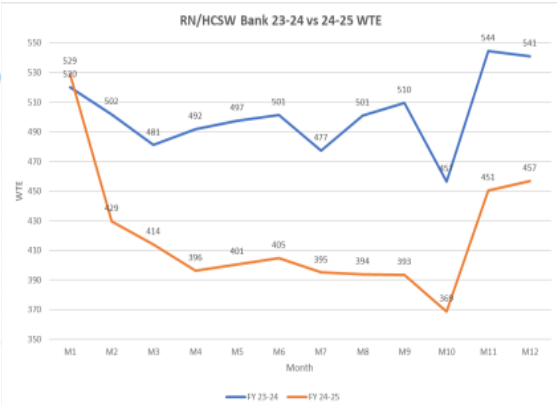
- **New Appraisal Policy, Process and Paperwork Launch – April 2025:**
- Policy has gone to TPAG, Process has been consulted on and soon to be socialised widely, Paperwork is with Comms at final print stage
- **In-depth Analysis of Compliance & Quality**
  - Triangulation of completion compliance and staff survey perceptions of quality. Focused interventions in staff groups and service lines that resonate as low compliance and low quality as priority, which will include support to Service leads and enrolment to training if necessary.
- **Digitisation of Appraisal Process:**
  - Exploring digital solutions to enhance compliance recording ongoing
  - A stakeholder task group will be formed to oversee implementation and effectiveness.

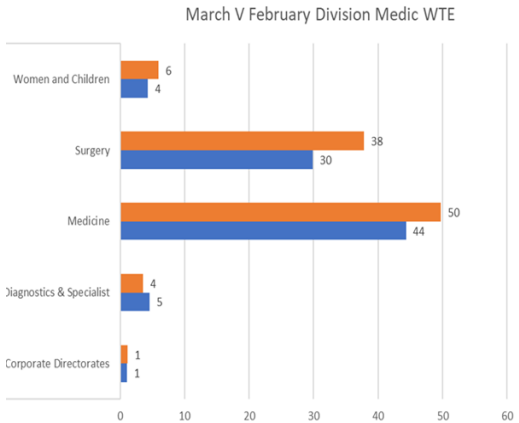
Expected Recovery Timeline:

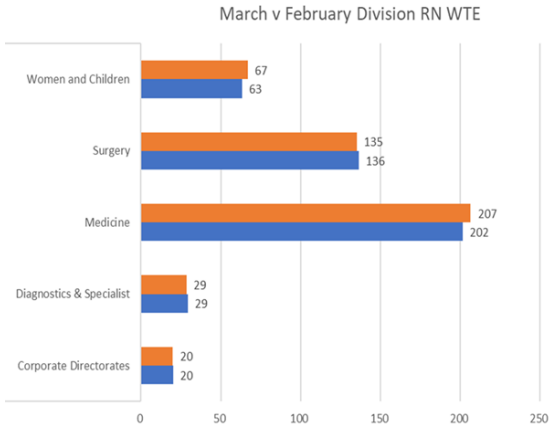
- **April 2025:** Launch of new appraisal policy, paperwork and process
- **August 2025** – Internal auditors conducting a review
- **October 2025:** Interim measure of impact of the new paperwork.
- **April 2025 – April 2026:** Digitisation T&F group to implementation

Workforce - Bank









Commentary:

- The Trust target of 6.5% has not been achieved in month 12.
- March is typically a high Bank use month due to annual leave levels.
- Medicine is the highest user of Bank & Locum staff.
- The Emergency Department, COTE and Acute Medicine are the highest users of temporary staffing in Medicine.
- In comparison with the M12 of the previous financial year there has been a reduction from 541 WTE RN/HCSW use in March 2024 to 457 WTE in March 2025.
- A year-on-year WTE comparison of RN/HCSW temporary staffing use shows the significant improvements achieved throughout the FY.
- The comparison shows a similar trend in M10 to M12 changes in WTE use for both financial years.

Planned Actions:

- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

Expected recovery:

- As the trend of M9-12 is broadly similar for both financial years, it is reasonable to assume that by M2 of FY 25/26, the bank use will reduce again to previous levels seen in FY24/25.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Thank you

Report to Trust Board of Directors	
Date	8 May 2025
Title	**Report to the Care Quality Commission - Section 31 Summary Reports**
Authors **Presenter**	Women's and Children's Division Director of Midwifery - Lisa Stephens Women's and Children's Division Speciality Director – Chris Edwards (Supported by Deputy Director of Quality - Suzie Cro) **Director of Quality and Chief Nurse – Matt Holdaway**

Purpose of Report			Tick all that apply ✓
To provide assurance	✓	**To obtain approval**	
Regulatory requirement	✓	**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report

The purpose of this coversheet is to summarise the key steps taken to eliminate immediate risk with respect to each point in the CQC Section 31 letter dated 9 May 2024. In summary, the CQC have received monthly reports and all these reports have been provided to Board members in the virtual "Reading Room" (Board access only). The summary position is that the Trust has fully met 2 out of the 8 conditions and it is likely that this will increase to 5 (if not 6) next month as for many conditions we are awaiting publication of updated guidelines or compliance checks for audits to be met and then sustained (full position at the end of this coversheet).

Table: Trust summary of position against CQC conditions

Total number of conditions	**Assurance rating**	**8**	**Target**
Conditions fully met		2 (7&8)	
Partially met (updated guidelines need to be published and/or audits do not yet demonstrate sustained compliance to the standards as set by the Trust)	Majority approximately 90% completed	6 (1-6)	July 2025
Not met as not started		0	

Background

One year ago, in May 2024, Maternity Clinical Teams were set up to lead the improvement work and they have completed quality improvement (QI) training. The last QI training session was in October and the Teams, who did not have a QI qualification, graduated at the Gloucestershire Safety Quality Improvement Academy (GSQIA) ceremony in February 2025. The teams are all making progress with their improvement projects and will continue to report on a monthly basis

to the Executive Led Maternity Delivery Group. There is an improvement programme for Maternity Governance and new structures have been implemented and these are now embedding well.

As required by CQC, the enclosed Reports and the Maternity Dashboards were sent to the CQC by the deadlines. The next report will be prepared and sent to CQC on 30 April 2025. The Trust are also providing assurance externally to the ICB Quality Improvement Group (QIG) fortnightly and external stakeholders are present (NHSE regional and national teams). A copy of the presentation provided to the last Group (4 April 2025) has also been provided to Board members for information. At QIG 2 work streams were closed (Agency staff induction and Maternity Obstetric Early Warning Scores (MOEWS) audit compliance) as significant progress had been made. Reporting on all metrics will continue to CQC.

Board members are asked to note that the CQC published their latest inspection report for the GRH site maternity inspection (which was carried out in March 2024) on 13 January 2025. Significant progress continues to be made with the Maternity Senior Leadership Team preparing for the next CQC inspection.

Recommendation

The Board is asked to note the contents of the table and receive assurance that a robust improvement programme of work is underway.

Enclosures

- Appendix 1 – summary position against conditions (see end of coversheet)

Reading Room (board access only)

- March 2025 CQC S31 Report
- 4 April 2025 ICB QIG Presentation (for information)
- Coversheet for new Maternity Dashboard highlights (as provided to CQC Feb data)

Appendix 1 - CQC S31 enforcement notice

Table: Trust summary of position against CQC conditions in the Maternity Service GRH

Total number of conditions	**Assurance rating**	**8**
Conditions fully met		2 (7&8)
Partially met (updated guidelines need to be published and/or audits do not yet demonstrate sustained compliance to the standards as set by the Trust)		6 (1-6)
Not met as not started		0

Table: Brief summary of metrics and targets

Condition	**Condition description**	**Met/ not met**	**Actions taken or left to take and focus**

1.	**Implement** an effective system for ensuring staff at Gloucestershire Royal Hospital **continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH**).	Partially met (approximately 90% complete)	- System implemented and described in PPH/MOH clinical guidelines.
			  ○ Reduce Checklist launched to support management.
			  ○ Carbetocin (drug) added to Caesarean Section (CS) management
			- Team PPH have oversight of compliance with systems for risk assessment and report to the Intrapartum Forum.
			  ○ Booking risk assessment compliance = 90% (target 90%)
			  ○ 36/40 compliance **78%** (target 90%)
			  ○ On admission 100% (target 90%)
			- Management is monitored by audits of the Reduce Checklist (stepwise management)
			  ○ Completion rates 85-100% (target 85%).
			Next steps
			- The Improvement work continues and is focused on improving

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
			outcomes. - To improve 36/40 risk assessment to the target by May 2025 the community Teams have been focused on this with their Production Boards reviewing data and taking actions.
2.	Ensure maternity staff at Gloucestershire Royal Hospital complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in line with national guidance.	Partially met (approximately 90% complete)	- System to ensure peer reviews implemented and described in Fetal Monitoring clinical guidelines. - Intrapartum Team have oversight of compliance. - Manual audits demonstrate compliance of **70%** and target 85% (15% improvement required to meet target). **Next steps** - Trialling this month, a 2-week Plan, Do, Study, Act (PDSA) cycle: dedicated to peer reviewers on Delivery Suite, allocated and time documented on board against service user name. This PDSA cycle is designed to test our operational capacity for peer review. Hourly peer review was added into our service and didn't consider the additional workload this would add. A thorough peer review takes 10 minutes to complete, if there are 3-6 labouring women who require hourly peer review this could be 100% of a midwife's capacity. - This PDSA cycle will include a survey of all the reviewers for their perspectives and opinions - Focus is now on operational capacity to facilitate this additional workload.
3	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital	Partially met (approximately 90%	- System implemented and described in Fetal Monitoring clinical guidelines. - Teams have oversight of compliance with system.

