Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 10 July 2025 at 09.00 to 12.30

Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

DRAFT AGENDA

REF	ITEM	PURPOSE	PAPER	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** *8th May 2025*	Approval	Yes	09.05
5.	**Matters arising**	Assurance		
6.	**Questions from the public**	Information		09.10
7.	**Patient Story**	Information		09.15
8.	**Chair's report** *John Cappock, Vice-Chair*	Information	Yes	09.25
9.	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	09.35
	MATERNITY SERVICES			
10.	**Maternity Services Regulatory Compliance Report (section 31 Notice Response)** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Yes	09.50
	GOVERNANCE			
11.	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director & Vice Chair*	Assurance	Yes	10.05
12.	**Trust Seal Report** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	10.15
13.	**Board Assurance Framework and Risk Report** *Kerry Rogers, Director of Integrated Governance*	Assurance	Yes	10.20
	PEOPLE AND ORGANISATIONAL DEVELOPMENT			
14.	**People and Organisational Development Committee Report** *Marie-Annick Gournet, Non-Executive Director*	Assurance	Yes	10.30
15.	**Engagement and Involvement annual review** *Claire Radley, Director for People & OD and James Brown, Director of Engagement, Involvement and Communications*	Assurance	Yes	10.40
16.	**Equalities Annual Report** *Claire Radley, Director for People & OD and Maria Smith, Associate Director of Education, Learning and Culture*	Assurance	Yes	10.50
17.	**Guardian of Safe Working Annual report** *Shyam Bhakthavalsala, Consultant Paediatrician and Neonatologist*	Assurance	Yes	11.00

BREAK (11.10 to 11.20)				
QUALITY AND PERFORMANCE				
18.	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Yes	11.20
19.	**Integrated Performance Report** *Al Sheward, Chief Operating Officer and Executive Director colleagues, Karen Johnson, Director of Finance*	Assurance	Yes	11.30
20.	***Quality Account*** *Matt Holdaway, Chief Nurse and Director of Quality (and Suzie Cro)*	Assurance	Yes	11.50
21.	**Annual Safeguarding Report** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Yes	12.00
22.	**Safer Staffing (Nursing) Report** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Yes	12.10
FINANCE				
23.	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director and Karen Johnson, Director of Finance*	Assurance	Yes	12.20
24.	**Any other business**	Information		12.30
25.	**Governor observations**	Information		
26.	**Date and time of next meeting:** 11 September 2025 at 09.00 Lecture Hall, Sandford Education Centre, Cheltenham General Hospital	Information		

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 8 May 2025, 09:00, Sandford Education Centre, Cheltenham General Hospital		
Chair	Deborah Evans	Chair
Present	Vareta Bryan	Non-Executive Director
	John Cappock	Non-Executive Director
	Sam Foster	Non-Executive Director
	Sally Moyle	Non-Executive Director
	John Noble	Non-Executive Director
	Andrew Champness	Associate Non-Executive Director
	Kaye Law-Fox	Gloucestershire Managed Services Chair/Associate Non-Executive Director
	Raj Kakar-Clayton	Associate Non-Executive Director
	Kevin McNamara	Chief Executive Officer
	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
	Claire Radley	Director for People & Organisational Development
	Kerry Rogers*	Director of Integrated Governance
	Al Sheward	Chief Operating Officer
Attending	James Brown	Director of Engagement, Involvement and Communications
	Neil Hardy-Lofaro	Deputy Chief Operating Officer
	Lisa Stephens	Director of Midwifery
	Sarah Favell	Trust Secretary
	Ramonique Banga	Corporate Governance Officer
Apologies	Marie-Annick Gournet	Non-Executive Director
	Jaki Meekings-Davis	Non-Executive Director
Observers		
Governors	Helen Bown, Douglas Butler, Mike Ellis, Andrea Holder and Ian Craw	
Other	Cath Hill, Advancing Quality Alliance (Aqua), Kate Hillier (Deputy Medical Director)	
Public	33	

Ref	Item
1	**Chair's welcome and introduction**
	Deborah Evans, Chair opened the meeting, welcoming all members of the public and governors in attendance. A particular welcome was extended to the new non-executive and associate non-executive directors attending their first board meeting (John Noble, Andrew Champness and Raj Kakar-Clayton). The Chair also noted the appointment of Sally Moyle as a substantive non-executive director, recognising her previous contribution to the Board as an associate non-executive director. A welcome was extended to Cath Hill, observer (Aqua) and to members of the phlebotomy service who had chosen to attend the meeting as observers. It was confirmed that the meeting was quorate.
2	**Apologies for absence**
	Apologies had been received from Marie-Annick Gournet, Non-Executive Director and Jaki Meekings-Davis, Non-Executive Director.

3	**Declarations of interest**
	There were no declarations of interest in respect of agenda items.
4	**Minutes of previous meeting**
	The Board reviewed the minutes of the public board meeting held on 13th March 2025 with no amendments to the minutes **RESOLVED:** The Board APPROVED the minutes of the meeting held on 13 March 2025.
5	**Matters arising**
	There were no matters arising.
6	**Questions from the public**
	A number of questions had been submitted by members of the phlebotomy service in respect of the ongoing industrial action. These questions were each read aloud to the Board with a response being provided by Claire Radley, Director for People and Organisational Development. Both questions and response would be published on the Trust website subsequent to the meeting.
7	**Patient Story**
	The Board received a presentation, including video, from the team (Rebecca Fell and Steve Lewis Smyth) which had developed 'Places to Escape', a virtual reality patient experience project. A demonstration had also been set up in an adjoining room for Board attendees to visit. This was a project designed and implemented with the support of patients and carers of patients requiring extended admissions for treatment. It used virtual reality headsets to bring comfort, connection and a sense of escape for patients, helping to combat feelings of isolation, boredom and loneliness. It had been piloted in oncology and critical care services with plans to expand its use. It was explained that through the use of virtual reality headsets patients were able to experience immersive 360-degree videos filmed across Gloucestershire, local landmarks and places of calm. The project had been supported by local businesses and charities as well as the Integrated Care Board. Other potential uses/benefits of the project were explored; recruitment, education and to celebrate achievements within the Trust. The presentation was well-received by all attendees and Deborah Evans, Chair, expressed her thanks and support for the initiative, particularly the evident partnership working with patients, carers and the wider community.
8	**Chair's Report** *Deborah Evans, Trust Chair*
	Deborah Evans, Chair, commented that the meeting had a full agenda and therefore her report would be taken as read with highlights flagged for the attention of the Board. She relayed to the Board the recent meeting between her and Andrea Holder (Lead Governor) and their counter-parts at Gloucestershire Health and Care NHS Foundation Trust which had been a constructive and positive meeting; sharing knowledge and experience with a particular focus on the role of the governor within Foundation Trust organisations. It was

	anticipated that this was the first of a number of positive interactions with our system partner organisation with a possible shared non-executive director event. Both the Chair and Kaye Law-Fox, Associate Non-Executive Director and Chair, Gloucestershire Managed Services, had recently attended an online Sikh faith knowledge session which had been well attended by Trust and system colleagues keen to improve their understanding of this important faith within our community. Finally, the Chair highlighted her attendance at a recent graduation from the Quality Improvement Academy where they had heard from a number of projects, primarily focusing on urgent emergency care, same day treatment and frailty assessment. It had been a great event, clearly demonstrating a grass root commitment to improvement work across the Trust. **RESOLVED:** The Board NOTED the report for information
9	**Chief Executive's Report** Kevin McNamara, Chief Executive
	Kevin McNamara, Chief Executive, presented his report to the Board, taking some items as read. He outlined the recent changes in the NHS national and regional structures with the announced abolition of NHS England, a restructuring of Integrated Care Boards and significant spending reductions with Integrated Care Boards being required to cut their running costs by fifty percent by December 2025 and all Trusts required to both reduce their financial deficits and to reduce the post 2019 workforce growth in corporate and non-patient support roles by fifty percent by December 2025. The Trust was being pro-active in addressing those challenges, working closely with system partners, and had introduced a recruitment freeze in corporate areas unless the roles were identified as required for patient/staff safety reasons or business critical. Staff have been kept informed of developments via a number of staff briefings and information sources via the intranet. It was recognised that this is a very unsettling time for staff affected. The recent Supreme Court ruling as to the definition of 'sex' was acknowledged with support being offered to colleagues concerned at the recent media coverage. The Trust was awaiting national guidance on key issues impacting it as both a provider of healthcare services and as an employer. Kevin McNamara extended his congratulations to all involved with the provision of nursery and early years support at Little Oaks Nursery, which had received a 'Good' rating following a recent OFSTED inspection. This childcare provision was a very important part of the staff offering and was widely valued by staff. A summary of performance highlights was provided, recognising the Board would be receiving the Integrated Performance Report later in the meeting. The improvements in urgent emergency care since the challenging Quarter 4 period were noted but it was acknowledged that the past financial year had been challenging with the Trust not able to consistently meet its performance target against the 4-hour standard and impact on ambulance services. It was confirmed that this area would be an area of whole Board focus during 2025/2026, together with the 12-hour wait target. Elective care and waiting times was identified as an area of improvement, following huge efforts by the relevant teams and the

	Trust was favourably benchmarked against other Trusts in the south west region. Kevin McNamara acknowledged there was considerable work to be done and the Trust was focused in its continuing efforts. Prompted by a question from John Noble, Non-Executive Director, there was a discussion about the importance of approaching future performance challenges on a system wide basis to maximise benefit to patient. It was recognised that 2025/2026 would be a period of significant transition, both with the national and regional restructure but also with the arrival of two new Chief Executives in partner organisations; the Integrated Care Board and Gloucestershire County Council. Kevin McNamara expressed his confidence that the Trust would continue to enjoy constructive and positive relations with those partner organisations, he would be working to ensure the Trust's voice was heard in any larger reconfiguration of the Integrated Care Boards. **RESOLVED**: The Board NOTED the report for information.
10	**Audit and Assurance Committee Report** John Cappock, Non-Executive Director
	John Cappock, Chair of Audit and Assurance Committee, presented the Key Issues and Assurance Report for the period March to April 2025, with the report being taken as read. The focus on the report was the draft Head of Internal Audit opinion for 2024/2025 which was indicated to be one of moderate assurance. Whilst this remained provisional, pending the final completion of some outstanding work it was not envisaged the opinion would change in the final report. This represented significant progress over the last year from the previous Internal Audit opinion (2023/24) of limited assurance. The contribution of many, particularly the executive team, to the improved governance position, acknowledged. It was confirmed that a primary focus of the Audit Committee remained on ensuring consistency of engagement with management actions resulting from the audit programme. The Internal Audit plan for 2025/2026 had been agreed and endorsed by the Committee. The Committee was proposing to carry out a deep-dive into the Single Action Tender process following a recent increase in the use of the procurement waiver process. Both Karen Johnson, Director of Finance, and John Cappock, Chair, considered this a useful exercise and a report would be going to the September meeting. Finally, it was reported that the Committee had considered the draft Annual Governance Statement in detail with contribution from both Internal and External Auditors. Overall, the Committee considered the content to be an accurate reflection of the Trust's systems of control but the Committee felt that the wording could reflect a more positive assessment of the Trust's position and trajectory, including maternity services progress to reflect the work undertaken during the year. Deborah Evans, Chair, noted the provisional Head of Internal Audit opinion and the assessment that governance/assurance provision was improving. She extended her thanks to the Executive team and their teams involved in driving this continuous improvement but was also clear that there was no room for complacency. **RESOLVED:** The Board NOTED the content of this report for assurance.

11	**Health and Safety Compliance reports: Annual Report and Management Framework** Kerry Rogers, Director of Integrated Governance
	Kerry Rogers, Director of Integrated Governance, presented both reports and highlighted the importance the Board was placing on ensuring it is fully sighted on health and safety issues affecting both patients and staff. It was intended that this first Annual Health and Safety Report would be the vehicle for providing on-going assurance directly to the Board on these issues. This would be in addition to operational escalation via the Trust Leadership Team and various health and safety specialist groups and additional assurance via both the Group Health and Safety Committee and Audit & Assurance Committee. Audit and Assurance Committee's focus would be on process and system management of health and safety. The approach at all meetings would be a group approach and she commented that the group approach had been in evidence at the recent Group Health and Safety Committee. It was confirmed that the report had been considered at both Trust Leadership Team and Health and Safety Committee, including extensive dialogue as to the risk rating of various elements, including water safety. The report, and risk ratings contained within, were recommended for Board approval. It was also flagged to the Board that the focus for 2025/2026 would be primarily on asbestos management, fire and water risks with an interim report scheduled to be considered by the Trust Leadership Team in June 2025. John Cappock, Non-Executive Director, commented on the discussions that had taken place between him and Kerry Rogers, Director of Integrated Governance, on the assurance role of the Audit and Assurance Committee. In addition to the twice-yearly substantive reports, which would then be incorporated into the Committee's Key Issues Report to Board, it had been agreed that there would be a standing opportunity for ad hoc reports to be brought to Committee. Assurance reports as to violence and aggression would be before both Audit and Assurance Committee and People and Organisational Development Committee. John Cappock had agreed to be non-executive champion for security issues. Both John Noble and Sam Foster, Non-Executive Directors, commended the work undertaken and the structures set out within the report. It was noted that the tone of the approach being taken was one of 'problem seeking', which was very important if the Board is to receive accurate assurance. The inclusion of a Health and Safety strategic risk on the Board Assurance Framework was discussed. Kevin McNamara, Chief Executive, expressed his gratitude for the work undertaken by Kerry Rogers, Director of Integrated Governance and acknowledged that the Trust was now addressing health and safety priorities with commitment and pace. There were resource implications, both for the Trust and System wide. The example was given of the importance of working with system partners to address the issue of patients with no criteria to reside. If the Trust was able to improve bed capacity this would in turn improve the Trust's ability to decamp wards and services to facilitate health and safety improvements. Kevin McNamara also emphasised the importance of ensuring timely feedback to staff that the work on the health and safety agenda was, at least in part, in response to their highlighting concerns regarding the impact of estate on both staff morale and patient care. It was recognised that the agenda was large and would require a multi-year approach but equally it should continue at pace.