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
	interpret fetal monitoring traces accurately and **escalate** in line with Trust guidance to ensure all women and birthing people and their babies are cared for in a safe and effective manner in line with national guidance.	complete)	- Compliance for accurate interpretation is at the Trust target of 85%. - Compliance with appropriate escalation is at 95% and the target is 100% (5% improvement required to meet target). - Since the launch of the audit (April 2024) we have seen an increasing rate in appropriate escalation improve from 46% in April 24 to a mean of 94% October-March 2025 - February 2025 saw a 95% against appropriate escalation. The drop of 5% was for a single case which did not result in an adverse outcome. This case is undergoing an MDT review, as in line with our audit process to assess the escalation response. The audit response is whenever there is a query surrounding obstetric escalation it has an MDT review **Next steps** - The RCOG/RCM escalation tool kit was launched in January 2025 to promote communication tools that reduce delays in escalation, flatten hierarchy and standardise the use of safety critical language Escalation toolkit | RCOG. - Our launch has included the tool on study day, inclusion in MDT Team Talk, awareness posters and fetal wellbeing champions.
4.	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **complete and escalate maternity early obstetric warning score (MEOWS) charts** in line with national guidance	Partially met (approximately 90% complete)	- System implemented and described in MOEWS clinical guidelines (Severely Ill Obstetric Patient M2010). - Compliance is monitored at the Postnatal Forum and any issues are escalated to the Perinatal Oversight and Assurance Meeting. - Current compliance for "Act on Amber" ○ Maternity Ward – 7 weeks

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
	during intrapartum and postnatal care.		at 100% (with 1 week with decrease in score but returned to 100%) ○ Delivery Suite – 11 weeks at 100% (with 1 week with decrease in score but returned to 100%) ○ Gloucester Birth Unit (GBU) – 70% (target 90%). **Next steps** - The new national maternal early warning score system is being implemented September 2025 and there is a plan for this. - Ongoing actions to improve GBU scores have been implemented. - The Policy has been reviewed and is awaiting publication.
5.	Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.	Partially met (approximately 90% complete)	- System described in VTE clinical guidelines. - Compliance with risk assessment at Booking >95%. - Compliance with risk assessment in the postnatal period >95%. - Manual audits demonstrate compliance with the “on admission” risk assessment 100% for the last 4 weeks. - Audits continue to ensure risk assessment actions are being enacted and current compliance is for pharmacological prophylaxis is at 70%. **Next steps** - Work continues to enable digital capture of the “on admission” risk assessment data. - Continue with weekly audits to demonstrate sustained improvement with pharmacological prophylaxis when indicated.
6.	Implement an	Partially met	- All agency midwives receive an

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
	effective system for ensuring **agency midwifery staff have a comprehensive induction to the unit, are able to access the maternity electronic records system and Trust policies, as well as enter and exit the unit without delay**.	(approximately 90% complete)	induction prior to commencing a shift as this is part of the shift booking process. - All band 7s can provide access to Badgernet. - Access cards are provided by the Flow Midwife. - Access to policies is supported in the clinical areas. **Next steps** - The current Trust Policy states that all temporary workers require an induction and the Trust Policy B0720 Temporary Staffing Procedure is being updated to reflect current Maternity processes and is awaiting approval from the Trust HR policy approval group.
7 & 8	Monthly reports to (to include PPH and Fetal Monitoring QI plan) Dashboard	Met	Monthly reports have been submitted to CQC, Trust Board, MDG and Q&P with the Perinatal dashboard demonstrating compliance. Progress is reported within the Division in the Perinatal Quality Surveillance Report.

Report to Trust Board			
Date	8 May 2025		
Title	Quarter 3 – Perinatal Quality Surveillance Report		
Author / Presenter **Sponsoring Director**	Lisa Stephens – Director of Midwifery and Dr Chris Edwards – Obstetric SD Matt Holdaway – Chief Nurse		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	
Regulatory requirement	✓	To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Purpose

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the GHNHSFT Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward-to-board' insight across the multi-disciplinary, multi-professional maternity services team. This is also presented to the LMNS.

Background

The PQS reporting style continues to develop, whilst maintaining the PQS model inclusion requirements. Perinatal quality issues using infographic-based detail. The paper presents a Quality Dashboard, Operational Activity of note, and Outcomes. Based on a request from the Maternity Delivery Group (MDG), the paper also presents emerging issues to date.

Risks or Concerns

Key issues to note

There was a total of 9 stillbirths in Q3. All cases have had a robust multi-professional review and have been taken through the local governance processes via patient safety review panel. A total of 5 cases have been reported as Patient Safety Incident Investigation (PSII) and 1 referred to MNSI. Following the initial MDT review, immediate learning and initial themes have been identified. Numbers of stillbirths per month will vary. For this reason, it is difficult to assess whether this short-term increase is significant or not. However, given the huge impact of each still birth a high level of surveillance is maintained.

There was 1 maternal death. This has been reported to MBRRACE and MNSI. The investigation is ongoing. There were no neonatal deaths. During Q3, there were 3 AER's and 5 PSII's and 2 new MNSI referrals. Improvement work continues with PMRT, particularly around parental engagement and timeliness of reviews.

The Midwifery vacancy rate has reduced to 10.38% with recruitment to obstetric vacancy in

progress.

The department continue to monitor caesarean section rates due to a steady increase, and impact upon patient and staff experience associated with increased operative deliveries. This is monitored through the intrapartum forum.

There has been continued improvements in USS waiting times associated with reduced fetal movements. The new pathway for daily CTG's for recurrent reduced fetal movements is working well. This is in place whilst we improve the pathway for ultrasound scanning in response to maternal reports of reduced fetal movements.

MDT Quality Improvement workstreams in response to the CQC S31 continue. With an improvement in Massive Obstetric Haemorrhage rates with the Trust average improving from a rate of 42.0 per 1000 births in April 2024 to 28.0 to 35.0 per 1000 births in Q3. The national average is 32 per 1000 births.

Financial Implications	
Approved by: Director of Finance / Director of Operational Finance	**Date:**
Equality, Diversity, Inclusion and Workforce Implications	
Sustainability (Environmental) Implications	
Recommendation	
The board are asked to note the contents of the paper	
Enclosures	
Q3 PQS 24/5	

Gloucestershire Hospitals
NHS Foundation Trust

Perinatal Quality Dashboard

Quarter 3, 2024

the Best Care for Everyone
care / listen / excel

Contents

Making data count

This report contains data from the Perinatal Quality dashboard. The report uses SPC charts to identify variation based on NHSE making data count guidance:

SPC Chart Guide

- The reference lines in the charts indicate the normal level of variation in the dataset – the upper and lower 'control limits' are calculated from the total average, + or – this standard amount of variation.
- Data points are highlighted in orange or blue if they fall above or below this 'normal' range. They are grey if they plot within the upper and lower control limits. (See key)
- This is not a RAG-rating or an indication of whether a data point is 'good' or 'bad', just highlights points of interest that fall outside expected variation

Variation		
		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Quality Dashboard

Quality measure	Regional benchmark if applicable	National Benchmark if applicable	Jun	Jul	Aug	Sept	Oct	Nov	Dec
After event Review (AER)	N/A	N/A	3	0	1	1	0	0	3
Patient Safety Incident Investigation (PSII)	N/A	N/A	0	0	0	0	2	2	1
Quality Summit (QS)	N/A	N/A	1	1	0	0	0	0	0
NEW MNSI referrals	N/A	N/A	0	0	0	0	1	1	0
Direct maternal death	0 per 100,000	13 per 100,000	0	0	0	0	1 (2.1 per 100,000)	0	0
Stillbirths (24 weeks gestation and above)	2.8 per 1000	3.4 per 1000 births	3 (7.69 per 1000)	1 (2.11 per 1000)	0	1 (2.2 per 1000)	5 (10.5 per 1000)	3 (6.8 per 1000)	1 (2.3 per 1000)
Neonatal Deaths (> 24 weeks gestation)		1.6 per 1000 births	1 (2.6 per 1000)	0	1 (2.24 per 1000)	0	0	0	0
Babies born at < 27 weeks gestation at GHNHSFT	3.6 per 1000	4.1 per 1000	0	0	0	0	0	0	0
Term admissions into the neonatal unit (ATAIN)	/	5% (50 per 1000 births)	4.9 (49 per 1000)	3.4 (34 per 1000)	2.7 (27 per 1000)	4.3 (43.3 per 1000)	3.4% (34.1 per 1000)	4.1% (41.5 per 1000)	3.4% (34.5 per 1000)
Coroner Regulation 28 made directly to the Trust	/	/	0	0	0	0	0	0	0

Operational Activity – Oct, Nov, Dec 2024

Births

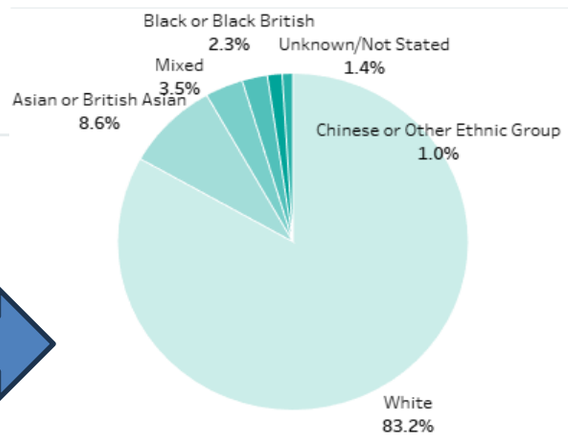
Location

Total Births (Registerable)

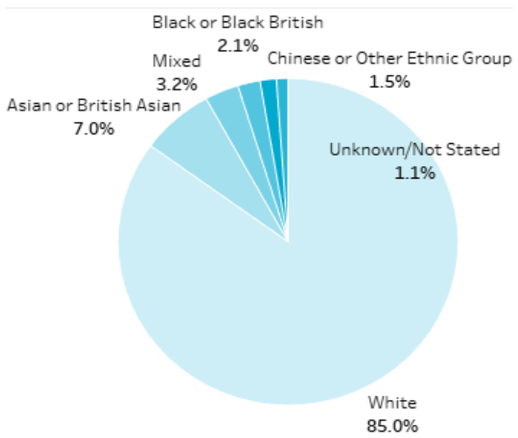
1,361

Delivery Suite Gloucester	Birth Unit Gloucester	Planned home birth	Birth Centre Stroud	BBA	Maternity Ward Glouces..	Triage Gloucester	Other
1,128	170	15	26	11	3	1	3

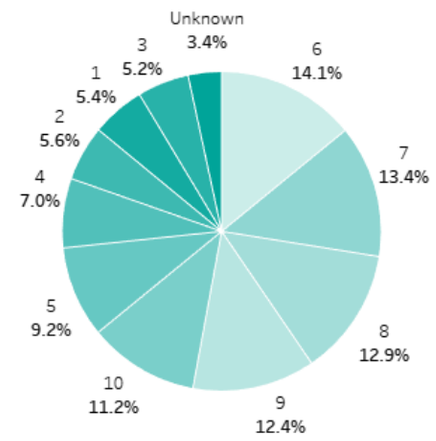
Bookings by Ethnicity



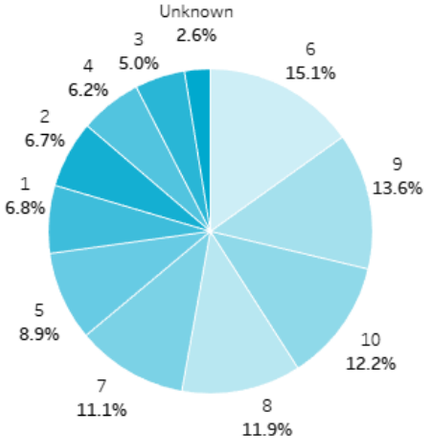
Births by Ethnicity



Bookings by Deprivation



Births by Deprivation



Births

Ethnicity

Deprivation

Operational Activity

Above Standard Deviation | Within Standard Deviation | Below Standard Deviation

C-sections

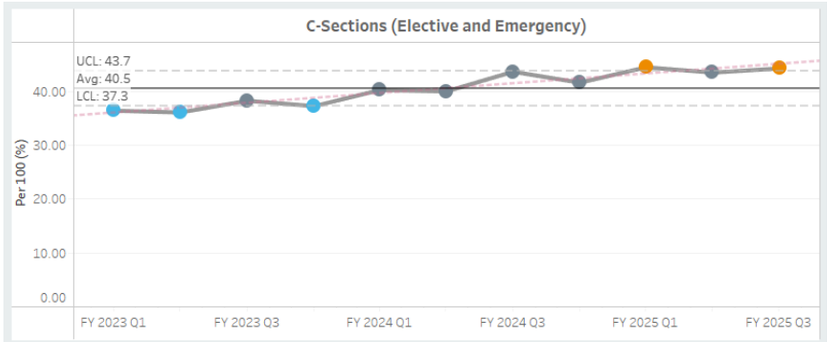
Latest Month

Metric ⓘ

Metric:	C-Sections (Elective and Emergency)
Rate of:	C-Section Births (Registerable)
Per 100 (%):	Registerable Births

44.2

Trend



Notes

We have noted a gradual increase in our caesarean section rate over the past 12 months in line with the national picture. Whilst we are not monitored on our overall caesarean section rate, an increase has an impact on staffing, patient and staff experience. Our elective caesarean section list is now running with 6 regular slots instead of 4. Maternity and obstetric staffing is being reviewed to improve the support to this service. A QI is commencing in Q4 by CDS lead Obs and Matron

Induction of Labour

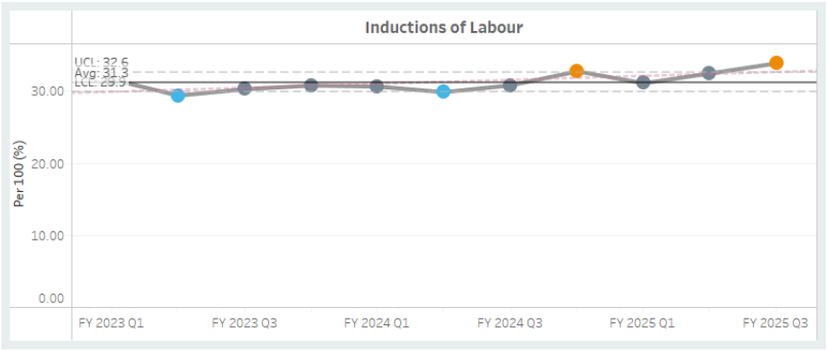
Latest Month

Metric ⓘ

Metric:	Inductions of Labour
Rate of:	Induced Deliveries (Registerable)
Per 100 (%):	Registerable Deliveries

33.9

Trend



Notes

The induction of labour QI is in progress. All preterm inductions of labour are now carried out on the delivery suite to ensure increased surveillance. Our induction of labour rate has remained stable since March 2024.

Instrumental Births

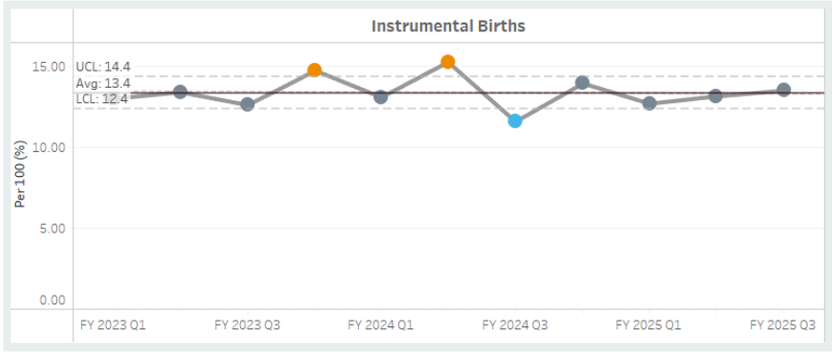
Latest Month

Metric ⓘ

Metric:	Instrumental Births
Rate of:	Ventouse and Forceps Births (Registerable)
Per 100 (%):	Registerable Births

13.5

Trend



Notes

To continue to monitor.

SVB

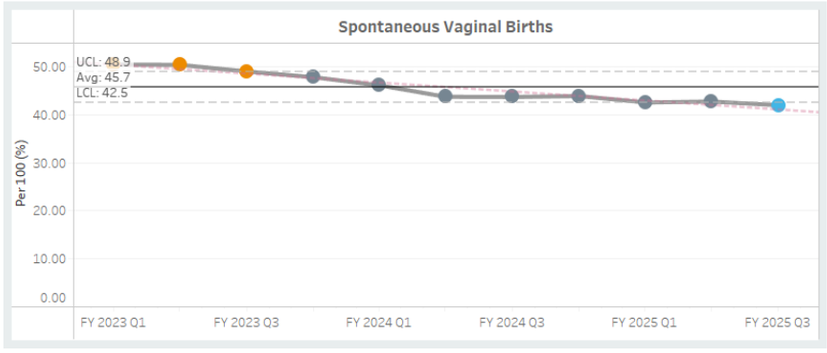
Latest Month

Metric ⓘ

Metric:	Spontaneous Vaginal Births
Rate of:	Spontaneous Vaginal Births (Registerable)
Per 100 (%):	Registerable Births

42.0

Trend



Notes

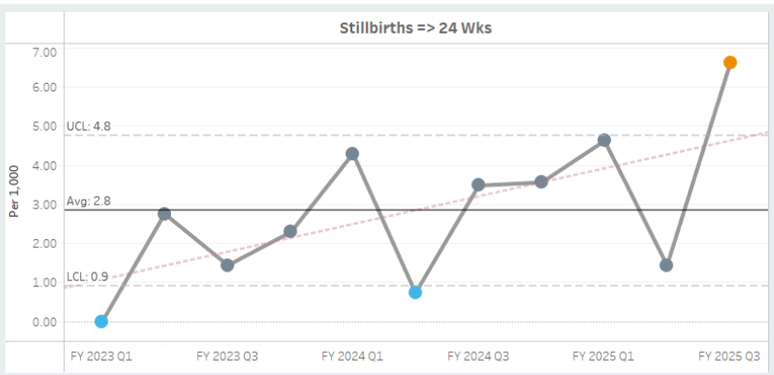
September saw a reduction in the number of spontaneous vaginal births and this is in line with the current National picture. This is in correlation with the increase in the number of caesarean sections.