	RESOLVED: The Board NOTED the report for assurance within the report and appendices and adopted the Trust Leadership Team's recommendations: 1. The Board confirmed its commitment to ensuring a safe and healthy workplace for all employees and visitors by supporting the improvement activity highlighted; 2. The Board confirmed its assurance that the key areas of improvement activity will address the shortcomings identified within the annual report. 3. The Board confirmed its assurance as to the adoption of the new Health and Safety Management Framework; 4. The Board approved and supported the need for urgent revision of the contract between the Trust and its wholly owned subsidiary, Gloucestershire Managed Services, in respect to the management of issues relating to fire safety, water management, asbestos management and ventilation with the aim of ensuring roles, responsibilities and expectations are clear.
12	**Modern Slavery Statement and Bribery and Corruption Statement** Kerry Rogers, Director of Integrated Governance
	Kerry Rogers, Director of Integrated Governance, presented the annual Modern Slavery statement for approval and signature by the Chief Executive. The Trust's Statement had not been updated since 2020. The recent review included commentary from the People and Organisational Development team, the Procurement team and the Trust's Lead for Safeguarding. It was confirmed that the Statement had been reviewed by the Audit and Assurance Committee (April meeting) and approved. The Statement was approved, subject to an amendment suggested by Kevin McNamara who was concerned as to the use of the term 'voluntary' in respect of employment with the Trust or suppliers. This would be changed to 'without coercion'. The draft annual Bribery and Corruption Statement was presented on behalf of the Head of Counter-Fraud Services for approval and subsequent signature by the Chief Executive. This Statement had been reviewed by the Audit and Assurance Com and approved for signature by the Audit and Assurance Committee. **RESOLVED:** The Board: 1. APPROVED the Modern Slavery and Human Trafficking Statement for signature by the Chief Executive and publication. 2. APPROVED the Bribery and Corruption Statement for signature by the Chief Executive and publication.
13	**Gloucestershire Managed Services: Reserved Matters (Articles of Association)** Kerry Rogers, Director of Integrated Governance and Kaye Law-Fox, Chair (Gloucestershire Managed Services)
	This report was presented by both Kerry Rogers, Director of Integrated Governance, and Kaye Law-Fox, Chair, Gloucestershire Managed Services (GMS). It summarised and reflected a recent review of key governance documents of the subsidiary, in the context of an emphasis on joint and effective group working. The review had identified the need to formally appoint Kerry Rogers as Company Secretary and had resulted in some updating of the entity's Articles of Association. Approval of both the Articles of Association and the Board's Terms of Reference are matters reserved to the Trust Board. **RESOLVED**: The Board APPROVED:

	1.The appointment of Kerry Rogers, Director of Integrated Governance as Company Secretary for GMS. 2. GMS Articles of Association (as amended) of Gloucestershire Hospitals Subsidiary Company, (Gloucestershire Managed Services). 3. Gloucestershire Hospitals Subsidiary Company Limited Board of Directors Terms of Reference.
14	**People and Organisational Development Committee Report** Vareta Bryan, Non-Executive Director
	The Key Issues and Assurance Report was presented by Vareta Bryan, Non-Executive Director, in the absence of Marie-Annick Gournet, Chair, who had prepared the Report prior to commencing a period of leave. Key issues from both the February and April Committee Meeting were summarised within the report, which was to be taken as read. Focusing on the sole item RAG rated as Red - Following on from the previous item relating to health and safety governance structures it was noted that primary responsibility for health and safety would no longer be within the remit of the People and Organisational Development Committee. The Committee would retain some shared oversight in relation to matters such as violence and aggression with it being proposed that a suite of reporting metrics would be developed by the Health & Safety team, in conjunction with Human Resources Colleagues, aligned with Health & Safety at Work Regulations and related well-being obligations. The remainder of the report was taken as read as the Board noted that both the Gender Pay Gap Report and Freedom to Speak Up Service Annual Report were agenda items before the Board. **RESOLVED**: The Board NOTED the report for assurance.
15	**Gender Pay Report** Claire Radley, Director for People and Organisational Development
	Claire Radley, Director for People and Organisational Development, presented this report, noting that it has been previously considered at People and Organisational Development Committee and had been circulated to all Non-Executive Directors for comment during March. It was noted that this report relates solely to direct employees of the Trust and did not include data relating to Gloucestershire Managed Services. It was before the Board for consideration, in compliance with national reporting requirements and represents a snapshot for employee pay as at 31 March 2024. The data was presented with medical/dental staff both included and excluded, to ensure the impact of that staff group on pay can be clearly identified as a significant factor contribution to the gender pay gap. This is as a result of the provision of Clinical Excellence Awards (a national performance reward system), with 64% awards made to men and 36% to women. The Board were advised that the impact of Clinical Excellence Awards will be less significant year on year as the Trust's Local Clinical Excellence Award Scheme closed in 2020. Only a small number of consultants receive a national Clinical Excellence Award. That cohort of employee will have a reducing impact on the gender pay gap as the awards expire and/or the individual retires or leaves the employ of the Trust. There was a general discussion regarding the disparity between genders in terms of applications for national Clinical Excellence Awards with work being undertaken to support female consultants to apply for such awards.

	The Board also considered the other Equality, Diversity and Inclusion initiatives set out within the report but it was also recognised that the majority of Trust employees pay was determined by reference to a nationally agreed job evaluation scheme (Agenda for Change). The Board also noted the inclusion of the Ethnicity Minority Pay Report 2024 and its content. **RESOLVED**: The Board NOTED the report for assurance.
16	**Freedom to Speak Up Report** Louisa Hopkins, Freedom to Speak Up Guardian
	Claire Radley, Director for People and Organisational Development provided an introduction to this annual report and summarised the regulatory context and the purpose of the Freedom to Speak Up Service. Louisa Hopkins, Freedom to Speak Up Guardian provided the board with an executive summary/ update of the work undertaken during the past year, following her appointment as a full time Guardian two years previously. Overall, the assessment was that the Service was improving, becoming increasingly effective across the Trust. The additional guardian resource (0.4 whole time equivalent) had facilitated significant improvements, particularly the growth of the Freedom to Speak Up Champion network which in turn provides grass root support to staff. It was noted that the number of anonymous reports were trending downwards and is now in line with national data. The Board were advised that this was considered an indicator of staff confidence, that they can speak up without fear of detriment. Overall, the Trust data was beginning to be more in line with national data, both patient safety reports and those concerning behaviours or conduct in the workplace. It was confirmed that the Trust's Freedom to Speak Up Policy had recently been updated to include recommendations from the National Guardians Office and recommendations arising from a 2024 Internal Audit report. The refreshed policy was to be implemented during Quarter 1 2025/2026. The Board were provided with information regarding the introduction of the 'Report, Support and Learn' system which would support the Freedom to Speak Up function to accurately record concerns and track outcomes. John Cappock, Chair of Audit and Assurance Committee, noted the progress made against the recommendations from the Internal Audit report issued in June 2024 but also highlighted the need to finalise and resolve the two outstanding recommendations, particularly the implementation of the revised policy. He was pleased to hear that this would be achieved within Quarter One 2025/2026. The increase in patient safety reporting was commented on by Mark Pietroni, Medical Director and during discussions it was confirmed that one area for increased scrutiny/a 'deep dive' planned by the Freedom to Speak Up Service would be a review of the barriers to access in patient safety reporting. Sam Foster, Non-Executive Director commented on the many positive approaches to patient safety reporting across the Trust and queried whether it was more an issue of staff not being clear of normal reporting processes as opposed to

	there being actual or perceived barriers. It was confirmed this would be considered within the proposed 'deep dive' review. Al Sheward, Chief Operating Officer, commented on the relatively high number of referrals where the service area could not be identified. He asked whether this could be improved upon through triangulation of data to identify 'hot spot' areas which would benefit from additional structured support. He also noted the statistics in relation to behaviour related concerns and was clear that this should remain a focus for the Board with the continuing work on Trust culture, including the Licence to Lead development programme, to ensure there was a clear Trust-wide understanding of what are the standards of behaviours expected and red lines which will not be tolerated. Claire Radley commented that this remained a focus for the People and Organisational Development team and it was anticipated that the introduction of the 'Report, Support and Learn programme together with the focus on restorative justice, would prompt improvements in this area. John Noble, Non-Executive Director, noted that the Trust has a high number of international workers and asked if it was known whether this cohort of employees experience additional barriers in raising concerns. Louise Hopkins confirmed that the Service were awaiting guidance on this topic from the National Guardian's Office and it would be a focus during 2025/2026. Kevin McNamara, Chief Executive, brought the discussion to a close by highlighting two areas which he wanted the Board to focus on in future discussions: (i) how does the Board get assurance that issues relating to persistent poor behaviours are being addressed and (ii) what is the Board's appetite to really manage the issue of poor behaviours. It was emphasised that it was the responsibility of the Board to set a clear expectation of behaviours. **RESOLVED:** The Board NOTED the report for assurance.
17	**Quality and Performance Committee Report** Sam Foster, Non-Executive Director
	This report was presented by Sam Foster, Committee Chair, who detailed the output from the March meeting which was a deep-dive review into the Complaints and Patient Advisory & Liaison Service. Overall, there was a noted improvement in performance but continued progress was required. It was acknowledged that the report before the Board was very detailed and work was being undertaken, with the support of the Director of Integrated Governance, to improve the effectiveness of the Key Issues and Assurance Report, alongside the annual review of the Committee's effectiveness generally. The Board's attention was brought to the continued Committee focus on maternity services assurance and issues of risk relating to Histopathology. Sam Foster spoke positively regarding the recent in-depth presentation received by the Committee into the operation of Children's Services. The consensus that this was a very effective presentation, enabling the Committee members to have a much better understanding of the Service, the context it operates within, its strengths and its areas of challenge, particularly recruiting and retaining skilled workforce. The Committee was agreed that future meetings should include focused service specific reports alongside regular reports for oversight and scrutiny.

	Mark Pietroni, Medical Director provided additional commentary on the Learning from Deaths process and the additional scrutiny of mortality linked to long-waits prior to admission for treatment. It was noted that whilst the Trust is not an outlier nevertheless it was an area the Trust would be focusing on with the aim of reducing delay related harm. It was recognised that this is not a matter which is solely in the Trust's gift with support needed from the Integrated Care Board and system partners to address discharge delay related harm; harm both to patients who remain in hospital once medically fit for discharge and the harm from delay caused by the lack of bed capacity impacting on clinical flow from Emergency Department to admission. Deborah Evans, Chair, commented on the ongoing review of pathways for child protection medical assessments. It was noted that the output of the review has been shared with both Trust and Integrated Care Board colleagues and it was currently with the Children Services team to create effective action plans in response to the review. In the interim, arrangements were in place to ensure prompt access to assessment.
18	**Integrated Performance Report** Al Sheward, Chief Operating Officer (Lead) and Executive Director colleagues,
	Al Sheward, Chief Operating Officer, presented the performance section of the Integrated Performance Report for the period February to March 2025 inclusive. It was noted that the report would be the last in the current format, with the new planning guidance providing new metrics for monitoring and assessment from 1 April 2025. Whilst the report was taken as read the following items were highlighted: **Performance** The Board were referred to the Single Oversight Framework slide (4/58) to note the significant improvement in the 52-week wait for treatment figures over the course of 2024/2025. In April 2024 there were 2738 patients waiting for treatment but due to efforts across all teams involved this figure was reduced to 124 in March 2025, with continued reductions into 2025/2026. The clinical and operational teams involved in this work were to be commended. These improvements were also evident in the 65-week figures with a reduction over the year from 379 to 4 patients waiting in excess of 65 weeks. It was noted that there was one patient waiting over 78 weeks but that was as a result of a national, not Trust issue, relating to ophthalmology grafting material. A number of services subject to 'watch measures' due to performance concerns had, over the year, performed sufficiently well to be moved from the watch category to the main data pack. The exception to this was barium enema performance which had performed less well during Quarter 4. <u>Urgent and Emergency Care</u> March had seen a deterioration in the number of patients waiting in the Emergency Department for over 12 hours before admission or discharge to alternative care. It is recognised that there is a clear correlation between the number of patients medically fit for discharge occupying beds and delayed admission from the Emergency Department. Board members concurred that work, with system partners, to improve the position regarding 'no

criteria to reside' patients must continue. Within the Trust, emergency care remained a primary focus for the executive leadership with the Medical Director, Chief Nurse and Chief Operating Officer meeting with the Service, shadowing senior leaders and overseeing the clinical flow process. Al Sheward detailed a plan to undertake a reset project in June 2025 but also highlighted that the team should be commended for the improvements seen in ambulance handover times, with average delay times reducing from 64 minutes in January to 45 minutes in March 2025.

Elective care

The positive performance against the 52-week wait target was noted.

Cancer

Unvalidated data for the Faster Diagnoses Standard (FDS) of 28 days indicates that the target of 75% was being exceeded, with performance at 82%. This would remain an area of focus in key specialities. It was recognised that improved performance at diagnosis stage would have a positive impact on the 62-day treatment target. Unvalidated data for March indicates that the Trust did not reach this target but it remains a focus for improvement with action plans in place.

Diagnostics

The deterioration in performance was noted (3.71% in a month) with the waiting list increasing from 13,292 (February) to 14,468 (March). Three specialities (ECHO, MRI and Cystoscopy) account for 66% of all breaches in this period. Both ECHO and neurophysiology recovery remained fluctuating with neurophysiology likely to continue to fluctuate until vacancies have been recruited to.

There was a discussion regarding the investment required for endoscopy. A business plan had been submitted seeking £5m investment but as a result of financial constraints only £1m had been identified by the Integrated Care Board. This would have an impact on the services that could be provided. It was confirmed this would be the subject of dialogue with the Integrated Care Board.

Angiogram waiting lists had improved but were expected to plateau as a result of the reduction in weekend additional lists. It was noted that Catheter Laboratory 3 was fully operational with significantly reduced cancellations. This facility would be used to further reduce/eliminate the angiogram waiting lists.

Histopathology remains subject to an improvement plan but it was recognised that the histopathologist workforce difficulties was a national issue, not unique to the Trust. Recruitment processes were confirmed as ongoing and short-term locum resource was being utilised.

The position regarding patients with 'no (medical) criteria to reside' was highlighted to the Board, with no material change since February 2024. This continued to impact patient flow and outcomes. Senior management concern regarding delay-related harm remains high with active ongoing discussions with system colleagues as to how to break the cycle. It was

recognised by all that the negative impact was significant, not only on those patients awaiting discharge but also those waiting for treatment. It was also impacting the Trust's ability to plan maintenance backlog work or undertake service reconfiguration as it was not possible to plan effective ward moves. Work on prompt discharge continues within the Trust but both Kevin McNamara and Al Sheward were clear that the role of system wide collaboration to achieving improvements in this area could not be overstated. It was confirmed those discussions would continue at a senior level with system partners.

Quality and Safety metrics

This section of the report was largely taken as read with Mark Pietroni, Medical Director, focusing on the SHMI (Mortality) data (slide 38/58) with the continued improved position during 2024 noted. Mark Pietroni reported that there was now considerably more confidence as to the accuracy of the Trust's coding data, which also directly impacts on the reliability of this national data measure. The coding team have been supporting work with clinical colleagues on how information is recorded in clinical noting to support accurate coding.

Matt Holdaway, Chief Nurse and Director of Quality, summarised the position as to the management of complaints and referrals to the Patient Advice and Liaison Service (PALS) service had recently reopened its facilities for face-to-face meetings with patients and families.

Use of Resources/Finance metrics

Karen Johnson referred the Board to slides 42 to 50 within the Integrated Performance Report. These slides summarised the year end position, as at the end of Month 12 (subject to the External Audit review of the accounts) with a number of positives to be noted including a small revenue surplus, delivery to plan on the Financial Sustainability Plan and reduced agency spend against NHS England target (2.5% of total pay bill against target 3.2%) with further improvement in bank staff spend.

It was noted that there had been challenges in meeting the capital spend targets with an overall net underspend on system capital of £35,000 and an underspend of £2.6m on IFRS16. The slippage against plan was recognised but it was important to note that most capital programmes are more than 12 months in length.

The positive cash position (slide 50) was noted but this would remain a focus in the new financial year with a paper going to the Finance and Resource Committee setting out the Trust's cash strategy. The importance of cash as an indicator of performance was emphasised.