Outcomes

Metric ⓘ

Metric:	Stillbirths => 24 Wks
Rate of:	Stillbirths => 24 Wks
Per 1,000:	Births => 24 Wks

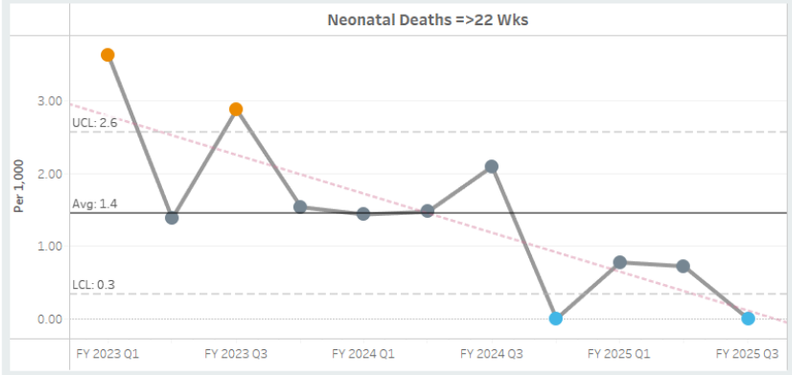
6.6



Metric ⓘ

Metric:	Neonatal Deaths =>22 Wks
Rate of:	Neonatal Deaths =>22 Wks
Per 1,000:	Live Births

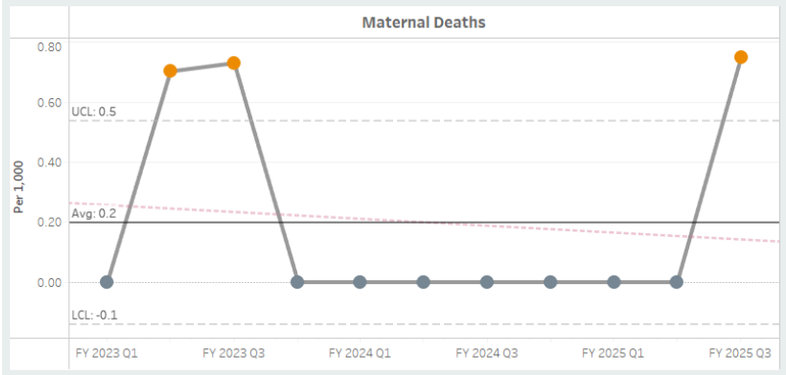
0.0



Metric ⓘ

Metric:	Maternal Deaths
Rate of:	Maternal Deaths
Per 1,000:	Maternities (Deliveries over 24 Weeks/Maternal Deaths)

0.7



What is the intelligence telling us?

There have been 9 stillbirths across the months of September, October, November and December.
This takes figure is outside of our upper control limit on the SPC chart. All cases have been through a robust multi-professional governance process, with 6 being reported as PSII's and 1 case fitting the criteria to be investigated by the Maternity and Neonatal Safety Investigations (MNSI) team. All of these cases are presented to the Trust Patient Safety Review Panel.

Immediate learning has been identified following the review of each of the cases and has been focused on reducing unwarranted variation in antenatal midwifery care, access to ultrasonography and access to interpretation for women for whom English is not their first language.

Stillbirths are uncommon but sadly a small number are expected every year. For a unit of our size this is around 15, although the number per month will vary. For this reason, it is difficult to assess whether a short-term increase is significant or not. However, given the huge impact of each still birth a high level of surveillance is maintained

What is going well?

- Robust governance processes to support the timely review of perinatal outcomes from a multi-disciplinary perspective
- Proactive support from community leads to audit and identify areas for improvement within midwifery fundamentals, providing 1:1 feedback where required
- Midwifery fundamentals represented on the production boards. Monitored weekly and presented monthly at Production board meeting led by the Head of Midwifery
- Midwifery fundamentals training launched with positive engagement and feedback from staff
- Changes to the PMRT process have been implemented to ensure it is more robust, increase parent engagement and the monitoring and completion of actions and learning

Outcomes continued

Focus for the next period

The external stillbirth review continues supported by the midwifery MIA. The table below identifies some emerging themes and the actions taken to address these so far

Emerging Theme	High level summary of actions in place
Scanning capacity	Ongoing issue. Seeking Exec sponsorship to escalate Risk Register scoring from 16 to 20. Escalation via MDG to Trust Board. Paper included within this pack
Information relating to reduced fetal movement's, a persistent theme	Trust has requested LMNS to lead on Community communication on acting on reduced fetal monitoring Trust has also led on posters/digital communication
Parental engagement in the PMRT process Delay in PMRT taking place	PMRT Action plan in progress and meeting timescales
Absent documentation of routine maternal observations including FH in community appointments	Included within Fundamentals of midwifery study day running Oct-Dec 2024 Audit plan in place
Poor quality reviews with no MDT initial review No assurance that any of the were actions were monitored or completed and therefore no evidence of learning	MDT reviews now 3 times per week Review of all action plan quality via SERG
Lack of information and triangulation with the datix system	Being reviewed by Patient Safety Team

Risks and resources required

Continued multi-professional support for incident reviews

To continue to utilise BI intelligence to monitor and recognise any deviations in data, and to escalate via the new governance structure

Patient and staff experience

To continue to inform and support parents to access the Maternity and Neonatal Independent Senior Advocacy service (MNISA)

Continued focus on improving parental engagement as per the Perinatal Mortality Review Tool (PMRT) process, under the leadership of the perinatal Quality and Governance Lead

Bereaved parents feedback to be shared, actioned and monitored at the patient experience monthly meeting as part of the new governance structure

Staff are supported to attend AER's, including stillbirths and neonatal deaths to support psychological safety, and to provide valuable insight and feedback

Where do we want to be?

To continue to implement and embed robust governance processes

Aim to meet or improve our local perinatal outcome rates against both regional and national benchmarking over the next 12 months

Robust intelligence regarding ethnicity and deprivation data in relation to outcomes

PSIRF

PERINATAL QUALITY AND SAFETY REPORT

Quarter 3 2024	
Met MNSI criteria	2
PSIIs	6
AERs	1
Quality Summits	0
Coroner Reg 28	0

Key Performance Indicator	2021-22	2022-23	2023-24	2024-25 YTD
Eligible for MNSI referral	12	8	12	6
Accepted MNSI referrals	11	6	12	5
MNSI referrals declined by HSIB	0	0	0	1
MNSI referrals declined by family	1	2	0	0

Risk ID	Risk	Risk owner	Current rating
409	Risk of first trimester screening offer being missed (if dating scan occurs after 14+1 weeks gestational window for screening), affecting patient pregnancy options and care pathway.	TJ	20
499	Midwifery staffing	LS	20
861	Massive obstetric haemorrhage	RH/VC	20
751	The risk of failure to provide a safe and high quality ultrasound service	AH	16

What is the intelligence telling us?

During quarter 2 there was 1 patient safety incident investigation reported. This case has been detailed in slide 10 and was a stillbirth at 28 weeks gestation. The learning identified was agreed to have likely impacted on the outcome for the baby.

A Quality Summit (QS) was held during July supported by the regional maternal medicine network to review the 3 cardiac arrest cases that had occurred over the past 12 months. The review highlighted good practice and a high standard of care, with praise for the multi-disciplinary teams involved.

All stillbirth cases, MNSI cases and cases reported as PSII's/requiring duty of candour have been provided with information both verbally and written, signposting them to the Maternity and Neonatal Independent Senior Advocacy Service (MN ISA)

What is going well?

We continue to embed PSIRF processes within maternity, the perinatal governance framework guidance has been drafted and shared with stakeholders for review prior to ratifying through Trust processes.

We continue to share learning via a variety of channels, including a theme of the month, quality and safety newsletter, rapid clinical learning and Fetal Wellbeing Wednesday

The clinical matrons have robust oversight of their clinical outcome and audit measures through the weekly production boards. A monthly production board oversight meeting is led by the Head of Midwifery.

Focus for the next period

- Increased frequency of MDT reviews
- Appropriate updating of risks on the risk register (dependent on rating) by risk owners
- Align Trust and LMNS risk registers, bi-monthly meetings to be scheduled

Risks & Resources required

- Obstetric time allocated for regular MDT reviews of patient safety incidents

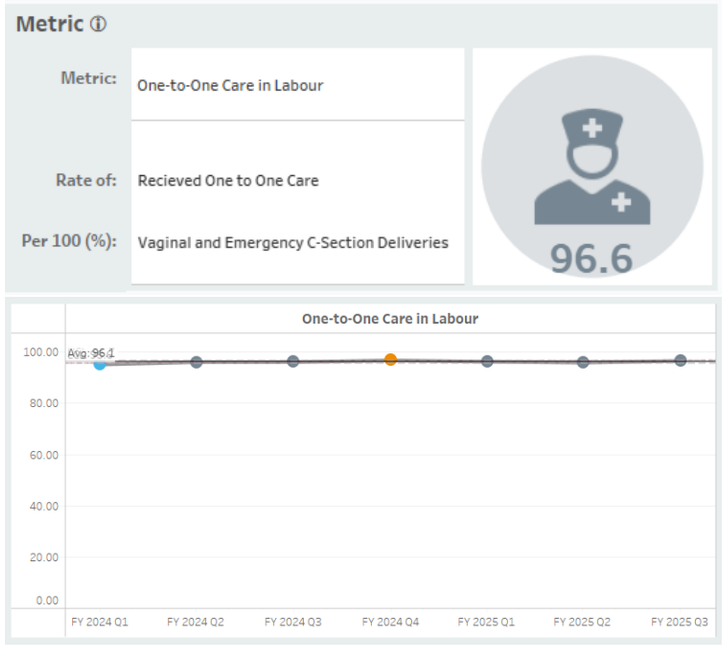
Patient and Staff Experience

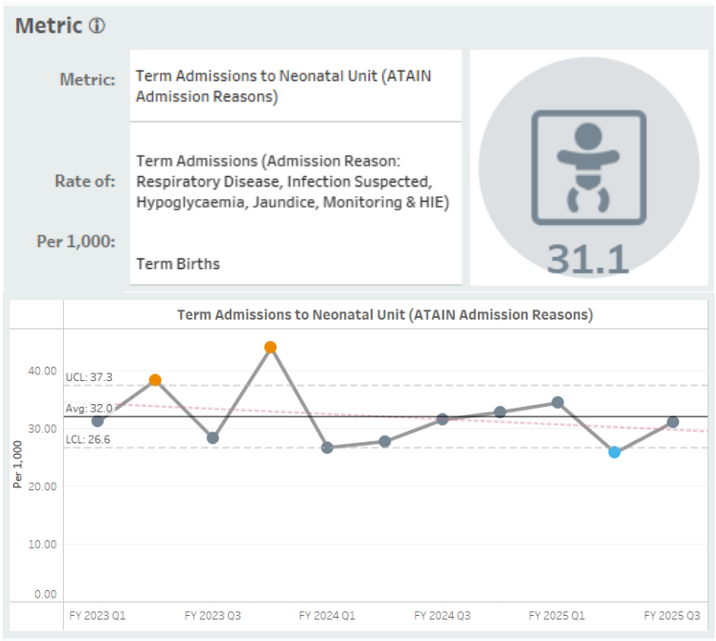
- PSIRF and wider governance training to be included within the PROMPT mandatory update day from January 2025
- Education and training on duty of candour to be provided during the PROMPT training day for all staff

Where do we want to be?

- Streamline MDT process with trigger list
- Continue to implement and embed robust governance processes and structure
- Wider maternity understanding of governance processes

Quality – Quarter 3





What is the intelligence telling us?

1:1 care in labour is defined as care provided to women throughout labour by a midwife solely dedicated to her care. This does not have to be the same midwife (NICE, 2015). 1:1 care in labour has remained reasonable consistent, but is however falling slightly below the required 100% figure. An action plan is now in place and will be monitored through perinatal oversight and assurance and action plan oversight. Staff will be asked to complete a datix when 1:1 care in labour is not achieved to understand why this has not occurred.

Our current ATAIN figures sit below the national benchmarking figure of 5%, however we currently have a backlog of ATAIN reviews requiring an MDT approach. As an updated position, we have now 50 open ATAIN cases with 31 overdue. Regular ATAIN meetings have been scheduled with a focus on reviewing cases involving low cord gases, low APGARS, and/or resuscitation required at birth

What is going well?

We continue to achieve 100% for our supernumerary delivery suite coordinator

ATAIN cases are now monitored on the governance production board weekly, and presented monthly to the Head of Midwifery at the Production Board meeting

Focus for the next period

1:1 care in labour – to update the current escalation policy in line with MIS requirements and continue to monitor

Datix review cases where 1:1 care has not been achieved who have not received 1:1 care in labour

Risks & Resources required

Obstetric resource is required for a full MDT review for ATAIN cases

Patient and Staff experience

There have been no themes reported through patient experience regarding lack of 1:1 care in labour, however we will continue to monitor

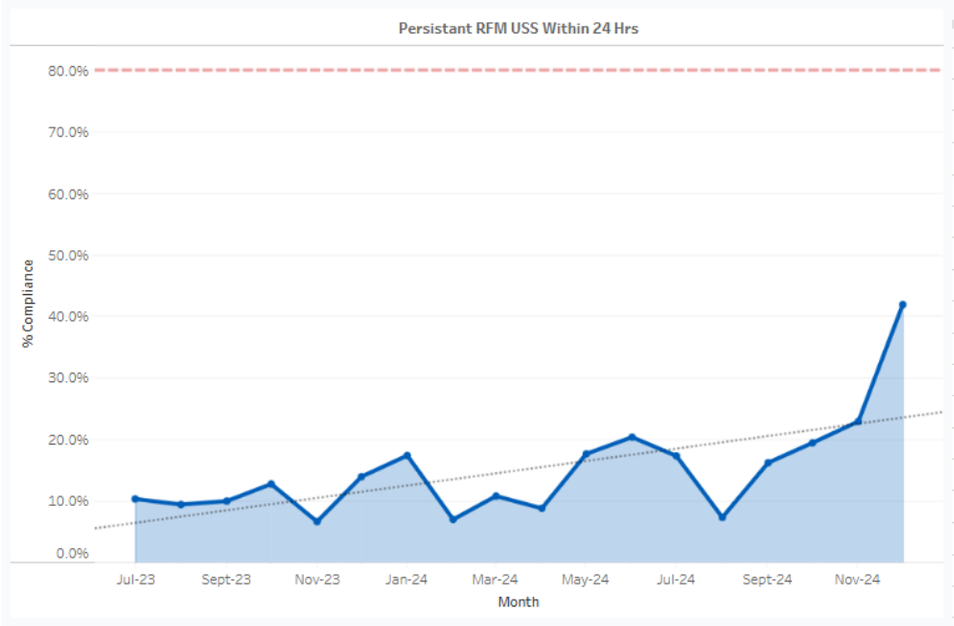
Where do we want to be?

To have a robust review process embedded for the review of all ATAIN cases, in a timely manner (the following month)

Completion of the 1:1 care in labour action plan

Achieving 100% 1:1 care in labour for all women

Priorities – Fetal Wellbeing



What is the intelligence telling us?

Improvement required with compliance with ultrasound scanning for persistent fetal movements within 24 hours in line with Saving Babies Lives Care Bundle version 2

Mitigation required for mothers with persistent reduced fetal movements who are awaiting ultrasound scan

Support for triage required for both midwives and obstetricians, on the recognition and management of women with risk factors for stillbirth who attend with fetal movements concerns

What is going well?

Updated position as of Q3

There have been further improvements to the ultrasound scanning compliance within 24 hours as per the slide below. Work will continue in this area with further improvement work expected month on month

The daily CTG's for women who experience recurrent fetal movements is now in place and women are invited to attend the day assessment unit (DAU) daily for fetal wellbeing reassurance until they have received an ultrasound scan to assess fetal growth and liquor volume

Focus for the next period

Recruitment to fetal wellbeing midwife post

Launch of CTG's on Badgernet

Risks & Resources required/ Where do we want to be?

Continued improvements in USS wait times for recurrent reduced fetal movements within 24 hours

Launch of triage QI

The flowchart for the management of reduced fetal movements is being finalised

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Fetal Wellbeing Wednesday

11 December 2024

Excessive Uterine Activity

Excessive uterine activity is the leading cause of fetal hypoxia/acidosis in labour (FIGO, 2015)

NICE (2022) defines excessive uterine activity as ≥5:10 or a contraction lasting longer than 2 minutes which leads to reduced resting time. This will automatically classify the CTG as **suspicious in labour and abnormal antenatally**. In cases where IA is performed, the recommendation is for transfer to an Obstetric Led Unit for continuous fetal monitoring.

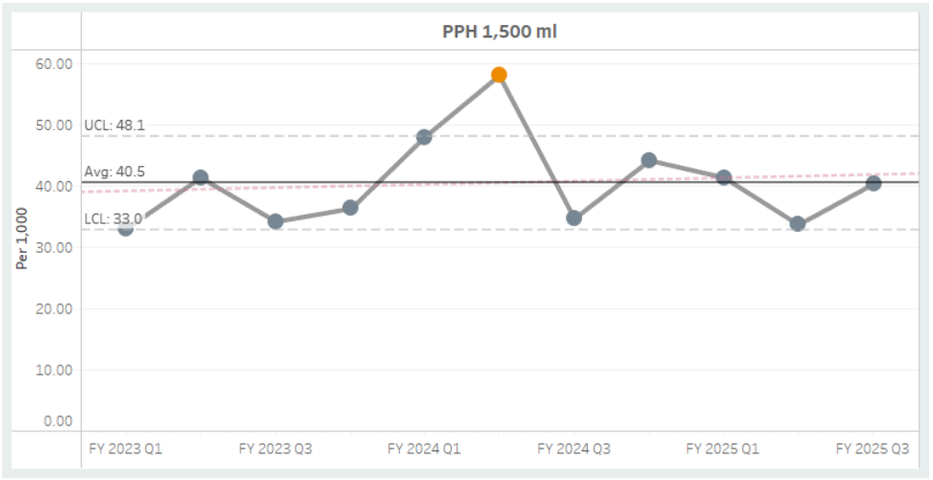
Correct terminology
Tachysystole – excessive uterine activity with no concerning FHR changes
Hyperstimulation - excessive uterine activity with concerning FHR changes

Considerations:

- Not all babies will cope with ≥4:10, consider this when titrating oxytocin, 3:10 is appropriate for a baby with reduced reserves and/or placental insufficiency e.g. SGA, FGR or pre-eclampsia
- Be proactive with tachysystole – it will eventually lead to hyperstimulation if not managed appropriately
- Progress is labour is important but not at the cost of a healthy baby
- Think about the activity and acuity on CDS, lower your threshold for tocolytics and reducing/stopping oxytocin when its busy
- Uterine activity should always be monitored, palpation is key to the best placement of the toco. Ask for help if having difficulties in obtaining a quality recording
- It takes 45 minutes for the action of oxytocin to be halved – consider Terbutaline in combination with stopping oxytocin to achieve timely intervention

	White - Normal	Amber - Suspicious	Red-Pathological
Contractions	<5:10	≥5:10 Leading to reduced resting time Hypertonus (Lasting ≥ 2 mins	

Priorities - MOH



CQUIMs Data	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
National average	31.0	31.0	32.0	32.0	32.0	32.0
Trust Data	37.0	41.0	32.0	28.0	29.0	35.0

What is the intelligence telling us?

- The REDUCE project continues to work well and show consistent improvements in our MOH rate.
- Massive obstetric haemorrhage rate sitting slightly above the national average for November. All MOH cases continue to have an MDT review for identification of learning themes and trends, with work ongoing via REDUCE.
- PPH risk assessment completed - audit shows 95% compliance.
- December saw a slight increase in the Massive Obstetric Haemorrhage (MOH) rate up to 39.2 per 1000
- As an updated position, January saw a reduction in the MOH rate down to 35.9 per 1000

What is going well?