Karen Johnson, Director of Finance, advised that overall, the Trust was in a positive position at financial year end but with no room for complacency going into the new financial year. These comments were supported by Kevin McNamara, Chief Executive, with commentary on the importance of improving productivity, particularly in light of the ongoing picture of financial constraint. The focus would be on making decisions early with subsequent effective delivery of plans. The impact of non-recurrent funding remained a focus for the new financial year.

	The Board then discussed the financial impact of national decisions and external decision making generally. It was acknowledged that system partners do not feel the same immediate pressures as the Trust, as the acute provider, and that this could result in a lack of responsive pace, as evidenced by the ongoing situation in respect of discharge ready patients. The high numbers of patients remaining as in-patients with no criteria to reside was identified as a financial pressure as well as a quality issue. **People** Claire Radley, Director for People and Organisational Development highlighted the key workforce issues as set out in slide 55/58 with good performance against indicators in turnover, vacancy and sickness rates as well as use of agency staff. Areas for improvement were appraisal rates, mandatory training and use of bank staff. The Board were advised that the appraisal process had been reviewed with improved appraisal paperwork introduced from April 2025. An internal audit would be looking at this area to support the improvements and provide assurance as to the impact of the process improvements. **RESOLVED**; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
	Two-minute silence observed: End of WWII (Europe)
19	**Maternity Services Regulatory Compliance Report** 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 were available to Board members). It was recognised that the Board meeting marked the anniversary of receipt of the s31 Notice from the Care Quality Commission and provided a useful opportunity to reflect on progress to date. Out of the eight conditions imposed two have been fully met with a further six being assessed as partially (90%) compliant, with an expectation at a further three conditions will be assessed as fully compliant by June 2025. Subsequent to the preparation of the board report compliance in respect of five of the conditions was confirmed. The Board was advised that this was prompting a change in external oversight focus from the specific conditions to a broader supportive oversight function. It was envisaged that sustained compliance would be achieved against all eight conditions by June and that this would then trigger a re-inspection by the Care Quality Commission. The Board discussed the long-term embedding of the positive governance changes made within Maternity Services and the culture changes needed to ensure sustained improvements. Both Matt Holdaway and Lisa Stephens, Director of Midwifery, expressed confidence that the changes made were sustainable, both the internal Trust processes but also the collaborative working with the System with a more collaborative approach evident at Quality Improvement Group meetings. Kevin McNamara, Chief Executive, commented that the Trust has been clear that it wishes to be within a larger regional system for maternity services as it was felt that collaborative working and more effective and immediate benchmarking would support the improvements in service needed. He was clear that the Trust's primary focus must be on the Board, and by extension

	the patients we serve, being assured of sustainable and consistent improvements in maternity services. Vareta Bryan, non-executive champion for maternity services, spoke positively of her assessment of the improvements within the service but noted that pace was needed to address the conditions put in place by Care Quality Commission and consequently resource should be monitored. **RESOLVED:** The Board NOTED the report for assurance.
20	**Perinatal Quality Surveillance, Q3, 2024** 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. It was noted that sadly there were 9 stillbirths recorded during Quarter 3. All were subject to a multi-disciplinary review process with five cases being reported as Patient Safety Incident Investigations (PSII) and 1 referred to the Maternity and Newborn Safety Investigations (MNSI) programme. During the period there was one maternal death which remained the subject of an investigation following referral, in accordance with process, to both MNSI and MBRRACE (Mother and Babies: Reducing Risk through Audits and Confidential Enquiries. The Board also considered workforce matrices for the period, noting the reduction of the midwifery vacancy rate to 10.38%. The continuing challenges with medical workforce recruitment were noted, with a report to be put before Quality and Performance Committee imminently. Matt Holdaway updated the Board on the position regarding ultrasound waiting times. It was noted there were improvements during the period, with the new pathway for daily cardiotocography (CTG) working well as a mitigation whilst work continues on the pathway for ultrasound scanning. Sam Foster, Non-Executive Director, then led a discussion about the need to tighten up assurance and data provision. Kevin McNamara was clear that this remained a priority for the Trust as the improvement journey continued. Both Kevin McNamara and Deborah Evans, were clear that the focus must remain on the patients and the need to understand why these tragic events had happened. It would be vital to receive thorough investigation reports to inform the continued quality work being led by Lisa Stephens, Director of Midwifery and Matt Holdaway. **RESOLVED:** The Board NOTED the report for assurance.
21	**Finance and Resources Committee Report**
	As Jaki Meekings-Davis, Committee Chair, was on leave it was decided that the report would be received as read. Questions were directed to Karen Johnson, Director of Finance. There was a discussion regarding the Board Assurance Statement process and the requirement to include an equality impact assessment for elements of the annual plan.

	RESOLVED: The Board NOTED the report for assurance.
22	**Annual Plan 2025/2026 submission and Board Assurance Statement Report** Karen Johnson, Director of Finance
	Karen Johnson presented this report on the final Annual Plan and Board Assurance Statement, confirming that it had been considered at a previous Finance and Resource Committee and extraordinary confidential board meeting where the detail of the plan had been considered, thus enabling the completion of the Board Assurance Statement. It was agreed that the report would be taken as read in light of the previous Board scrutiny. **RESOLVED:** • The Board NOTED the final Annual Plan submission for assurance. • The Board NOTED the completed Board Assurance Statement.
	Any other business
	There were no items of business to note.
	Governor observations
	Andrea Holder, Lead Governor provided her observations on the meeting, commending the Patient story. She also commented on the positive meeting with the Chair and Lead Governor (Gloucestershire Health & Care Trust) and expressed the hope that there would be future collaborations between the Councils of Governors. She expressed her thanks to the teams involved in the improved performance figures within the Integrated Performance Report.

Close: 12:30
Date and time of next meeting: 10 July 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	September 2025
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	Completed Response provided by Medical Director. Requirement to use national data.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors			
Date	10 July 2025		
Title	Patient Story		
Presenter **Sponsor**	Katherine Holland, Head of Patient Experience Helen Brooke, Ward Manager, Woodmancote Ward		
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	**x**
To provide advice		To highlight patient or staff experience	**x**

Summary of Report

Katherine Holland and Helen Brooke will be presenting a narrative story of the support and care provided to a socially isolated stoke patient during an extended admission to Woodmancote ward (Stroke Unit).

It is intended to demonstrate the personalised and compassionate care provided by the ward in often challenging circumstances.

Risks or Concerns

There are no risks or concerns with the report.

Financial Implications

Nothing to report.

Recommendation

The Board is asked to NOTE the content of the patient story and consider its application to support the wider patient experience.

Enclosures

1. Purpose

This report describes some of my activities as Chair of the Trust since the May 2025 Board meeting, and also 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. Non-Executive Directors and Associate Non-Executive Directors

- Sam Foster has resumed chairing our Quality and Performance Committee and is also acting as Non-Executive Maternity Champion while Vareta has a break over the summer
- John Cappock, our chair of Audit and Assurance Committee is visiting each of the four clinical Divisions to observe their quarterly executive reviews or specialty reviews. Many internal audits are Division specific or require Divisional action so these visits will provide useful insights
- The Council of Governors has approved a selection process for a Non-Executive Director to follow on from Jaki Meekings Davis when she completes her term in January 2026
- Kaye Law-Fox and her team celebrated National Healthcare estates and facilities day on 18th June which included presentations of the work of Gloucestershire Managed Services and opening the refurbished domestics rest room at GRH.

3. Quality, Safety, Patient and Colleague Experience

- Emma Mawby, one of our public governors for Gloucester introduced me to colleagues who are active in the trans movement in Gloucestershire. I was interested to learn about their experience of health services in our county and nationally. We also discussed the uncertain situation following the recent Supreme Court judgement.
- In my capacity as link non-executive director for neuro diversity I introduced our lead, James Clifford, to Lisa Armstrong who is the lead for the Integrated Care Board. This seemed a useful change of personal experience and building an understanding of neurodiversity and creating a more inclusive work environment. Marie Annick Gournet is in active dialogue with the BME network, and brings a wealth of experience from her role with the University of Bristol on reparatory justice and civic involvement.

4. Governance and Assurance

- I attended the NHS Providers online Good Governance conference in May which had a day devoted to patient safety, which included an interesting discussion about how services which have to extend beyond their capacity due to workload fluctuations are able to plan in advance how they accommodate this safely

- Our company secretary, Sarah Favell has done a very thorough job of reviewing the "Fit and Proper Person" requirement for all our directors and reporting on them. This has been in place since 2014 and was strengthened in 2018 following a report by Tom Kark QC. Sarah has also improved the content of our Annual Report enormously.
- Will Cleary Gray and I met to Jen Cleary who is the Trust sustainability led to review my role as Non-Executive Sustainability champion and to talk about the work we are doing within the Trust and across the Integrated Care System. A key point of discussion was how to secure ownership from Divisions and whether they should be given individual carbon reduction targets recognising that many of our activists on sustainability are clinicians.

5. Visits and Ambassadorial Roles

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

- Shadowing Bilgy Pellissery, one of our staff governors and observing a robot assisted laparoscopic prostatectomy. This was a superb example of team work, as the robot failed and had to be replaced with the backup machine. Bilgy was so central to both the operation and coordinating everything that I was shadowing the medical team and will look forward to a future visit to accompany Bilgy in her own clinic.
- A visit to Same Day Emergency care at Gloucestershire Royal Hospital with Andy Anduvan. This service is a jewel in our crown according to national experts and our registrars who rotate around all the Trusts in the northern part of the Severn Deanery
- A meeting of the Big Space Cancer Appeal Board with our Chief Executive, Kevin McNamara in which we reviewed the Lions at Large event and celebrated that the appeal has raised over £9 million
- As it is proposed that Gloucestershire is to be aligned with Bristol, North Somerset and South Gloucestershire I have continued my regular meetings with key figures including Ingrid Barker, chair of the two Bristol Trusts and Steve West who is Vice Chancellor at University of the West of England and a non-executive of that Integrated Care Board

6. Contributing to our One Gloucestershire Integrated Care System

We are continuing to work closely with our colleagues across the Integrated Care System and keeping close to developments for Integrated Care Boards. This includes the usual Board and development meetings and one to ones.

Chief Executive Report to the Board of Directors – July 2025

1. People, Culture and Leadership

1.1 Changes to NHS Regulatory bodies

As part of the NHS 10 Year Health Plan, the government announced on Friday 27 June, further changes that will significantly alter the NHS regulatory landscape. The purpose of the changes described by the Department of Health and Social Care is to reduce complexity, improve accountability, and focus on patient-centred care. Currently, over 150 bodies are involved in assessing quality and issuing guidance across health and care settings, and the number has grown over the past decade, often resulting in overlapping responsibilities and uncoordinated recommendations that have placed additional burdens on NHS staff and organisations.

To address this, the government plans to abolish 201 organisations and bodies, including the Health Services Safety Investigations Body, the National Guardian's Office (Freedom to Speak Up), Healthwatch England, Commissioning Support Units, and Integrated Care Partnerships. This move is intended to simplify the system, eliminate unnecessary bureaucracy, and redirect resources to frontline services.

The government also announced it will revitalise the National Quality Board (NQB), which will be tasked with developing a new national quality strategy by March 2026, the first quality strategy since 2008. The NQB will serve as the central authority on quality, with all other bodies, including Royal Colleges, feeding into its work. This is designed to bring clarity and coherence to the quality landscape, which has become increasingly fragmented.

These reforms are positioned as a shift toward more agile, action-oriented structures with a focus on enabling better collaboration between health services, local government, and other partners, while ensuring that patients are heard and that staff are supported in delivering high-quality care. Further details are expected in Dr Penny Dash's forthcoming report on patient safety across the health and care system.

Details on the announcements are expected to be within the NHS 10 Year Plan that will be published on Thursday 3 July.

1.2 Armed Forces Week

The end of June was Armed Forces Week and as a Trust we are proud to support the Armed Forces Covenant. This is a commitment we take seriously, and we have made real progress in identifying and supporting veterans, serving personnel, reservists and their families.

Patients are now routinely asked if they are part of the armed forces community, both through TrakCare and our digital records. The Trust is also a gold award employer, and we also offer reservists and cadet instructors up to two weeks of additional leave each year to support their training.

At a time when international stability feels increasingly fragile, the importance of national defence is clear. Our reservists play a key role in that effort and bring back valuable

experience that enhances our work here in the NHS, particularly in leadership, teamwork and adaptability.

1.3 Phlebotomy Industrial Action – update

A delegation of Phlebotomy staff, alongside UNISON representatives, attended our Trust Board on 8 May 2025 where they were able to ask their questions directly to the Board and have those points answered. These have all now been published on our website: Public Questions at Trust Board May 2025

Following the Board meeting, Senior Leadership from the Trust, including our Medical Director and Director for People met with UNISON to try to resolve the current issues. I also wrote directly to the Phlebotomists offering to meet, if they pause their strike action, to allow truly constructive discussions to take place, but the offer was declined.

In June 2025, at the Trust's request, UNISON confirmed their support to submit a job description that aligns with the role the Phlebotomists have been carrying out, so that a job evaluation panel can reconvene. This will follow the agreed process for job evaluation which includes local management input prior to a panel conveying.

The Trust is supportive of undertaking a formal job evaluation panel to review the revised/new job description, person specification and any additional supporting documents the Phlebotomist wish to submit. In line with agreed processes, the Trust has also recommended we would seek the involvement of ACAS to conciliate, as their independent expertise will help us to find a way forward.

1.4 Gloucestershire's 12-hour ED Performance

In June 2025 the Trust was recognised as one of the top 20 most improved organisations in England for 12-hour Emergency Department performance over the past year.

As part of NHS England's 2024/25 Integrated Urgent and Emergency Care (UEC) Incentives Scheme, Gloucestershire achieved a 2.25% improvement in reducing the number of patients waiting over 12 hours in A&E. This places the Trust among the most improved performers nationally, and as a result, we will receive an increase in the capital budget to support out urgent and emergency care improvements. We are working through the wider implications of this increase before being able to identify how this money will be spent.

This achievement reflects the hard work and commitment of teams across the Trust and contributes to the broader national progress in emergency care delivery, including improved 4-hour ED performance and supporting our ambulance services to improve response times.

However, we know there is more to do in this space and we have set reducing 12 hour waits in ED as a priority for us as an Executive Team this year to build on some other areas of progress we made in areas such as boarding patients over the past year.

1.5 Proud to Care

We have recently published our first “Proud to Care” review of the year, covering the period from April 2024 to March 2025.

Despite the many challenges of the past year, our dedicated staff and volunteers have shown remarkable resilience, commitment and compassion. Their work makes a profound difference every day.

The review showcases the remarkable work carried out across the Trust over the year, highlighting key achievements, innovations and the unwavering commitment of staff to delivering high-quality care.

You can find out more and read the review on the Trust website: Proud-to-Care 2025

2. Quality, Safety and Delivery

2.1 Urgent and Emergency Care

We continue to see notable improvements across several urgent and emergency care metrics. In June, our Emergency Department (ED) attendances across both sites saw 13,290 patients, a decrease of 809 from May with an average of 443 patients per day and a high of 575 on 23 June, the most attendances in a single day for more than two years.

Reducing 12-hour breaches remains a key priority for the Trust. The proportion of patients of patients completing their ED journey in less than 12 hours increased, as did the number of patients who met the 4-hour, 8 and 12-hour standards. These increased to 63%, 86% and 92% respectively. the proportion of patients ready to proceed within target times improved to 82%.

We routed an additional 68 patients through Same Day Emergency Care (SDEC) pathways, including Medical SDEC, Surgical Assessment Unit (SAU), Hyper Acute Stroke Unit (HASU), Trauma Assessment Unit (TAU), and Urology Assessment Unit (UAU) at Cheltenham.

The Trust continues to meet the new national standard for maximum ambulance handover times. Hours lost to delays reduced from 1,820 in April to 1,099 in May (a reduction of 721 hours) with an average handover time of approximately 23 minutes.

The number of patients with no criteria to reside (NcTR) stabilised, ending June 2025 at 119, which is a positive change from 140 patients in April 2025, however there is more work to be done across the system to sustain this change. This measure is being changed, and will be known as DRD We continued to increase the numbers of patients being discharged home which has positively impacted on the Average Length of stay in the hospital by another day.

2.2 Elective (Planned) Care

Elective recovery of the longest waiting Referral to Treatment (RTT) patients has been demonstrated through the progress made in 52 weeks breach reduction: 97 in April (down from 125 in March) and 78 in May to 43 in June.

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. As a result, as of 6th June 2025 the trust is ranked 10th best nationally for 52 weeks RTT reduction out of 132 acute providers.

In regard to cancer performance the 28 day Faster Diagnostic Standard (FDS) continues to over-achieve against the original 75% with achievement 80.9% in April, 82.2% in May and a current month-end performance of 85.9% June 2025 (pending final confirmation) . Nationally only 9 out of 42 ICB's exceeded the year end target set by NHS England and Gloucestershire registered in the top four best performing trusts out of this group (achievement of 81.5%).

Delivery of the 62-day 75% national performance target set by NHSE has proved extremely challenging as demonstrated in April performance (68.6%) and a small improvement in May (69.1%) and June (69.9% pending final confirmation). This has largely been attributed to two specialties (Lower GI and Urology) who have significant challenges in pathology turnaround times and surgical operating capacity. Each tumour site has a robust recovery plan in place, with additional capacity anticipated later in the year to deliver large-scale performance improvements. A national recovery initiative "Days Matter" led by NHSE will support trusts in improving performance in Gynae-Oncology, Urology and Colorectal by 5% in Q3 and 10% by year-end which GHFT have committed to participating in as a revised approach to accelerated recovery.

2.3 National Urgent and Emergency Care Plan

In June NHS England published the national Urgent and Emergency Care Plan that supports the work already underway across the system improve how people access advice and care, to develop community services and support, reducing the need for hospital care and to improve flow and patient experience within our hospitals.

The launch of the Integrated Urgent Care Service in the county – bringing together NHS 111, a local doctor-led Clinical Assessment Service and the Primary Care Out of Hours service – is already playing a key role in joining up advice and care and ensuring patients get the right support in the right place, 24 hours a day, 7 seven days a week.

Good progress has also been seen in improving ambulance handovers and more joint working, supporting patients when they need admission and the right support when they are ready to leave hospital, with ongoing care if needed.

The Home Assessment Team, social workers and community services are all working in our Emergency Department with specialist paramedics to help avoid hospital stays where possible and reduce waiting times.

The progress of our Integrated Flow Hub also demonstrated that we can make better decisions and improve the experience of patients by bringing health and care teams together, including the voluntary and community sector, to work as one.

Work continues to review the plan and planning in detail for winter with our partners, to ensure that we are well placed to make significant progress in the right direction for the benefit of patients."

The national Urgent and Emergency Care Plan can be found here: NHS England- Urgent & Emergency Care Plan 2025-26.

2.4 National investigation into maternity and neonatal care

Wes Streeting, Secretary of State for Health and Social Care, announced at the end of June that there would be a national investigation into maternity care and a maternity and neonatal taskforce to share learning and best practice will be established.

The investigation will consist of two parts. The first will urgently investigate up to 10 of the most concerning maternity and neonatal units, to give affected families answers as quickly as possible.

The second will undertake a system-wide look at maternity and neonatal care, bringing together lessons from past inquiries to create one clear, national set of actions to improve care across every NHS maternity service.

The national review will pull together recommendations from inquiries to assess progress and to provide clarity on direction for the NHS.

As a Trust, we are determined to learn and change when things go wrong and over the past four years, we have made improvements to our maternity services, but recognise there is more still to do.

Following Panorama in 2024 we asked ourselves a number of critical questions and commissioned two independent reviews into our neonatal and maternity services, which we plan to publish towards the end of the summer.

Extensive work has taken place over the last several years, to improve our services and the care we provide, and also to plan well for the future. This has included significant midwifery recruitment in particular and more safety measures.

A critical element is ensuring that improvements that we make are sustained and we know that more challenges remain and we need to be relentless in focusing on them, including governance, culture and staffing levels.

More information can be found on the Government website: National maternity investigation launched to drive improvements

2.5 Maternity Health Needs Assessment

A maternity health needs assessment is underway with NHS Gloucestershire to informa proposals for the future of maternity services in the county.

Over the last few years there has been some important changes in several areas of care and the choice women and families want in maternity. Overall birth rates are down, whilst the number of women having an induction has been increasing in Gloucestershire with 38.68% in May 2025 compared to 30.80% in April 2022, which is in line with national figures.

There have also been changes in the number of spontaneous vaginal births, which have been decreasing over time, whilst the number of elective and emergency Caesarean sections have been increasing, both nationally and within Gloucestershire (45.27% in May 2025 compared to 34.99% in April 2022). The change in Caesarean rates has therefore

required a change in the resource needed with an increase in obstetric consultant time and an increase in theatre sessions.

There have also been changes in national demographic trends, such as an increasing age of women giving birth, leading to more complexity. In addition, the evidence indicates that between 44.2% to 46.2% of pregnant women have multimorbidity (two or more long-term health conditions).

The health needs assessment involves a review of nationally available data and trends, and the evidence base for what works in terms of quality and safety. To further support the development of the needs assessment, the views of women and birthing people, their families, staff and community partners will also be included through surveys and engagement.

Once the national review and the local needs assessment process are complete, it will help in setting out ideas on how services could be developed. We are keen that any proposals for future service development are co-designed through meaningful engagement.

2.6 Entonox Processing Unit

The Trust has invested in new technology to improve both the safety of midwives and the environment.

The Trust has introduced an Entonox Processing Unit designed to counteract the harmful effects of nitrous oxide found in Entonox, a commonly used pain relief gas in labour and delivery suites.

Entonox, also known as ‘gas and air’, is a mixture of nitrous oxide and oxygen and is widely used to help manage pain during labour. While Entonox is safe for women in labour, long-term exposure in confined spaces can pose health risks to staff. Entonox also has a significant carbon footprint, with its use at the Trust contributing the equivalent of approximately 500 tonnes of carbon dioxide each year, the same as driving over 7 million miles in a car.

The new unit collects nitrous oxide that women in labour breathe out, significantly reducing it from the delivery room. It then converts the gas into harmless substances, creating a cleaner and safer space to work and reducing its environmental impact. For women in labour, their treatment is exactly the same, however, Entonox is delivered through a mask rather than a mouthpiece.

This new technology is part of a wider effort to reduce the environmental impact of hospitals and anaesthetic gases. It also forms part of the Trust’s sustainability strategy, reinforcing its commitment to supporting the NHS’s goal of achieving net-zero carbon emissions by 2040.

2.7 Research and Innovation

Over the last few weeks, there have been a number of highlights from across our research and innovation teams that showcase the incredible work happening across our Trust.

Dr Sarah Vinnicombe has been involved in a collaborative research trial (the BRAID Trial) with the University of Cambridge, and the interim results of the study have been published in The Lancet. Sarah has been cited as one of the co-authors, and Gloucestershire Hospitals was the second-highest recruiting site, a fantastic achievement that reflects the dedication of our clinical researchers and research, innovation and genomics (RIG) delivery team. You can read more here:

- *The Lancet: BRAID Trial interim results*
- *BBC News: Extra scans for women with dense breasts*

We have also had several other exciting research funding successes. Our research, innovation and genomics team, supported by Lisa Riddington and the library team, helped secure two NHS NetZero InSites grants. Only four were awarded nationally. These include:

- *GREENHAND*, a greener carpal tunnel pathway
- *HOME*, remote blood pressure monitoring for new and expectant parents

Two Somerset, Wiltshire, Avon & Gloucestershire (SWAG) Cancer Alliance grants were also awarded. One focuses on Artificial Intelligence (AI) in prostate biopsies (Dr Bhim Odedra and Mr Jeremy Nettleton) and the other on improving gastrointestinal (GI) biopsy sampling (Dr Luke Materacki).

Finally, three University of Gloucestershire Small Grants went to Collette Townsend, Dr Helen Makins and Sophie Finch-Turner for work spanning infection prevention, pain management and maternity care.

These achievements speak volumes about the innovation and commitment to research across our Trust. Congratulations to all involved.

2.8 Tower update

There are real challenges across our estates, with many areas requiring urgent attention and some of our buildings are over 175 years old and date back to 1848 in Cheltenham.

The Tower Block in Gloucester was built in 1975 with an expected life span of 25 years, which means we are now 25 years beyond that and external work is well underway to improve it, but significant improvement needs to be made internally.

Chief amongst these is fire safety and a need to invest heavily in upgrading our fire infrastructure, including upgrading the fire alarm systems, fire doors, training and planning, with a focus on the Tower Block. We are also keen to improve the ward environments, including replacing the nurse call systems, and potentially more, as we go.

In order to replace the fire systems within the Tower we need to work floor by floor to allow the work to take place. Work is already underway to involve services and staff in the Tower and we anticipate the works will take three to four years in total to complete.

There has been a renewed focus to ensure all fire exits are clear and accessible and that the clutter that can build up in areas is reduced, as they presents a risk to staff and patients. There is also a programme to map each area, review fire evacuation plans and ensure training is up-to-date and that each ward has a nominated fire wardens.

A joint exercise is also scheduled with the Fire and Rescue Service in September.

3. Strategy

3.1 New MRI scanner at both hospitals

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 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.

The new scanner opened in 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.

In early June, we cut the ribbon on our new £2.5 million modular MRI unit at Gloucestershire Royal Hospital. This purpose-built facility is designed to improve patient experience, enhance diagnostic capacity and provide a modern and efficient environment for our staff. The unit features the latest MRI technology and reflects our commitment to delivering timely, safe and high-quality care.

This marks a major milestone in our recovery journey following 18 months of reduced MRI capacity due to estate-related challenges. This will make a real difference to patients as we will be able to see more people, more quickly and importantly, reduce delays for urgent and emergency patients waiting in ED and acute medicine.

4. Regulatory

No update to present

Kevin McNamara
Chief Executive

Report to Board of Directors					
Date	10 July 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					

Background

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).

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 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 and for assurance to the Quality and Performance Committee. There is an improvement programme for Maternity Governance being led by the Deputy Director of Quality on behalf of the Chief Nurse and Director of Quality.

Position

The summary position is that the Trust has self-assessed that it has fully met 6 out of the 8 conditions with ongoing work to sustain this position and to make further improvements.

Table: Trust summary of position against CQC conditions

Total number of conditions	**Assurance rating**	**March 2025**	**April 2025**	**May 2025**	**June 2025**
		Total conditions = 8			
Conditions met	Fully met and sustained	2 (7&8)	2 (7&8)	2 (7&8)	6 (2 CTG peer reviews, 3

					CTG interpretation/ escalation, 6 Agency, 4 MOEWS
	Targets met	0	3 (2 CTG peer reviews, 3 CTG interpretation/ escalation, 5 VTE)	5 (1 PPH, 2 CTG peer reviews, 3 CTG interpretation/ escalation, and 6 Agency, MOEWS)	1 (VTE) Action – guidelines being reviewed after MBRRACE report published.
Improvement required	Targets not all met	6 (1-6)	3 (1 PPH, 4 MEOWS & 6 Agency)	1 (5 VTE)	1 (1 PPH) New digital data report available for 34-36/40
Not met as not started		0	0	0	0

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 31 July 2025. The Trust are also providing assurance externally to the ICB Quality Improvement Group (QIG) monthly (next meeting 14 July 2025). 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 has continued to CQC. 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)

- May and June 2025 Reports

Appendix 1 - 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**).	Improvement required Not consistently meeting target	We have self-graded this as "amber" as consistency in maintaining compliance needs to be sustained. Booking risk assessment compliance = May **89%,** (target 90%) **Production Board** (snap shot check) 36/40 compliance = April **89 %** (target 90%) Production Board (snap shot check.). New report produced digitally for 34-36/40 PPH risk assessment and data quality checks being completed so that we can use this rather than manual audits. On admission risk assessment is 90% (target 90%). Reduce Checklist (stepwise management) - Completion rates range 85-100%. **Next steps** - Our PSIRF response continues and we collecting data to carry out thematic reviews to steer the improvement work and the next quarterly thematic

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
			review is due in July 2025.
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.	Met and sustained for 3 months	Completion at 85% (target consistently met for 3 months) **Next steps** - Continue with dedicated peer review midwife on delivery suite to sustain improvement.
3	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **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.	CTG met and sustained for 3 months	- Intrapartum Team and Forum have oversight of compliance. - Targets sustained for last 3 months **Next steps** - Work continues with meeting the intermittent auscultation (IA) standards. - Fetal monitoring QI plan to be refreshed now new fetal wellbeing midwife in post.
4.	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **complete and escalate maternity early**	Met and sustained	- System implemented and described in MOEWS clinical guidelines (Severely Ill Obstetric Patient M2010). - Current compliance for "Act on Amber"

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
	obstetric warning score (MEOWS) charts in line with national guidance during intrapartum and postnatal care.		sustained within 90-95% range. **Next steps** - The new national maternal early warning score system is being implemented in December 2025 and there is a plan for this.
5.	Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.	Met	- On admission risk assessment average is 95% for the last 6 months for the manual audits. Note - we are still trying to obtain accurate digital oversight data. - Pharmacological prophylaxis for those requiring treatment is 100% for both antenatal and postnatal women at the spot checks. **Next steps** - Work continues to enable digital capture of the “on admission” risk assessment data. - Update of guideline M2014 to reflect review against MBRRACE recommendations.
6.	Implement an effective system for ensuring agency midwifery staff have a comprehensive induction to the	Met	- Very low agency usage. - Clear processes in place.

Condition	Condition description	Met/ not met	Actions taken or left to take and focus
	unit, are able to access the maternity electronic records system and Trust policies, as well as enter and exit the unit without delay.		
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.

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – JUNE 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.

The main business of the Committee related to the conclusion of year end procedures, receiving the report and findings from the external auditor, scrutinising the annual report, accounts and annual governance statement.

The Committee recognised the considerable year on year progress that has been made with reductions to significant weaknesses reported, plans in place to address the remaining areas of weakness and good sustained in year progress around follow up actions. The Committee was happy to adopt the going concern basis and retained several unadjusted misstatements highlighted by the Auditors and was also happy to retain the water provision. The Committee scrutinised the Annual Governance Statement, considered significance questions and concluded that the assessments made were fair, reasonable and consistent with regular updates to Board.

The conclusions, detailed in the next paragraph, were reported to the confidential Board meeting on 26th June prior to approval by the Board of the Annual report and accounts.

Audit Committee has appropriately scrutinised the annual report and accounts, has had an opportunity to question and challenge the Executives on the content and assumptions, has had the opportunity to discuss findings with the Auditors in private and in full Committee and recommended their approval to the Board.