Continued improvements via REDUCE project

Carbetocin audit achieved 100% (100% of CS received Carbetocin)

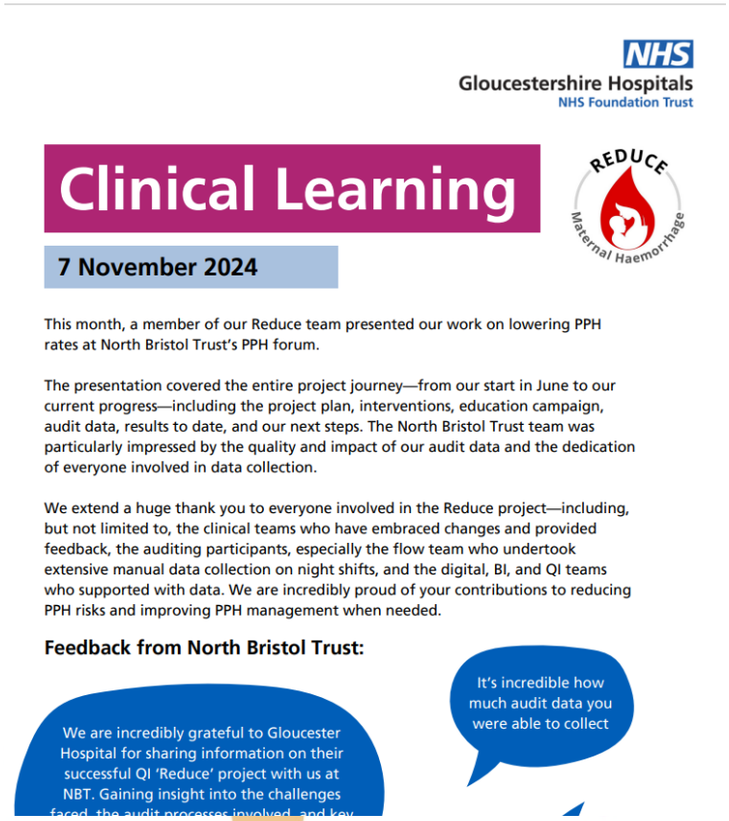
PPH/MOH data presented at tertiary unit's PPH forum, excellent feedback received

Focus for the next period

- Deep dive into themes around PPH and MOH
- Literature review on patient experience of PPH
- Meeting with Head of Patient Experience to be arranged
- The REDUCE team are meeting to plan next steps
- Update REDUCE proforma following staff feedback
- Robust datix incident reviews of PPH cases between 500-1499mls

Risks & Resources required/ Where do we want to be?

- Rotem – increased use – cross-divisional discussion underway. Procurement of additional Rotem to be progressed via 2024/25 business planning process.
- Risks: manual audit = time intensive
- Risk identified through MDT review of escalation when cell selvage in use with measurement of ongoing blood loss



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Clinical Learning

REDUCE Maternal Haemorrhage

7 November 2024

This month, a member of our Reduce team presented our work on lowering PPH rates at North Bristol Trust's PPH forum.

The presentation covered the entire project journey—from our start in June to our current progress—including the project plan, interventions, education campaign, audit data, results to date, and our next steps. The North Bristol Trust team was particularly impressed by the quality and impact of our audit data and the dedication of everyone involved in data collection.

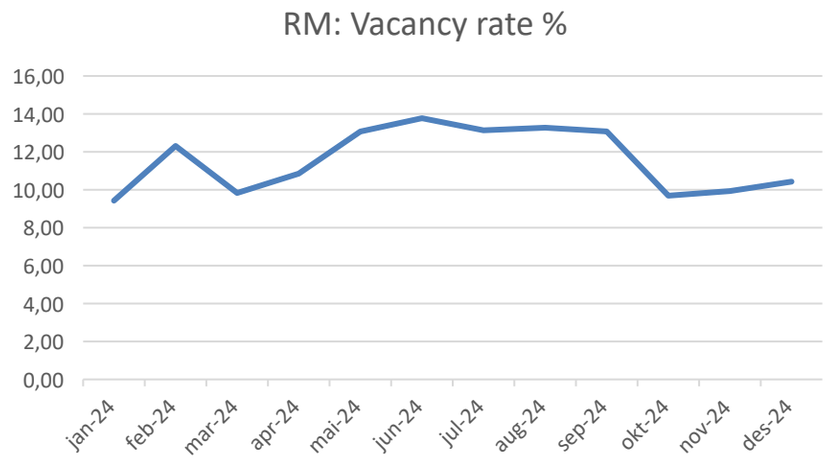
We extend a huge thank you to everyone involved in the Reduce project—including, but not limited to, the clinical teams who have embraced changes and provided feedback, the auditing participants, especially the flow team who undertook extensive manual data collection on night shifts, and the digital, BI, and QI teams who supported with data. We are incredibly proud of your contributions to reducing PPH risks and improving PPH management when needed.

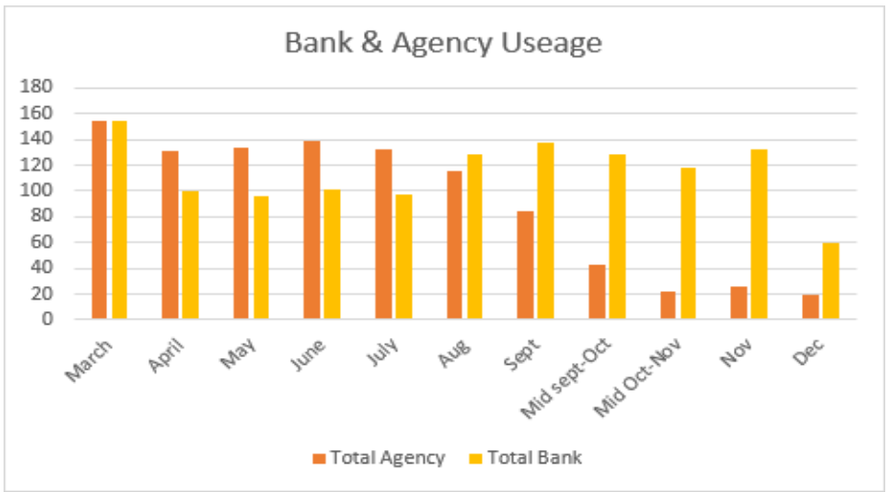
Feedback from North Bristol Trust:

We are incredibly grateful to Gloucester Hospital for sharing information on their successful QI 'Reduce' project with us at NBT. Gaining insight into the challenges faced, the audit processes involved, and key

It's incredible how much audit data you were able to collect

Workforce (Maternity) – Q3





What is the intelligence telling us?	What is going well?
• Vacancy rate by 25.66 WTE – vacancies now at 10.38 % • To review risk on register and downgrade • As the substantive vacancy rate has reduced so has the bank use. • Obstetric consultant gaps are due to short and long term absence, 1x Locum Consultant roles are currently being advertised ; 1 x substantive post	• 100% supernumerary status of labour ward coordinator • Midwife to birth ratio 1:24 • Recruitment to Consultant vacancy and locum consultant joined us • Plan for another 24 (headcount) midwives joining team by March 31st
Focus for the next period	**Risks & Resources required/ Where do we want to be?**
• Campaign to attract midwives into working in the community teams / CTP launch • IEM recruitment programme through Torbay alliance (NHS) progressed (8 midwives over next year) • Request to recruit additional substantive Consultant is being progress via MIS Year 5 funding request.	• Birthrate plus assessment planed for spring 25 • Recruitment plan to continue • Benchmarking exercise for medical workforce required to ensure that sufficient capacity is available.

Neonatal Workforce

What is the intelligence telling us?

- The Neonatal Unit are budget compliant with meeting the Local Neonatal Units Standards of Tier 1 and Tier 2 separate rotas for the junior medical workforce to meet BAPM requirements.
- There are gaps within the rotas due to sickness absence and maternity leave, however these gaps are filled largely by internal locums. The LMNS have been informed of these standards being met through the SW NICU/LNU Medical Workforce Stocktake.
- The Unit remains challenged in relation to nurse staffing. September 24 nurse staffing figures demonstrate a gap of 14 WTE, comprised largely of maternity leave (6.7 WTE), one long term sickness absence, a small number of vacancies (5 WTE) and two members of staff appointed but not yet in post. Maternity leave is only predicted to slightly decrease from its current level.

What is going well?

- There continues to be no vacancies in band 2/3 or 4 roles. The vacancies are only in band 6/7 neonatal nursing roles that require QIS qualification.
- BAPM compliant in neonatal medical staffing.

Focus for the next period

- Succession planning for ANNPs.
- Continue with the neonatal retention and recruitment action plan with no overdue actions, 6 in progress

Updated position:

The neonatal unit have now successfully recruited into the operational matron post

Risks & Resources required

- Escalation plans have been instigated when activity increases/staffing is impaired to support nursing, which has included utilising all nursing time into clinical shifts (cancelling/postponing study leave/admin time/teaching days), flexing staff on and off shifts to match demand and booking of bank/agency nurses. However, this then impacts on the available time for admin, training and other management requirements such as conducting appraisals.
- Bank are utilised if required however there is a very limited pool of bank staff with neonatal skills, especially so if QIS cover is needed.

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – MARCH 2025

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meetings are available. This report is a summary of discussions held at the meeting.

Items rated Red

Item	Rationale for rating	Actions/Outcome
SRO9 Failure to deliver Recurrent Financial Sustainability	A three part agenda item reflecting financial performance in the current year and longer term challenges in securing a recurrent position and strengthened balance sheet. The planned outcome for 2024/25 is positive in terms of Income and Expenditure but, as previously indicated, the Trust's financial position is unsustainable and requires significant reductions in costs in order to live within its income level or increased sources of income.	The Committee noted the current and projected position of the Trust and the efforts across the wider NHS community in terms of reducing the costs and coverage of back office and operational services, rebasing the block contract, increasing theatre capacity and better understanding of Out of Area contracts.
Performance Report Month 11	At month 11 the Trust is reporting a small a deficit of £2.1m which is £0.2m favourable to plan. Without the benefit of a number of non-recurrent items, this would have been a £14m deficit. The forecast outturn remains at breakeven but remains under pressure. Reduced income from non-contracted activity is of increasing concern and is to be investigated. The Committee reviewed and agreed the level of provisions to be included within the annual accounts.	The Committee received the report as assurance of the depth of analysis and understanding of the longer term position. A detailed paper re cash and balance sheet management to come to the next meeting. Levels of provisions were APPROVED as per recommendations.
Financial Sustainability Plan Report Month 11	The outcome for 2024/25 is on target to achieve 100% of the stretch target although, as previously reported, this figure comprises too high a proportion of non recurrent savings – thereby storing up additional problems for 2025/26 and beyond. £32m of the target £39m savings programme for 2025/26 has been identified although that figure includes a significant level of risk - £12m is rated red. The new focus at Divisional level is generating a positive response. Productivity improvement remains static at around 11% less productive against 2019/20 when account is taken	Final FSP plans for 2025/26 to be reviewed at next meeting including the latest national level assessment of the Trust's position.