The Committee recorded its thanks to the Trust Finance and Governance teams, the wider Trust Executive team and the external and internal auditors for their contributions.

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 remain 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 final Head of Internal Audit opinion for 2024/25 which confirmed a return to a moderate level of assurance. This 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 reports related to Data Security and Non Medical Referring. Both reports provided helpful challenge and effective responses to the findings.

In respect of follow up work, good progress was reported including closure of fairly long standing GMS assurance mapping and Freedom to Speak Up actions.

The Committee has recently taken responsibility for oversight of Health and Safety and received its first composite update at this meeting. There are a number of very concerning items flagged and at

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.

this point the Committee is not assured. However, the Trust is now far better sighted on the various risks and as a result is much better placed to address and to ensure that scarce resource is appropriately deployed.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Health and Safety	Fire risks, window security, water risks are key areas of concern	Comply with enforcement notice and ensure delivery against the various improvement actions
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit opinion	Rated Amber as a result of there being two significant weaknesses reported related to financial sustainability and the ongoing CQC maternity section 31. However, important to note the sustained progress year on year with a reduction from four significant weaknesses to two and good progress on follow up work.	Ensure delivery against agreed outcomes in the management responses.
Internal Audit	**Two final reports**, Data Security Protection Tool kit (DSPT) and Non Medical Referrer reports. DSPT is a statutory requirement and at the time of reporting the Trust was amber against 4 of 12 standards with an expectation of all being green by end June. Non medical referrer was rated moderate for design and limited for operational effectiveness. Rated amber pending delivery of management actions but it is important to note that this was a management driven audit to validate and address concerns which is exactly how internal audit should be used. The audit appears to have been very well received by the team and will have a positively impact	Ensure delivery against agreed outcomes in the management responses.
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. Some new risks highlighted. Several Committee members commented on the dissonance between some current risk scores and target scores and welcomed the proposed July workshop to address risk appetite.	Committee will receive an update on risk appetite and next steps.
	Rationale for rating	**Actions/outcomes**

Items Rated Green			
Item			
Annual report and accounts. Rated as green Notwithstanding the two significant weaknesses it is important to record and give credit for the significant improvement year on year in the production and outcome achieved. This year has set a high bar and based on auditor feedback, compares favourably with what other Trusts have achieved. **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. **Internal Audit follow up report** – Generally looking much better and clearly a lot of work has gone in to get us to this point. Four long standing management actions have been closed off.			
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.			
Good focus on non-traditional audit Committee areas, with focus on patient added value			
Matters arising. No outstanding matters on this occasion			
Counter Fraud report – Excellent, clear digestible report. Year end counter fraud annual outcome recorded 11 of 12 standards as green with one amber			
Single tender actions report – enhancements to justifications around single tender waivers noted			
Trust seal – regular periodic update			

REPORT TO BOARD

Date	10 July 2025
Title	Trust Seal Report
Author /Sponsoring Director/Presenter	Kerry Rogers, Director of Integrated Governance Sarah Favell, Trust Secretary

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 Trust's Standing Orders require that the use of the seal is authorised by the Board of Directors and entered in the Register of Sealings. The seal is used to execute deeds (e.g. conveyances of land) or where it may be required by law. The Trust Secretary is Custodian of the Trust seal.

During the period April 2024 to March 2025 the Trust Seal was used to execute the following deeds:

No.	Description and parties	Date	Signatories:	Witnessed:	Documentation:
307	Aviva Investors Energy Centres No.1. Limited Partnership	17.10.24	Kevin McNamara Karen Johnson Kerry Rogers	Lisa Evans	Scanned copies of document front sheet and signature page on file. Hard copy to Trust Solicitors.
308	Rooftop Lease, related to Aerial site situated at rooftop of the tower block, Gloucester Royal Hospital	03.12.24	Kevin McNamara Karen Johnson	Lisa Evans	Scanned copies of document front sheet and signature page on file. Hard copy to Trust Solicitors.
309	Lease Renewal: 8 Pullman Court, Great Western Road, Gloucester (Ground, first and second floors) Parties: (1) Seafayre Properties Limited (2) GHFT	31.03.25	K McNamara M Holdaway	Sarah Favell	Scanned leases on file. Hard copies to Trust Solicitors.

Recommendation

The Board is asked to NOTE the use of the Trust Seal.

Report to the Board of Directors			
Date	10 July 2025		
Title	Board Assurance Framework and Trust Risk Register Report Q1 2025-2026		
Author / Presenter **Sponsoring Director**	Sarah Favell, Trust Secretary 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

This report provides information to the Board in relation to the management of strategic risks which may impact on the realisation of the Trust's strategic objectives. It also provides a summary of the current position of the Trust Risk Register (operational risks scoring in excess of 16)

The Board Assurance Framework (BAF) provides details of strategic risk, the primary control framework, the assurances provided and actions underway to mitigate risk to the achievement of the Trust's strategic objectives.

This report outlines:

- Board Assurance Framework review process during period (April to June 2025) including Summary BAF
- Update on revision of Board Assurance and wider risk process
- New Strategic risk – Health and Safey Compliance
- Trust Risk Register – assurance that management is active in identifying, reviewing and mitigating red operational risks

Financial Implications

None

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

Recommendation

The Committee is invited to:

1.1. **NOTE** 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. **ADOPT and APPROVE** the recommendation of the Audit and Assurance Committee to accept and adopt the new strategic risk concerning Health and Safety regulatory compliance on the Board Assurance Framework and with Audit and Assurance Committee as oversight committee.
1.3. **NOTE** the summary of the Trust Risk Register and Board Assurance Framework (June 2025)

Enclosures

Board Assurance Framework (BAF) and Trust Risk Register Report

BAF Summary (June 2025)
Strategic Risk form – Health and Safety compliance
Summary of Trust Risk Register (June)

BOARD ASSURANCE FRAMEWORK and TRUST RISK REGISTER
UPDATE REPORT JUNE 2025

1. CONTEXT

1.1. The Board Assurance Framework is an essential strategic tool, designed to identify manage and mitigate strategic risks to ensure the delivery of safe, effective and sustainable healthcare services. It highlights the Trust's major risks as identified by the Board, that could impede the Trust's strategic objectives, offering a structured approach to risk management that aids in decision-making, strategic planning, and resource prioritisation.

1.2. It is important that both the Board Assurance Framework and Trust Risk Register (operational risks) are used to enhance accountability, transparency and compliance with regulatory requirements, integrating risk into the overall governance framework and promoting continuous improvement through regular reviews.

1.3. It is recognised that there is significant interplay between the Trust's operational and strategic risks, with the latter being the drivers to inform the identification, review and re-assessment of the former. It is proposed that this interplay will be reflected in the proposed redesign of the Board Assurance Framework post the implementation of the Trust's new strategy.

2. PURPOSE OF REPORT

2.1. This report provides information to the Board in relation to the management of strategic risks which may impact on the realisation of the Trust's strategic objectives.

2.2. To provide the Board with updates regarding the management of strategic risks, their primary controls, and the range of assurance in place as detailed in the Board Assurance Framework for the period April to June 2025.

2.3. To provide a snapshot picture of the Strategic Risks as at 30 June 2025.

2.4. To provide the Board with assurance that management is active in identifying, reviewing, and mitigating red operational risks.

3. BOARD ASSURANCE FRAMEWORK PROCESS

3.1. Strategic risks are reviewed by the responsible Executive Directors and provided to the relevant Board Committee for further review and approval.

3.2. Paragraph 4.2 below sets out those risks which have been reviewed by the responsible Executive Director and relevant Board Assurance Committee during the reporting period (April to June 2025).

3.3. Paragraph 4.3 sets out the strategic risks which have not been reviewed during the relevant period and sets out the current status of these risks and timescales for review by both the responsible Executive Directors and Board Committees. However, it should be noted:

3.3.1. Strategic Risks 6 and 7 have been outstanding for review since May 2024. This has been escalated to the relevant Executive Directors and it is expected that the reviewed Strategic Risk will go before the relevant committees during July 2025, with an updated Board Assurance Framework report being tabled for the meeting of the Audit and Assurance Committee in September 2025.

3.3.2. Strategic Risk 5 has been the subject to review by the relevant Executive Directors and will be put before the Quality and Performance Committee July meeting.

3.4. The current risk management process for the review of Strategic Risks has provided adequate oversight during this period but there is now, with the implementation of a new Trust Strategy in Quarter 2, 2025, an opportunity to review current process and implement significant changes to improve the mechanisms in place.

3.5. This work is being carried out in parallel with the development and approval of the Trust's next Trust Strategy, and is anticipated to be finalised in Summer 2025. As part of the alignment work with the strategy development process, there will be a review of the Board's risk appetite statement as part of a Board development session.

3.6. Our Head of Risk and Safety has undertaken an exercise to align the Operational Risks with the current Trust Strategic Objective. This work will inform the revision of the Board Assurance Framework, with a new format Board Assurance Framework document. It is proposed that each Strategic Risk will identify the key operational risks which are drivers in the score assessment of the Strategic Risk. This work will also be informed by the Board's review of its Risk Appetite, scheduled for the Board Development Session.

3.7. The Trust Secretary is meeting with Committee Chairs during July and August 2025 to discuss the role of the Assurance Committees in challenging risk reviews and scoring. Guidance notes will be provided to both Executive Directors and Committee Chairs as part of the refresh exercise.

3.8. It is proposed that future Committee scrutiny of risks is much more deliberately focused on the correct identification of the risk, its link to the achievement of the Trust's Strategic Objectives, and the confidence held by the executives that the controls as described are effectively mitigating the risks, such that members of the Committees can be assured accordingly.

4. CURRENT STRATEGIC RISK SUMMARY

4.1. The Board is invited to note the Summary Report annexed (appendix 1) to this report.

4.2. Key changes to the Strategic Risk profile during the reporting period are as follows:

Risk	Description	Change	Current Score	Target Score
SR2	Failure to successfully embed the quality governance framework	• Reviewed at Quality and Performance	12 3x4	9 3x3

		Committee June 2025. • Relevant factors for improved current score included recent CQC report on Medicine, Cheltenham General Hospital. • Update of detailed action plans/mitigations	(formally 20) 	
SR9	Failure to deliver recurrent financial sustainability	• Updated target scores (annual for next 4 years) • Updated controls • Additional updated control narrative regarding Financial Sustainability Programme	16 4x4 Previous score - 20 	By March 2026 –20 (5x4) By March 2027 – 15 (5x3) By March 2028 – 10 5x2
SR10	The risk to patient safety, quality of care, reputational damage and contractual penalties as a result of the areas of poor estate and the scale of backlog maintenance.	• No change to risk score following review. • Updated controls, actions and assurance commentary • Due for review by Estates Capital Group June 2025	16 4x4 	16 4x4
SR12	Failure to detect and control risks to cyber security	• Improved risk score • Additional information regarding controls and mitigation	15 3x5 	12 3x4
SR13	Inability to maximise digital systems functionality	• No change to risk score following review. • Updated controls narrative	12 3x4 	6 2x3

SR 16	Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve. (Culture and Retention)	• Improved risk score following review • Actions on track re controls	16 4x4 Previous score - 20	12 3x4
SR17	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve (Recruitment and attraction)	• Improved risk score following review • Actions/mitigations on track	16 4x4 Previous score – 20	12 3x4

4.3. Strategic risks not reviewed in this reporting period

Risk	Description	Update	Current score	Target score
SR 1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Executive update requested. Last reviewed June 2024. Requires update and review of current score post completion of Annual Report which evidenced some significant improvements with ambulance times and other metrics	25 5x5	9 3x3
SR5	Failure to implement effective improvement approaches as a core part of change management (quality improvement methodologies)	Reviewed by management team. To be reviewed at Quality and Performance Committee July 2025. Scoring remains unchanged	16 4x4	6 2x3
SR6	Individual and organisational priorities and resources are not	Under review by Executive Director as outstanding since May 2024.	12 4x3	6 2x3

	aligned to deliver integrated care	Relevant to current refresh of strategy.		
SR7	Failure to engage and ensure participation with public, patients and communities	Under review by Executive Director as outstanding since May 2024. Relevant to current refresh of strategy	6 3x2	3 1x3
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Last reviewed January 2025. To be reviewed by September 2025. Need to include assessment of additional regulatory disclosure requirements (Annual Report Manual)	9 3x3	9 3x3
SR14	Failure to invest in research active departments that deliver high quality care	Last Reviewed January 2025 Agreed return for Finance and Resource Committee review in November/December 2025	3x12	6 2x3

5. NEW BOARD ASSURANCE RISK

5.1. The Board of Directors approved, at the board meeting on 13 March 2025 the addition of a new risk in relation to Health and Safety. Please find attached final draft Risk (appendix 2) which has been reviewed by the Audit and Assurance Committee (June 2025) and is recommended for approval by the Board.

5.2. It is proposed that this risk, once approved at Board (July) will be assigned to the Audit and Assurance Committee with additional ownership of the staff wellbeing aspects via the People and Organisational Development Committee.

6. TRUST RISK REGISTER (RATED RED – SCORING 16 OR ABOVE)

6.1. The Trust Risk Register (Appendix 4) holds 42 risks with a number of risks relating to fire safety and asbestos being escalated. This is in the context of a renewed focus on health and safety compliance with the introduction of the Health and Safety Framework and recent enforcement action. This reflects the removal of previous governance and reporting barriers that had perhaps masked compliance concerns.

6.2. The Trust Risk Register profile demonstrates an emerging concentration on statutory risk compliance. Of the twelve identified safety risks, only one scores higher than 12. The risk threshold for quality risks is higher and has eight quality risks scoring between 15 and 20. The five business risks predominantly relate to IT infrastructure, digital systems and cyber security. Currently financial risks are included within the Strategic

Risks and not reflected in the Trust Risk Register. It is intended that this will be reviewed within the work being undertaken to align risks to the Trust's Strategic Objectives and Risks following implementation of the Trust's Strategy (Summer 2025).

6.3. The above work referenced at paragraph 3.4-3.8 above, together with the refresh of the Risk Appetite (scheduled for summer 2025) will prompt a review of the current Trust Risk Register, both in terms of scoring and alignment to the Strategic Objectives and Risks.

6.4. The Trust's Risk Register is regularly reviewed by the Risk Management Group chaired by the Medical Director and attended by Divisional and Risk management. Risks are regularly reviewed by Divisional and Service Management utilising the Datix Risk Management System.

6.5. Seven risks have been escalated to the Trust Risk Register during the relevant period (March to June 2025).

- #368 – The risk of statutory intervention as a result of a failure to manage asbestos in our buildings in line with the Control of Asbestos Regulations 2012, leading to harm
- #850 – The risk of increased workplace stress due to an imbalance of workforce against workload
- #722 – The Risk that the Trust is unable to retain members of the substantive workforce (risk replaced #236 below)
- #1012 – The risk of critical disruption to operational and clinical services, due to decreased sustainability and delays in development of digital services, systems and infrastructure caused by strategic and tactical workforce constraints.
- #363 – The risk of statutory intervention due to non-compliant fire safety infrastructure
- #674 – The risk of harm affecting patient and staff safety due to the inefficient evacuation of a hospital building in the event of fire due to poor uptake in evacuation drills/training and a clear evacuation plan.
- #911 – The risk of significantly reduced quality of patient care and management caused by insufficient general anaesthetic workforce to manage clinical demands on the service.

6.6. Two risks have been downgraded from the Trust Risk Register during the relevant period.

- #499 – The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and the avoidance of hard, including treatment delays.
- #236 – The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague well-being and staff retention (risk superseded by #722 above.

7. RECOMMENDATIONS:

The Board is invited to:

7.1. **CONFIRM** it is assured or otherwise with regard to the management of strategic risk (and its association with corporate risks) and the developing agenda, 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.

7.2. **ADOPT and APPROVE** the recommendation of the Audit and Assurance Committee to accept and adopt the new strategic risk concerning Health and Safety regulatory compliance on the Board Assurance Framework and with Audit and Assurance Committee as oversight committee.

7.3. **NOTE** the content of the current Trust Risk Register (Appendix 3) and updated risks during the relevant period.

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges**								
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	June 2024	June 2024	CNO/ MD/C OO	QPC	3x3=9	N/A	5x5=25
SR2	Failure to successfully embed the quality governance framework	Dec 2022	October 2024	June 2025	CNO/ MD	QPC	3x3=9	5x4=20	3x4=12
2.	**We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**								
SR1 6	Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve. (Culture and Retention)	Jan 2023	Septemb er 2024	June 2025	DFP	PODC	3x4=12	N/A	4x4+16
SR1 7	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve (Recruitment and attraction)	May 2024	June 2025	June 2025	DFP	PODC	3x4=12 Mar 26	N/A	4x4+16
3.	**Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other**								
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	October 2024	October 2024 (awaiting review July 2025)	MD/C NO	QPC	2x3=6	N/A	4x4=16

4.	**We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners**								
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Apr 2024	Apr 2024	COO/ DST	QPC	2x3=6	N/A	4x3=12

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	May 2024	-	DID	QPC	1x3=3	3x3=9	3x2=6
7.	**We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources**								
SR9	Failure to deliver recurrent financial sustainability	July 2019	May 2025	May 2025	DOF	FRC	Mar 26:5x4=20 Mar 27:5x3=15 Mar 28:5x2=10 Mar 29:5x1:5	4x5+20	4x4+16
8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**								
SR10	The risk to patient safety, quality of care, reputational damage and contractual penalties as a result of the areas of poor estate and the scale of backlog maintenance.	July 2019	October 2024	February 2025	DID	FRC	4x4=16	N/A	4x4=16
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	October 2024	January 2025	DID	FRC	3x3=9	N/A	3x3=9

9.	**We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care**								
SR12	Failure to detect and control risks to cyber security	Dec 2022	October 2024	May 2025	CDIO	FRC	3x4=12	N/A	3x5=15
SR13	Inability to maximise digital systems functionality	Dec 2022	October 2024	October 2024	CDIO	FRC	2x3=6	N/A	3x4=12
10.	**We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**								
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	May 2024	January 2025	MD	CIRG	2x3=6	N/A	3x4=12

Heat Map: Board Assurance Framework, Current Risk Ratings plotted: The risks highlighted in **white** are discussed in the covering paper.

		Consequence				
Likelihood		**1**	**2**	**3**	**4**	**5**
	5	**5 Rating**	**10 Rating**	**15 Rating**	**20 Rating**	**25 Rating**
						SR 1
	4	**4 Rating**	**8 Rating**	**12 Rating**	**16 Rating**	**20 Rating**
				SR6	SR16, SR17 SR5 SR9 SR10	
	3	**3 Rating**	**6 Rating**	**9 Rating**	**12 Rating**	**15 Rating**

			SR7	SR11	SR2 SR13 SR14	SR12
		2 Rating	**4 Rating**	**6 Rating**	**8 Rating**	**10 Rating**
	2			SR7 Patient and Public Engagement		
		1 Rating	**2 Rating**	**3 Rating**	**4 Rating**	**5 Rating**
	1					

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
	Failure to implement a robust health and safety governance framework which defines the role of the board and those in safety leadership, the structure through which the health and safety vision and commitment is set, safety objectives are agreed and the framework for monitoring performance is established with a view to ensuring compliance with legislation	A well-led and established integrated governance health and safety framework that meets the needs of the Trust, its wholly owned subsidiaries and other entities and allows for assurance in relation to compliance for health and safety	Health and safety governance ensures an organisation has effective systems for managing risks, protecting employees, patients and the public, and meeting legal obligations related to health and safety. It involves setting policies, assigning responsibilities, monitoring performance, and learning from incidents to continuously improve safety practices. Failure to implement a robust 'Group' health and safety governance framework has led to unidentified non-compliances across the Group (Trust and GMS) and a disjointed mechanism of assurance.	• Lack of structure, processes, and accountability necessary to make sound risk-related decisions and ensure compliance • Specific roles and responsibilities for health and safety management not clearly defined across the Group • Unidentified non-compliance within the Group leading to harm to staff, patients and visitors • Prosecution by enforcing authorities for systemic or persistent breach of regulations • Fines (into £millions) • Duplication of reporting in some areas and / or inadequate reporting in others within the Group • Personal injury claims and legal fees or complaints • Inquest • Reputational damage / adverse press • Individual directors and managers held accountable under s.37 HSWA 1974	Audit & Assurance Committee	LT	H&S resources #943 3 x 4 = 12 Asbestos #368 4 x 4 = 16 Water safety #355 2 x 5= 10 #377 2 x 4 = 8 #765 2 x 5= 10 #840 3 x3 =9 #810 1 x 4 = 4 Fire safety #363 4 x 5 =20 #374 3 x 5 = 15 #461 3 x 5 =15 #674 3 x 5 = 15 #886 5 x 3 =

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

							15 #55 3 x4 =12 #87 3 x3 = 9 #239 2 x 3 = 6 Ventilation #399 3 x 4 =12 #344 3 x 3 = 9 #352 3 x 3 = 9 #842 3 x 4 =12 Safe access and egress #655 2 x 3 = 6 #268 1x 4 = 4 Electrical Safety #364 2 x 4 = 8 #375 3 x 3 = 9 Waste #653 3 x 2 = 6 Decontamination #869 3 x 2 =

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

							6

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	The Trust has identified gaps in Group governance. In the absence of a robust governance structure, there is inadequate direction and oversight of health and safety compliance. This includes the lack of clear escalation routes in relation to significant health and safety issues. This places the Group at risk of unchecked poor performance. Examples include: • Lack of accountability framework • Implementation of a Group H&S framework • Poor alignment with ACOPs, HTMs and Building Notes • TLT, Sub-board and Board unsighted on key health and safety risks or breaches of legislation • Lack of robust fire strategy, gap analysis and action plan • Insufficient asbestos survey and management plan • Water Safety processes • Lack of cohesive estates strategy to known estates risks	**3x2=8**	There will always be a risk of harm within the healthcare environment. The target score is based on the potential for moderate harm or breach of legislation (3) but with a low likelihood of this occurring. This would be achieved with robust governance that identified gaps at the earliest opportunity, addressed them and provided assurance of a fit for purpose compliance process.	**Risk opened in February 2025**

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

	• Capital planning and funding allocation not aligned to health and safety risks • CQC identified governance weakness increasing likelihood of regulatory intervention The score is based on a high-harm consequence and high likelihood of a consequence materialising			

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Group H&S Committee Group H&SC • New Group Health and Safety Framework • GMS Compliance reporting moved from Contract Management to Group H&SC • Trust Health & Safety Policy and associated subject-specific policies • GMS Board and health and safety committee • Group H&SC reporting to Trust leadership team, Audit and Assurance Committee and Board • Appointed exec with accountabilities	• Accountability framework for ACOPs, HTMs • Standardised and agreed Terms of Reference for H&S Sub-groups • Sub-group gap analysis against ACOPs, HTMs, HBN etc. • Sub-group - robust action plans aligned to ACOPs, HTMs, HBN etc. • Strategies, policies and procedures aligned to ACOPs, HTMs, HBN etc. • Clear escalation routes for significant health and safety issues • Robust reporting mechanism within the Group • Robust Health and Safety Communication Strategy

ACTIONS PLANNED

Action	Lead	Due date	Update	Status
Develop and agree a Group H&S Framework	LT	April 2025	H&S approval in February by TLT, Group H&SC and Board	Complete
Review of reporting structure for Trust H&S Committee	LT	April 2025	Moved from PODC to TLT and A&A in April 2025	Complete
Deliver annual health and safety performance report to Board	LT	April 2025	Received by Board May 2025	Complete

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Group H&S governance framework implementation plan including alignment to ACOPs, HTMs, HBN etc.	LT	1 – 3 years / April 2028	Implementation plan drafted.	In progress and on target
Develop Accountability Framework	LT	July 2025	Draft accountability framework in place. To be consulted on via H&S Governance Workshop on 20 June	In progress and on target
Interim Health and Safety Plan for 2025-2026	LT	July 2025	Drafting	In progress and on target
Develop a Health and Safety Communications Strategy and brand	LT/ JB	September 2025		Not started

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• H&S route to Board now clear • Reporting structure defined with oversight through TLT and A&AC • Audit reports from Authorised Engineer now tabled at Group H&SC, TLT and A&AC • KIAR reporting	Rated inadequate in AE audit for asbestos	Monitoring of H&S governance framework implementation plan

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Trust Risk Register Summary – Risks scoring 16 above

Risk ID	Risk Description	Division	Type	Subtype	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
135	The risk of delays in patient pathways, due to insufficient consultant radiologists	Diagnostics and Specialties	Quality	Delayed diagnosis or treatment	5	4	20	3	⟷	21/08/2025
264	2404 Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Diagnostics and Specialties	Workforce	Recruitment and retention	4	4	16	6	↑	17/03/2025
266	3682 The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Medical	Statutory	Integrated care board risk	4	4	16	6	↑	28/02/2025
333	3968 Risk of a delay to follow-up appointments leading to significant reduction of vision due to insufficient resources to correctly prioritise patients on the waiting list.	Surgical	Workforce	Staffing and competency	4	4	16	6	↑	28/11/2025
363	3371 The risk of statutory intervention due to non-compliant fire safety infrastructure including an obsolete fire alarm at GRH, poor compartmentation / fire doors and insufficient break-glass points; leading to harm to patients, visitors and staff.	Corporate	Statutory	Prosecution	4	5	20	6	↑	08/09/2025
368	3751 The risk of statutory intervention as a result of a failure to manage asbestos in our buildings in line with the Control of Asbestos Regulations 2012, leading to harm.	Gloucestershire Managed Services	Statutory	Breach of legislation	4	4	16	5	↑	04/09/2025
385	3876 The risk of reduced quality of care for dying patients due being unable to discharge to a place of their choice and dying within hospital	Corporate	Quality	Integrated care board risk	4	4	16	2	⟷	14/07/2025

401	3904 The risk of core IT infrastructure equipment failure and loss of access to business critical data as a result of environmental hazards, e.g. heatwave, floods water leaks and ingress etc.	Corporate	Business	Digital risk	4	4	16	3	↑	30/06/2025
425	2424 The risk of increased financial impact on theatres and the trust due to ageing and ineffective air handling units	Surgical	Business	Facilities related	4	4	16	6	↑	02/03/2025
426	2268 The risk to patients within the Minors Area of the Emergency Department due to overcrowding and staffing	Medical	Statutory	Integrated care board risk	5	4	20	4	↑	01/07/2025
458	3326 The risk to quality from an inadequate bed base, estate and facilities within the Department of Critical Care in Gloucestershire Royal Hospital (DCCG)	Surgical	Quality	Estates – condition, space, housekeeping	4	4	16	1	↑	01/09/2025
534	2895 There is a risk the Integrated Care Board (ICS)/ Trust has insufficient capital due to the Capital departmental expenditure limit (CDEL) and/or is unable to secure additional borrowing to address critical digital, estate or equipment risks	Corporate	Business	Service interruption	4	4	16	6	↑	01/07/2025
722	4006 The risk that the Trust is unable to retain members of the substantive workforce.	Corporate	Workforce	Recruitment and retention	4	4	16	8	→	29/08/2025
751	The risk of failure to provide a safe and high-quality maternity ultrasound service	Women's and Children's	Quality	Staffing and competency	4	4	16	3	↑	27/06/2025
764	S2045 The risk of reduced quality of care in the fractured neck of femur (NOF) pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Roy	Surgical	Quality	Clinical Standards	4	4	16	8	↑	30/04/2025
841	The risk of being unable to deliver acute and cancer patient care due to a critical shortage of Interventional Radiologists	Diagnostics and Specialties	Workforce	Recruitment and retention	5	4	20	6	↑	14/07/2025
850	The risk of increased workplace stress in Oncology due to an imbalance of consultant	Diagnostics and Specialties	Workforce	Recruitment and retention	4	4	16	2	→	31/05/2025

	workforce across Oncology against workload									
911	The risk of significantly reduced quality of patient care and management caused by insufficient general anesthetic workforce to manage the clinical demands upon service	Surgical	Quality	High patient demand	4	4	16	4	↑	02/09/2025
1016	The risk of reduced quality of service provision caused by insufficient Critical Care consultant workforce to manage the clinical demands upon service.	Surgical	Quality	Staffing and competency	4	4	16	4	↑	12/05/2025

KEY ISSUES AND ASSURANCE REPORT
PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE - JUNE 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
Workforce Race Equality Standard (WRES)	Despite some improvements (e.g. 2% increase in BME staff and a 3.4% drop in reported harassment), the Trust remains below national averages for most indicators. Disparities in recruitment persist—BME applicants remain nearly twice as likely to be unsuccessful.	Continued implementation of the Report, Support and Learn system. Increased focus on embedding EDI responsibilities across all roles. Need for clearer metrics and greater cultural accountability. Emphasis on shifting from equality to equity

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Recruitment and Workforce Sustainability	Improvements noted in time to hire, use of robotic process automation, and hard-to-fill roles. However, branding impact not yet assessed, and ongoing agency/bank reliance remains.	Continued rollout of rostering tools, medical rate card, and job plan reviews. Evaluation of inclusion champions and interview workshops.
Staff Experience Improvement Programme	New workstreams launched and strong thematic insights from survey data, but timeliness of response remains a concern.	Teams encouraged to act more visibly on results. Cultural heat mapping and restorative justice work underway. Focus on involving staff in action planning.
WDES (Workforce Disability Equality Standard)	Scoping exercise revealed poor staff experience related to reasonable adjustments. Managers not always equipped to respond effectively.	Focus on line manager support. Access external funds to support staff. Integrating support mechanisms into HR processes.

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.

People Metrics & Appraisal programme	Improvements noticed in bank usage and new appraisal process, but digitalisation and impact measurement are still in early stages	12-month digitalisation project launched. Shift toward continuous feedback culture. Internal audit underway to monitor effectiveness
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Guardian of Safe Working Hours	Fewer exception reports noted, largely due to improved rostering and substantive staffing. Issues raised were related to temporary pressure, not chronic workforce gaps.	Reports monitored and addressed via standard processes. Resident Doctors Forum and educational leads engaged.
Involvement & Engagement Annual Review	Positive feedback from local partners. Community-based initiatives (e.g. dementia playlist) well-received. Emphasis on face-to-face engagement highlighted.	Ongoing engagement with Healthwatch and ICP. More granular data requested to understand household demographics in minority communities.
Items not Rated		

Risk register:

No new closed risks. Visibility on live risks (e.g. industrial action) raised. Risk 807 (visa extensions) actively monitored.