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

---------- Capital Programme report Month 11	of non-controllable factors. This would remain a focus throughout 2025/26. ---------- RE 2024/25 outturn, the total capital allocation is £48m and spend to month 11 is £28.5m against a plan of £43.3m – a breakeven position is forecast for the year end. At the time of the meeting, this position had improved to £4m behind plan. As in previous years, this weighting of expenditure towards the financial year end puts inordinate pressure on staff and contractors as well as increasing the risks of non-delivery of targets. Re 2025/26 plans, the proportion allocated to the Trust had not yet been determined.	---------- The Committee received the report as evidence of assurance of the position. Smoothing the profile of capital expenditure throughout the year to be considered as a committee objective for 2025/6.
2025/26 Planning and Budget Setting	The 2024/25 exit run rate is £86m deficit – the revenue budget for 2025/26 is a breakeven position – this gap providing evidence of the huge challenge facing the Trust and wider system. These figures do not take account of investments yet to be agreed by the ICB, deployment of recovery funds etc and any activity or inflationary pressures above funded levels.	The Committee noted the underlying position at the end of 2024/25, level of sustainability schemes required and AGREED the budget setting proposal for 2025/26.
Estates Risk Register	The Estates Risk Register contains a number of high scoring risks which have proven difficult to clear or mitigate to a satisfactory level. Paucity of capital funds, availability of expert staff and the complex nature of many of the infrastructure challenges mean that this position will not change in the short to medium term. The Committee received an update on work underway to manage/reduce risks and noted that no new risks had been opened during this reporting period. Two risks due for closure remained open whilst changes were made.	The Committee received the report as assurance of the depth of analysis and understanding around this subject and understanding of available remedies.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Estates Capital Delivery Deep Dive 2024/25 and 2025/26	A two part agenda item including a review of lessons learned during 2024/25 re capital delivery and impact on plans for 2025/26.	The Committee were assured by the work on lessons learned, thanked the teams involved for delivery of a complex

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

Estates Capital Plan	34 major schemes and 104 backlog schemes had been delivered – a huge amount of work for the Trust and GMS. RE 2025/26, the range and complexity of schemes and infrastructure projects had the potential to impact on operational delivery – in particular the ward decant programme due to begin in year at the Tower block to support fire alarm replacement works. The Committee were concerned to hear that Building Control permissions were still awaited from the relevant Local Authority.	programme and APPROVED the Estates Capital Plan for 2025/26 including the challenges around the range and complexity of schemes. NOTED the timetable regarding additional capital bids from national allocations.
Contract Management Group Exception report	The report provided assurance to the Committee of the robust management of the Estates and Facilities contract between GMS and the Trust. Good governance work on fire and water was noted, although the challenge of limited resources was affecting performance. The Permit to Work system and Contractor Control were areas planned to be improved in coming months. The potential for a new switchboard system – a joint GMS and Digital scheme was discussed – still to be scoped.	The Committee received the report as evidence of effective working of the new governance arrangements and was assured by the widening focus of the agenda under consideration.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
Specialised Commissioning Delegation Risk Share Arrangement		APPROVED
GMS Board KIAR	- The Committee considered the report and commended GMS and the Trust on progress in many areas as well as the effective functioning of the revised governance arrangements. Although areas of high risk remained to be addressed, the Committee felt confident in the ability of the new arrangements to address them.	NOTED
GMS Dividend	An interim dividend of £1,979k was recommended for 2024/25.	APPROVED

Items not Rated

Costing Submission/National Cost Collection	The Committee received details of the requirements for the 2025 submission and		The Committee noted the gap analysis, APPROVED the high level costing plan and

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	the Trust's costing strategy.		would receive confirmation of the adequacy of resources available for the task at a future meeting.

Business Case Process and Revised Templates for Revenue Investments
To include ICS Investment Decision matrix/ Schedules of Costs and Benefits/Risk Appetite/Equality Impact and Sustainability Impact Assessments. APPROVED

GMS Governance documents -
A full review had been undertaken to ensure governance frameworks remained effective, aligned with current legislation and regulatory requirements and organisational objectives and the revised documents. APPROVED

Investments

Case	Comments	Approval	Actions
NONE			

Impact on Board Assurance Framework (BAF)

SR 9 : Failure to deliver recurrent financial sustainability – This remains the biggest concern for the Committee. There has been no improvement in the underlying position. Additional controls around new workforce targets had been included.
SR 10 – Condition of the Estate - another issue of huge concern with no potential for a rapid change in fortunes. A workshop to review and learn from the 2024/25 programme experience would take place in April. BAFF to be reconciled to the Risk Register.
SR 11 – Sustainable healthcare This was to be reviewed in May once full implementation of the 2024/25 programme was complete.

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Report to Trust Board			
Date		8 May 2025	
Title		**2025/26 Annual Plan**	
Author / Sponsoring Director/ Presenter		Author - Ian Quinnell – Deputy Director, Strategy & Transformation Sponsoring Director – Karen Johnson – Director of Finance	
Purpose of Report (Tick all that apply ü)			
To provide assurance	ü	To obtain approval	
Regulatory requirement		To highlight an emerging risk or issue	
To canvas opinion		For information	ü
To provide advice		To highlight patient or staff experience	

Summary of Report

To present the final Annual plan to Board for 2025/26.

The annual plan submission included the activity and performance plan, financial plan, workforce plan and the Board Assurance Statement.

The details of the plan was presented to the private section of an exceptional Board on 25th March 25. This paper provides a summary of the plan and details of the Board Assurance Statement.

During the initial submission of the plan the Board was unable to support three statements in the Board Assurance Statement;

1. The process of the equality and quality impact assessment – this is shown as appendix 3
2. The overview of the priorities and investments with the plan – this is covered in this paper
3. The profiling of the financial plan (triangulation of the plan was covered during the meeting on the 25th March) – this is covered in this paper.

The financial plan is showing breakeven however that now assumes the Trust has a savings target of £41.8m which is c5% of spend. We have programmes totalling £34M at varying levels of risk, with a gap of £7.5M to target at this point. In addition to this, we have £12.2M of high-risk programmes.

In addition to delivering £41.8M of savings, the Trust is planning to deliver an additional £15.3M of cost weighted activity across both elective and non-elective settings, meaning an overall productivity gain of £57M (representing 6% productivity improvement, against a target of 4%)

The operational plan is showing delivery of all targets and now includes c£7.1m of additional expenditure from ERF funds to support the delivery of elective recovery. A contribution is also included from ERF funding (c£11.6m) to the overall position alongside a non-recurrent reallocation of system funds to GHT (c£30.8m).

The workforce submission is currently showing an increase of 41.79WTE, this will be adjusted to reflect the recent national announcement of a headcount reduction of 150 WTE, giving a net reduction of 108.21WTE.

Investments included in the plan are;

➢ Security ➢ Elective recovery schemes ➢ MES pathology to develop the case for change ➢ Productivity for non pay growth
Financial Implications
To note
Approved by: Director of Finance | **Date:** 15th April 2025
Recommendation
• The Board is asked to note the final submission • The Board is asked to note the Board Assurance Statement.
Enclosures

Planning 2025/26

The annual plan submission included the activity and performance plan, financial plan, workforce plan and the Board Assurance Statement.

The details of the plan was presented to the private section of an exceptional Board on 25th March 25. This paper provides a summary of the plan and updates to complete the Board Assurance Statement.

During the initial submission of the plan the Board was unable to support three statements in the Board Assurance Statement;

1. The process of the equality and quality impact assessment – this was covered during a Board development session on 8th April 25.
2. The overview of the priorities and investments with the plan – this is covered in this paper
3. The profiling of the financial plan (triangulation of the plan was covered during the meeting on the 25th March) – this is covered in this paper.

In summary the plan for 25/26 shows a financial breakeven position assuming a savings target of £41.8m which is c5% of spend. We have programmes totalling £34M at varying levels of risk, with a gap of £7.5M to target at this point. In addition to this, we have £12.2M of high-risk programmes.

In addition to delivering £41.8M of savings, the Trust is planning to deliver an additional £15.3M of cost weighted activity across both elective and non-elective settings, meaning an overall productivity gain of £57M (representing 6% productivity improvement, against a target of 4%)

The operational plan is showing delivery of all targets and now includes c£7.1m of additional expenditure from ERF funds to support the delivery of elective recovery. A contribution is also included from ERF funding (c£11.6m) to the overall position alongside a non-recurrent reallocation of system funds to GHT (c£30.8m).

The workforce submission is currently showing an increase of 41.79WTE, this will be adjusted to reflect the recent national announcement of a headcount reduction of 150 WTE, giving a net reduction of 108.21WTE.