Action: Request enhanced visibility on live employee relations and industrial action cases.

Report to Board of Directors			
Date:		10 July 2025	
Title:		Engagement and Involvement Annual Review	
Author / Sponsoring Director/ Presenter		James Brown / Juwairiyia Motala	
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

Background

This is the fifth formal report on our engagement and involvement activity. The report has been shared and discussed at both Council of Governors and People and OD Committee. It has been endorsed by and is recommended to Board by People and OD Committee.

Purpose

- To present the Engagement and Involvement Annual Review 2024-2025.
- The Annual Review will be published to sit alongside our Annual Report and Quality Accounts.
- The review provides a summary, case studies, and activities over the last year, as well as next steps.
- The review will also be used as part of the refreshed CQC framework and the expected changes within the NHS 10 Year Plan for community and public engagement.

Key issues to note

- The annual review sets out why engagement and involvement are important to the Trust and how we have worked with local people, community groups, and partners over the last year.
- The review sets out who our local communities are and the challenges of health inequalities across the county.
- Our commitment to engagement is a core element of the Care Quality Commission (CQC)'s well-led domain. We have previously shared the draft annual review with CQC as part of the Well-led review.
- The Trust has continued to develop and improve the Community Engagement Tracker, detailing the monthly activity undertaken, themes, and impact.
- The CQC has significantly changed the focus of much of its regulatory framework, with a primary focus on ‘people and communities’ and assessing how NHS organisations involve, engage, and listen to local people in improving services.
- The NHS 10 Year Plan and Dash Reports (due in July 2025) are expected to set further recommendations to strengthen participation and community engagement.

The draft has been shared with the ICB, Healthwatch, local community partners for review and comment/suggestions, has been incorporated into the final version of the review.
Risks or Concerns
The Engagement and Involvement Annual Review links directly to the Board Assurance Framework SR7: Community engagement and participation
Financial Implications
None

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

Recommendation
• Reflect on any areas for future development within our community engagement programmes; • That the Board approve the Engagement and Involvement Annual Review for publication.
Enclosures
PDF Draft Engagement & Involvement Review PDF Engagement & Involvement Review Summary Sheet

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Engagement and Involvement Review

Building Bridges, Building Health:

A Year of Engagement and Partnership

2024 – 2025

Welcome to our

Engagement and Involvement Annual Review

We are excited to share this report which brings together the work across our services with our community partners, which we feel shows just how important building local connections continues to be in improving the health and wellbeing across Gloucestershire.

Through this report we are pleased to share some of the successes that have been achieved over the last 12 months, working in partnership with our staff, patients and communities.

We believe that building and maintaining strong relationships between our services and the communities we serve, improves the quality and access to health and care services.

Our driving ambition is to put people at the heart of what we do, being curious and involving them in their care and in shaping change. By building connections, we can understand different ideas and experiences and listen to what matters most.

We would like to thank everyone who has worked with us over the year: the patients and community groups who have brought their fresh eyes, insights and creative challenge to our work and our colleagues across the Trust who have worked with us on a range of projects to help improve the experience.

Finally, we want to thank the Gloucestershire Hospitals charity for continuing to support many of our key projects, including funding to help the successful work of our Young Influencers who have flourished in the last year. We are also grateful to our Governors who have actively been involved at many events this year, come rain or shine, and have helped us reach a wider range of communities.

Bryony Armstong

Public Governor for Cotswolds

Chair of GHFT Young Influencers Group

Deborah Evans

Trust chair

Executive Summary

"The healing journey can only begin when you feel heard"

Juwairiyia Motala

Our review highlights the work we have done this year in building and maintaining our connections. We believe that through by approaching our work with curiosity and openness we have been better able to build our partnerships between services and the communities helping to understand what really matters and improve what we do, together.

Our driving ambition is to put people at the heart of what we do, being curious and involving them in their care and in shaping change. By building connections, we can understand different ideas and experiences and listen to what matters most. This approach has played a pivotal role in helping people in under-served communities access essential health and care support, improving their lives through partnerships with local organisations and groups across Gloucestershire.

Over the past year, we have engaged with over 17,968 people through 64 community events, gaining valuable insights into how we can improve access to services, increase planned care appointments, and reduce the need for emergency attendance.

Highlight(s) of the year

Highlights of our engagement and involvement work over the year include:

01 **Community Playlist for Dementia Awareness:** Sounds of the Soul

02 **Breast Cancer Awareness Event –** Jewish Community

03 **Update on Collaborative Community Engagement Work –** Community Voices

04 **Inclusive Language Guide:** Communication that Reflects Our Values

Executive Summary

Our commitment to improvement is driven by regularly reviewing feedback and supporting communities, all in alignment with the Trust's values to ensure meaningful engagement and quality improvement across the organisation.

The Trust is part of the One Gloucestershire Integrated Care System, which includes other health, social care, and Voluntary and Community Sector (VCS) organisations. We continue to follow the joint Working with People and Communities' strategy with a focus and commitment to working together for local people.

Our Engagement and Involvement Tracker has continued to evolve and provides a map for how we work, where we work and the impact and influence on our services. This report outlines our achievements, challenges, and future priorities for the next 12 months.

We are grateful for the valuable feedback, innovative ideas, and unique perspectives from local people that help shape our services and how we work. Working in partnership with our community isn't simply a box to tick; it's the key to unlocking better health outcomes. By understanding the needs of local people, we can transform our services and empower communities to focus on what matters most to them.

Thank you to everyone who has worked with us over the year: the patients and community groups who have brought their fresh eyes, insights, and creative challenge to our work, and our colleagues across the Trust who have worked with us on a range of projects to help improve the experience.

Find out more here:
www.gloshospitals.nhs.uk/listen-action-impact

Who we are and what we do

We are an NHS Foundation Trust of over 9,000 staff, providing care for the population of Gloucestershire and beyond.

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. We also provide Maternity Services at Stroud Maternity Hospital and a range of outpatient clinics and some surgery services from community hospitals throughout Gloucestershire.

Gloucestershire Royal Hospital

Cheltenham General Hospital

Stroud Maternity Hospital

Our vision is to provide

the **Best Care for Everyone**

Which serves as our guiding principle and shapes the way we are working in partnership with our communities.

Our Values

caring

We care for our patients and colleagues by showing respect and compassion

listening

We actively listen to better meet the needs of our patients and colleagues

excelling

We strive to excel through learning, and we expect our colleagues to do and be the best they can

Our partners

We are committed to working with our partners to deliver the best outcomes for our local communities. This means playing an active role in the Gloucestershire Integrated Care System, (ICS), and formal partnerships with our regional collaboratives and neighbouring NHS Trusts.

We also work closely with a wide range of diverse community organisations, including Inclusion Gloucestershire, Healthwatch and the VCSE Alliance to ensure we listen and understand the needs of our local population and to ensure we can shape services effectively.

Our commitment to engagement and involvement

Why is engagement and involvement important?

Our colleagues, patients and communities are at the heart our ambition to deliver the best care for everyone. By actively listening to those who use and care about our services, we can better understand diverse health and care needs and respond accordingly.

What are we doing?

We are committed to embedding engagement and involvement throughout our hospitals.

Our goal is to ensure that the voices of patients, carers, and colleagues are continually heard and that they shape our decision-making process. We strive to make our organisation a great place to work and receive care.

What will we achieve?

By working together, we can make better decisions, and we will be able to:

- Improve the quality of care and services;
- Improve patient safety;
- Improve colleague and patient experiences;
- Shape services around what local communities tell us that matter most to them;
- Attract, recruit, and retain the best staff to the Trust;
- Support and celebrate the diversity of our local community in promoting healthy living.

An Introduction to Gloucestershire

Gloucestershire is a county of contrast.

It has areas of breathtaking beauty, with charming hamlets, picturesque towns, and stunning landscapes that include ancient forests, iconic rivers, and three Areas of Outstanding Natural Beauty. It is also home to areas of deprivation and rural isolation, impacting access to opportunities, health and support services.

Gloucestershire also has a changing and evolving cultural diversity and history, with a mix of rural and urban communities, and where more than 100 languages are spoken. At Gloucestershire Hospitals NHS Foundation Trust, our team of over 9,000 colleagues, representing more than 75 nationalities, blend a dynamic mix of cultures and expertise that deepens the care we provide.

Working hand-in-hand with partners and local communities to build connections, the Trust is dedicated to enhancing health and well-being while ensuring equitable access to services and we recognise our role as a local anchor institution. We remain committed to addressing ongoing health and community challenges which can only be met by working together in partnership.

Our Gloucestershire Population

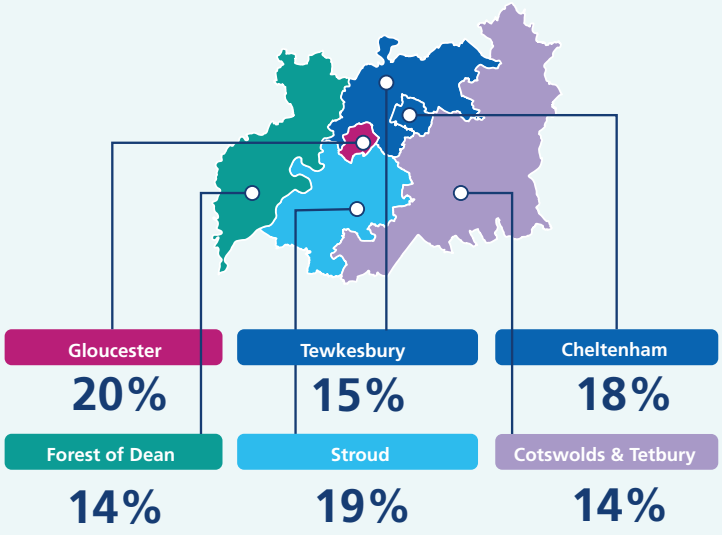
Total population: 2021

645,076
people

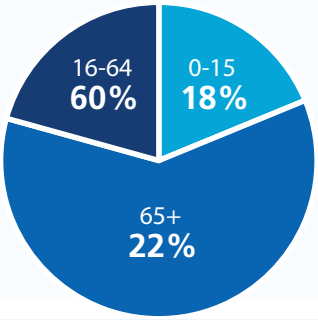
49% male

51% female

Population distribution of Gloucestershire, 2021



Broad age range



Pregnancy and birth

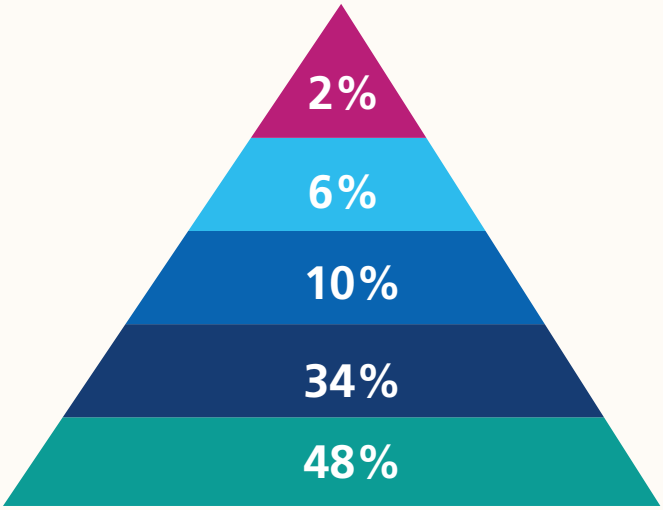
5486
Women giving birth

5571
Babies born

Unpaid carers

51863 (8.5%)
Of Gloucestershire's residents

Marriage and civil partnership



- Widowed or surviving civil partnership partner
- Separated but still legally married or still legally in a civil partnership
- Divorced or civil partnership dissolved
- Never married and never registered a civil partnership
- Married or in a registered civil partnership

Our Gloucestershire Population

Household composition

- **30%** One person household
- **19%** Couples with no children
- **25%** Couples with children
- **9%** Lone parent family
- **17%** Other households

Disability

16.8% of the population are disabled under the Equality Act (2010)

6.4% Of the population are not disabled but do have a long term physical or mental health condition(s)

Religion

- **49%** Christian
- **41%** No religion
- **6.2%** Not answered
- **1.4%** Muslim
- **1%** Sikh
- **0.6%** Hindu
- **0.5%** Other religion
- **0.3%** Buddhist
- **0.1%** Jewish

Ethnic Groups

- **87.7%** White British
- **5.4%** White other
- **2.9%** Asian, Asian British or Asian Welsh
- **2.2%** Mixed or multiple ethnic groups
- **1.2%** Black, Black British, Black Welsh
- **0.7%** Other ethnic group

Who do we engage and involve

Our Engagement and Involvement Strategy outlines our commitment to actively engaging and involving people in shaping our plans to improve services and listen to what truly matters to our communities.

In Gloucestershire, we are part of the One Gloucestershire Integrated Care System, connecting NHS organisations, councils, Healthwatch, charities, and the community, voluntary, and social enterprise sector (third sector) with the shared aim of enhancing the health and well-being of local people.

By building community connections and working closely with our partners, we can better coordinate services and plan care in a way that improves population health and reduces inequalities among different groups.

Central to this effort is our approach to engaging and involving people. A cornerstone of this work is the co-designed ICS 'Working with People and Communities' strategy, further supported by the groundbreaking Memorandum of Understanding with VCS partners. This agreement solidifies our commitment to working together for the benefit of local people.

To facilitate this collaboration, we established 'Get Involved in Gloucestershire,' an online participation platform where people can share their views, experiences, and ideas about local health and care services.

We remain dedicated to working in partnership to make it easier for people to share their experiences and ensure we can listen to the voices from our vibrant and diverse communities.

Our service users and supporters

Patients, service users, carers and families are at the heart of all that we do. We need to continue to involve them as we strive to embed person-centred care across all our services.

Our Places + Communities

Understanding what matters most to our local communities is really important to us, particularly given the diverse rural and urban needs as well as specific community groups.

Our partnership with the Voluntary, Community and Social Enterprise Sector (VCSE) and Healthwatch helps provide vital insight and reach into groups with particular needs across our communities so that our services are accessible and responsive to all.

We are continually strengthening our ability to engage and involve local people to ensure that what matters to them is used to influence decision-making.

Our Partners

We work closely with our partners across the 'One Gloucestershire' Integrated Care System (ICS) to join up health and care services for local people.

Vision: The Best Care for Everyone

Strategic Objective

Involved People 'Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Our Service User + Supporters

Patients, service users, carers and families are at the heart of all that we do. We need to continue to involve them as we strive to embed person-centred care across all our services.

Our Colleagues

We have a large workforce of some 9,000 people and over 450 volunteers, who live in our communities.

The Trust also has elected and appointed Governors, who provide valuable scrutiny and challenge and represent the local voice at Board level.