Investments included in the plan are;

- Security
- Elective recovery schemes
- MES pathology to develop the case for change
- Productivity for non pay growth

7.0. Recommendation

Board is asked to:

- To note the summary of the plan – included in the report

- To note the profiling approach to the plan – appendix 2
- To note the investments included in the plan – included in the report
- Approve the Board Assurance Statement – Appendix 1
- To note the presentation of the EQIP process – Appendix 3

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Impact Assessments

(quality, equality and health inequality)

Board Development Session

Presenter
Chief Nurse and Director of Quality – Matt Holdaway
authors

the Best Care for Everyone
care / listen / excel

Situation

What (current situation)

- A quality impact assessment is a process to evaluate the potential impact of proposed changes (or business cases) on **patient safety, clinical effectiveness, experience, equality and diversity and health inequalities**. The process is to ensure that any risks are identified and then action is taken to understand the risks and then to mitigate/control any risks.
- Request from NHSE in 2023/24 that we have Quality Impact Assessment processes as part of the planning guidance.
- Where are we now…
  - No written QIA guidance but an expectation that this process should be completed for:
    - Policies (100%),
    - Business cases (getting better),
    - “Big” organisational changes (this is part of project or programme management to complete impact analysis) as part of the change.
- QIA should be undertaken at the planning stage of the change process and refreshed during the project/programme cycle

So What

- Need guidance so that we have clarity for **when** we would carry out QIA (should be **proportionate** to the work proposed – i.e. the more significant the change the more rigorous assessment)
    - Developing new services
    - Changes to existing services
    - Cost Improvement plans
    - Managing cost pressures / disinvestment
    - Trust Policies
    - Part of investment Business Case process (template on the intranet)
- **QIA tool** support our assessments
- This shouldn't be a one off activity as should be completed at "beginning, middle, end and post" change
- Need to be clear within the programme that **actions** will be taken to address any issues (positive/negative)

Now what

- The responsibility for QIA sits with the SRO / service leader leading change
- The QIA assessment should be based on data/evidence.
- The potential adverse impacts should be risk assessed using scoring matrix and be clear within the QIA tool.
- We need to complete our guidance document so we clear on our processes for when we can expect QIA (Deputy Director of Quality / end of May 2025)
- QIA tool needs to be updated to include quality, equality and health inequality (QIA task and finish steering Group / end of May)
- As part of the guidance document we need to complete training needs analysis for QIA so that managers can access training so know how to apply process and tool and have this available on the intranet (early June intranet pages completed).
- Board members should see that impact assessment process has been completed within Board papers when they include large scale changes and can/ should request.
- Ongoing monitoring and continued assessments will be the responsibility of the SRO for the programme.

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Thank you

Section B: Provider Assurance (GHFT) at 30 April 2025

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	The Board has taken assurance from Finance and Resources committee, that the annual plan is aligned from a workforce, activity and financial perspective. Presentations incorporate each element and shows the flow between them.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	Achieved through the sub-committees of the board. The financial sub-committee which reviews financial governance including scheme of delegation and standard financial instructions. Investment decisions are taken through an operational and clinical governance process (through divisional quality boards and Divisional Operational Group) into Trust Leadership Team where impact assessments are used to understand clinical risk associated with change of service. The trust implemented a formal governance process during 2024/25 that reviews each investment requirements against a number of criteria including clinical and quality impact.

Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	The prioritisation of investments is linked to the Trust's Risk Register, its Board Assurance Framework and quality priorities presented to committees and approved for system discussion. These are the Trust's highest risk area and support the planning guidance. The review process is completed with system partners and weighted in order to prioritise schemes that delivered the greatest clinical benefit to patients across the system. The impact of these schemes not being supported was presented to finance and resources committee in line with the planning governance process. Board have had sight of the impact of investments on the Trust Risk Register in formal and in seminar session. A paper has also been circulated to Board members detailing the investments that are now confirmed within the plan.
A robust quality and equality impact assessment (EQIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes	Specific EQIA's have not been reviewed by the Board yet but our focus is as always to deliver on the fundamentals of good care, maintaining our collective focus on the overall quality and safety of our services. The plan has been driven by organisational risk and the need to protect access to essential services and to narrow health inequalities. The Board has ensured that

		quality and safety have been safeguarded and that attention to challenged services has influenced the plan A task and finish group is running ICB wide to develop documentation and formalise the process. There will be a requirement for individual service changes that pertain to the operational plan to have the agreed EQIA completed. The outcomes and resulting actions of these assessments will have oversight from the appropriate divisional boards, and Trust Leadership Team. We are refreshing our guidance to ensure service line managers and divisional leadership teams have the required tools, approach and support to fulfil the requirements. This EQIA process was scheduled as part of a Board workshop on the 8th April but subsequently circulated to provide additional confidence of the process to be overseen by Divisional Boards and the Trust Leadership Team.
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes	Regular system meetings have been in place and system workstreams created to address the financial challenges. These include clinical representation. A Trust Programme Board for planning established and chaired by Director of Finance to oversee submission.

		There is a set of agreed systemwide priorities including a risk framework of how to deal with deviation from the plan.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	The plan clearly highlights the level of performance that will be achieved against the national priorities. Benchmarking opportunities have been explored and are embedded into the plan. Productivity opportunities reflect national guidelines. The checklists have been shared and understood by Board Members.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Yes	The Board has had oversight of the utilisation of resources within the Trust and there are regular updates to Finance and Resources committee on progress of this. The Trust is rolling out productivity performance across the organisation to increase visibility and ownership.
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	Yes	The high-level plan has been assessed using the trust's risk assurance framework and the plan is able to demonstrate achievability of the national planning guidance.

		The plan does hold a level of risk around deliverability and impact on quality and this will be built upon on through Quarter one and reported through sub committees of the board.
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes	The board is aware and understands the level of risk within the plan. Board sub committees have scrutinised the development of the plan during the planning round. Profiling and triangulation of the plan was included in a paper circulated to Board members showing the profiling approach. The triangulation of the plan was covered in the Board meeting on 25th Mar 25

Appendix 2

2025/26 Financial Plan Profiles
April 2025

1. Overview

As part of the 2025/26 financial planning process the Trust submitted its financial plan, with system partners, at the end of March 2025.

The plan contained information regarding the capital and revenue positions and incorporated a range of profiles for the timing of income, expenditure, and savings. This paper provides a simple overview of the basis of the profiles that were used within the submission.

2. Profile

a) Capital

Capital expenditure has been included based on the phasing of when works are expected to be completed from plans put forward.

Month	1	2	3	4	5	6	7	8	9	10	11	12	FY
Capital £'000s	3,656	2,241	2,463	2,040	2,248	3,038	3,860	6,429	4,438	6,879	6,892	7,973	52,157
Capital %	7%	4%	5%	4%	4%	6%	7%	12%	9%	13%	13%	15%	

b) Revenue income

Income is based on available working days per month

Month	1	2	3	4	5	6	7	8	9	10	11	12	FY
Income £'000s	-64,869	-64,796	-68,120	-73,933	-64,967	-70,913	-73,951	-64,978	-67,939	-67,952	-64,911	-70,934	-818,263
Income %	7.9%	7.9%	8.3%	9.0%	7.9%	8.7%	9.0%	7.9%	8.3%	8.3%	7.9%	8.7%	

c) Revenue expenditure – pay.

Pay expenditure is based on equal 1/12ths with adjustments then layered on for the anticipated financial sustainability impacts (c£15.6m). No adjustments for bank holidays or weekend enhancements have been made as previous analysis has shown that impact is minimal compared with the overall pay bill.

Month	1	2	3	4	5	6	7	8	9	10	11	12	FY
Pay £'000s	43,196	43,191	42,647	42,526	42,537	42,558	42,421	42,466	42,512	42,531	42,536	42,656	511,777
Pay %	8.4%	8.4%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	

d) Revenue expenditure – non pay

Non pay expenditure is based on equal 1/12ths with the impact of financial sustainability schemes (c£24m) included. In 2023/24 phasing was used for drugs and clinical supplies based on 2022/23 activity trends however this

wasn't reflective of the actual 2023/24 activity and therefore was not continued in 2024/25.

Month	1	2	3	4	5	6	7	8	9	10	11	12	FY
Non pay £'000s	26,883	26,865	23,191	25,817	25,822	25,826	25,442	25,446	25,453	25,180	25,187	25,374	306,486
Non pay %	8.8%	8.8%	7.6%	8.4%	8.4%	8.4%	8.3%	8.3%	8.3%	8.2%	8.2%	8.3%	

e) Financial sustainability schemes

Schemes are included on the basis of plans submitted / expected and the NHS England requirement of having no more than 20% of schemes in Q1 and no more than 55% in Q2.

Month	1	2	3	4	5	6	7	8	9	10	11	12	FY
Red £'000s	537	537	1,687	1,891	1,891	1,909	2,042	2,042	2,042	2,077	2,149	1,849	20,653
Amber £'000s	243	261	572	686	680	680	1,103	1,096	1,093	949	941	922	9,226
Green £'000s	716	721	3,578	755	745	720	685	642	594	961	883	895	11,895
FSP £'000s	1,496	1,519	5,837	3,332	3,316	3,309	3,830	3,780	3,729	3,987	3,973	3,666	41,774
FSP %	3.6%	3.6%	14.0%	8.0%	7.9%	7.9%	9.2%	9.0%	8.9%	9.5%	9.5%	8.8%	

f) Cash

The cash profile is based on the combination of factors outlined above. The number of days operating cash is based on the total pay and non-pay position over 365 days (c£2.24m per day)

Month	1	2	3	4	5	6	7	8	9	10	11	12
Cash £'000s	50,167	38,917	33,183	56,875	50,930	45,059	52,282	45,758	45,094	35,005	42,894	45,497
Nos of days cash	22	17	15	25	23	20	23	20	20	16	19	20

The position currently assumes that all financial sustainability schemes will be delivered. If we assume that green schemes are secure a cash scenario is shown below where the impact of not delivering red or amber schemes occurs.

Month	1	2	3	4	5	6	7	8	9	10	11	12
Cash	49,387	37,339	29,346	50,461	41,945	33,485	37,563	27,901	24,102	10,987	15,786	15,618
Nos of days cash	22	17	13	23	19	15	17	12	11	5	7	7

This also assumes that the ICB deliver their plan that allows the transfer of non-recurrent support to the Trust which currently totals c£42.4m.