Our service users and supporters

There are lots of ways people presently share their experiences and are actively involved and engaged in shaping local health and care services in Gloucestershire, including:

- Elected and appointed Governors
- Trust Membership
- Get Involved section of our website:
  www.gloshospitals.nhs.uk/about-us/get-involved
- Get Involved in Gloucestershire
  getinvolved.glos.nhs.uk/
- Gloucestershire Voluntary and Community Sector Alliance
- Young Influencers
  www.gloshospitals.nhs.uk/about-us/get-involved/our-youth-group
- Online patient experience websites, including NHS Choices and Care Opinion
  www.careopinion.org.uk/services/rte
- NHS Friends and Family Test questions
  www.gloshospitals.nhs.uk/contact-us/friends-and-family-test/
- Patient Advice and Liaison Service
  www.gloshospitals.nhs.uk/contact-us/patient-advice-and-support/
- Directly with our complaints, concerns and customer service team
- Healthwatch Gloucestershire
  www.healthwatchgloucestershire.co.uk
- Engagement on social media
- Patient Stories
- Through engagement activities and events
- Attendance at Trust Board and Annual Members Meeting

We know that there is more we can do to increase opportunities for involvement and to ensure this reflects the diverse communities we serve. We continue to learn so we can be more innovative, and resourceful in how we engage people to improve experience for both patients and colleagues.

The impact of involvement and engagement over the last year

The Trust is actively engaged in a diverse number of projects, in partnership with local communities, and the impact of this work is tracked through our Community Engagement Tracker.

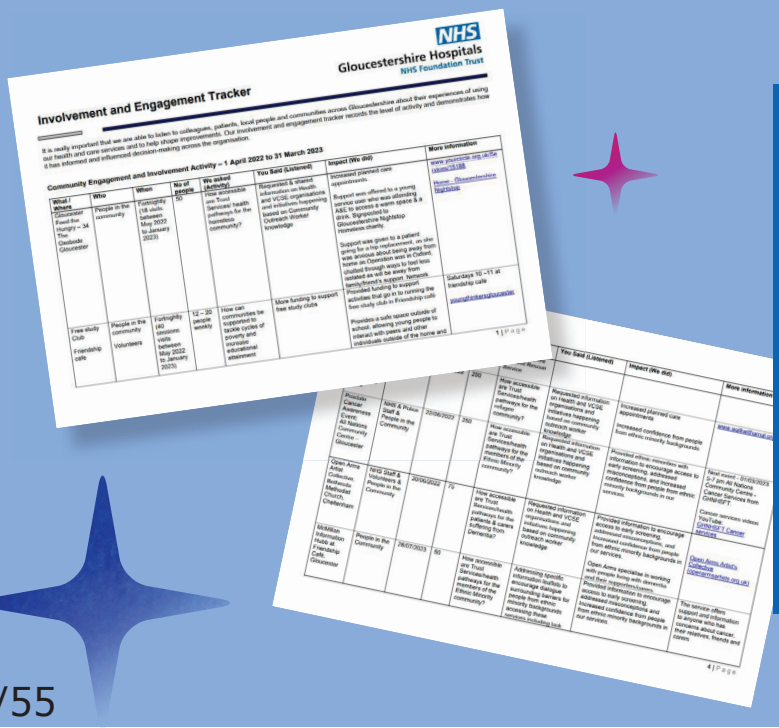
Our team used the Community Engagement Tracker to systematically monitor and analyse our community connections, and this helps us improve services, build relationships with stakeholders, and make evidence-based decisions on what local people have told us matter most to them and where together we can make a difference.

The Tracker focuses on connecting community members with Voluntary, Community, and Social Enterprise (VCSE) groups, building local relationships, and enhancing healthcare services based on community feedback.

From April 2024 to March 2025, the Community Engagement Team engaged with over 17968 people by participating in and attending 64 community group events and activities. This work has increased access to VCSE services, improved attendance at health appointments, and enhanced access to healthcare information.

We measure success through engagement metrics and data analysis, using these insights to adapt our services to better meet the needs of local people and communities. Our commitment to improvement is driven by regularly reviewing feedback and supporting communities, all in alignment with the Trust's values to ensure meaningful engagement and quality improvement across the organisation.

At the heart of this impact and change, is the connections with our communities and partners, ensuring we are working together to address challenges, improve access and share learning.



Find out more here:

Community Engagement Tracker

Case studies and impact

01 Domestic Abuse and Sexual Violence Consultation Network

Brief description:

Over the past year, the Community Engagement and Involvement Team has collaborated with the Domestic Abuse and Sexual Violence Consultation Officer from the Office of the Police and Crime Commissioner, a representative from Adult Social Care at Gloucestershire County Council, and the GDASS Health Independent Domestic Violence Advisor (HIDVA). This partnership, built on over a year of joint working, has been instrumental in deepening our understanding of the lived experiences of domestic abuse in Gloucestershire. As we prepare for the 16 Days of Action Against Domestic Violence in November 2025, we aim to bring together our shared learning in a way that creates lasting impact - particularly for women from minority backgrounds, whose experiences are too often overlooked.

Who did we speak to?

We listened to many women with lived experience of domestic abuse, with a strong focus on those facing multiple and intersecting barriers, including language, cultural expectations, and systemic gaps in care. Their stories and insights have shaped our work and reinforced the urgent need for more inclusive, trauma-informed support services.

What and how did we ask?

Through community conversations, targeted consultations, and online and in-person engagement, we invited women to share their experiences with accessing (or being denied) support. Our approach was rooted in listening, collaboration, and empathy – working with professionals across health, social care, and the voluntary sector to ensure we captured a complete and honest picture.

01 Domestic Abuse and Sexual Violence Consultation Network

What did people tell us?

Many women spoke of the deep and lasting impact of trauma, particularly when compounded by cultural stigma and language barriers. One particularly powerful and heartbreaking story came from a woman from the Bangladeshi community who speaks little English and has been repeatedly failed by the system. Following the deaths by suicide of two of her children and years of domestic abuse, she has struggled to access the help she desperately needs. Interpreter costs have prevented meaningful support from mental health services and domestic abuse charities. Language barriers during police calls placed her in further danger, and health services lacked the cultural understanding or flexibility to meet her complex needs. She has little family and community support. Her story, and others like it, highlight a stark and urgent truth: local services are not working for everyone.

What did we do?

These experiences are helping us reshape how we work together. We now recognise that health services, especially hospitals, must play a central role in addressing the inequalities that survivors from minority groups face. Through this partnership, we are taking steps to ensure hospitals are more accessible, inclusive, and culturally sensitive. We are advocating for trauma-informed care with appropriate language support and are committed to removing the barriers that stop survivors from getting the care they need, when they need it.

Highlighting the Need for Focused Health Inequalities Work:

The hospital's role in this partnership is essential. Stories like the one shared above make it clear that health inequalities are not abstract; they have real, often devastating consequences. Survivors of domestic violence from minority groups are falling through the cracks. Access to services cannot depend on English fluency or internet literacy. We want to ensure that Gloucestershire Hospitals ensure that interpreter services are consistently available and that clinical pathways account for trauma, cultural context, and socioeconomic barriers. As part of this partnership, our hospital is committed to being part of the solution, embedding equity into every level of patient care and advocating for system change to support the most vulnerable.

Find out more here:

Domestic Abuse and Sexual Violence Consultation

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02 Accessible Information Standard – Making Communication Inclusive

Brief description:

The Accessible Information Standard (AIS), developed by NHS England, ensures that people with a disability, impairment or sensory loss receive information in a way they can understand. Gloucestershire Hospitals NHS Foundation Trust has taken significant steps to embed this standard, reducing health inequalities by improving how patients access and receive important healthcare information.

Who did we speak to?

We engaged with patients who have communication and accessibility needs, as well as carers, reception staff, and digital and patient experience teams. These audiences were essential in understanding the barriers faced and the practical steps needed to implement changes across the Trust.

What and how did we ask?

We gathered feedback through hospital-based interactions, conversations with patient groups, digital service assessments, and ongoing consultation with frontline teams. We also reviewed data from service requests, feedback to the Patient Advice and Liaison Service (PALS), and accessibility audits of patient materials and communications.

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02 Accessible Information Standard – Making Communication Inclusive

What did people tell us?

Patients and carers told us that accessing hospital letters and information in suitable formats (such as large print, Braille, or Easy Read) is critical to feeling included and confident in their care. Many shared experiences of missing vital information due to inaccessible communication, which highlighted a clear health inequality.

What did we do?

Gloucestershire Hospitals NHS Foundation Trust launched a new initiative, led by the digital and patient experience teams, to ensure that all written communication, such as appointment letters and test results, is available in accessible formats. These include Large Print, Easy Read, and Braille versions. Once a need is identified, it is flagged in the patient's electronic health record, so it only needs to be requested once. The initiative follows the five key steps of the AIS: Identify, Record, Flag, Share, and Meet communication needs.

We have also made patient information leaflets available in accessible digital formats and worked to improve the accessibility of the Trust website, ensuring compatibility with screen readers and allowing content to be resized or read aloud. This has significantly reduced communication barriers and improved patients' overall experience.

"Providing fair access to healthcare is a core value of the NHS and one we are committed to upholding. We continue to work hard to make sure our services and patient communications are inclusive and easy to access. I'm proud of the effort our teams have made to help us take this important step forward"

Kevin McNamara,
Chief Executive

Find out more here:

Visit our Accessibility Statement and AIS Information Page

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03 Young Influencer Development

Brief description:

The Trust Young Influencers group enables the Trust to maintain meaningful dialogue with young people aged 14-22 years to ensure their voices are heard in our decision-making process. They meet monthly face to face or via teams and over the last year the group's membership has doubled. Together, they provide feedback to improve service provision across the Trust and collaborate with external organisations to build relationships and establish a wider reach in the community.

Who did we speak to?

In August 2024, the Young Influencers ran a stall at the No Child Left Behind family event in Cheltenham. Here they engaged over 150 children and young people to write or draw on a leaf what 'health' meant to them. The following month, the group created a Wellbeing Tree outside the Gloucester Hospital chapel. The tree trunk and branches represent the Trust, and the leaves represent the children the young people in the community it serves.

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03 Young Influencer Development

What did we do?

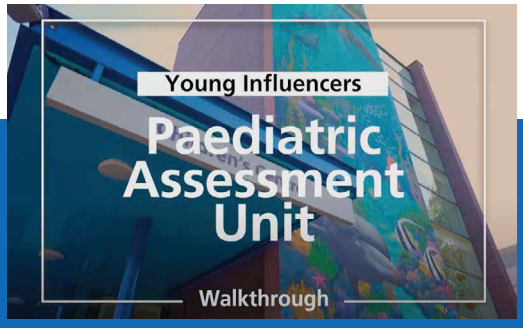
Over the last year, the Young Influencers have supported internal projects such as the redesigning of the children's and young people's outpatient department in Battledown, Cheltenham. They reviewed and provided back on the proposed designed as well as providing suggestions for colours, all of which were actioned by the artist.

To make the hospital feel safer and more accessible for young people, the group filmed a walk through of the Children's Emergency Department and the Paediatric Assessment Unit (PAU). This has also been shared with wider organisations such as the ICB SEND team.

The Young Influencers also use their voice to support wider projects. They participated in a workshop for the Gloucestershire Council Preparation for Adulthood team, offering valuable insights into 'What is exciting about adulthood? What are your concerns about adulthood? And What is important when preparing for adulthood?'

What did people tell us?

Young Influencer members participate because they understand their value and the impact they can have when given the opportunity. They are proud to represent the Trust and feel they are offered a safe space to speak openly and honestly.



Watch our PAU walk through video here

Watch our Young Influencer short demo here

04 Community Playlist for Dementia Awareness: Sounds of the Soul

Brief description:

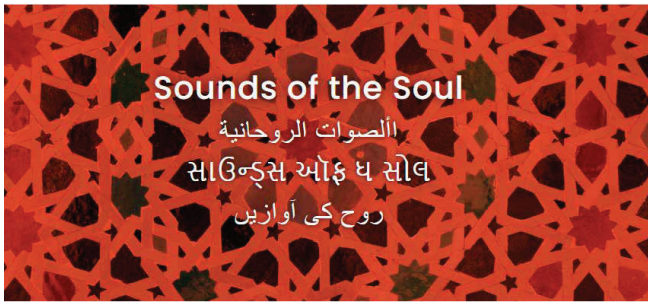
"Sounds of the Soul" is a co-created, culturally sensitive musical playlist developed to support Muslim people living with dementia and their carers. This initiative uses spiritually significant sounds to enhance connection, identity, and emotional well-being for individuals affected by memory loss.

Who did we speak to?

We engaged with members of the Muslim community in Gloucester, including carers, the South Asian Women's Group, the Men's Group at the Friendship Café, and several individual contributors. We also consulted with Mufti Abdullah Patel, who endorsed the project.

What and how did we ask?

Conversations were initiated at the 2023 Dementia Education event at the Friendship Café. Follow-up engagement included group discussions and one-to-one consultations with community members and carers. We asked about the types of spiritual and cultural sounds that resonate personally and might be meaningful for someone living with dementia.



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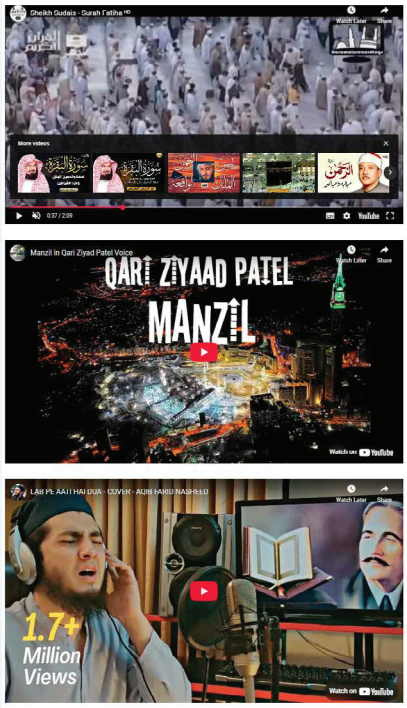
04 Community Playlist for Dementia Awareness: Sounds of the Soul

What did people tell us?

Community members expressed a strong interest in music and recitation as tools to reconnect with faith, family memories, and cultural identity. They shared personal favourites, such as specific Qur'anic recitations, nasheeds, and poems. There was clear enthusiasm for developing a resource grounded in lived experience and spiritual significance.

What did we do?

Together with Mindsong and the Gloucestershire Hospitals Engagement and Involvement Team, we created a ten-track "Sounds of the Soul" playlist. It includes Qur'an recitations and vocal-only nasheeds chosen for their soothing and spiritually uplifting qualities. The playlist was endorsed by Mufti Abdullah Patel and launched for Dementia Action Week. It is now accessible via YouTube, Spotify, Mindsong's website, and multilingual printed materials for use in mosques, community centres, and care homes.



Find out more here:

www.mindsong.org.uk

Watch the video

05 Breast Cancer Awareness Event – Jewish Community

Brief description:

This collaborative project between Gloucestershire Hospitals NHS Foundation Trust (GHFT), the Engagement and Involvement Team, Patient Experience, and the Engagement and Experience Team is part of a broader effort to ensure that healthcare services are inclusive, culturally sensitive, and responsive to the needs of diverse communities in Gloucestershire.

The initiative began with an important conversation to understand the specific health and wellbeing needs of the Gloucestershire Jewish Community, including a meeting with Abigail Fisher, a community representative. That meeting led to a commitment to active, ongoing engagement with the community to ensure their voices are heard, and their concerns are addressed in a meaningful and sustainable way.

Who did we speak to?

Abigail Fisher
Representing the Orthodox Jewish community

Jenny
Community leader within the Cheltenham Hebrew Congregation

Broader Jewish community members through direct engagement
Event attendance, and feedback

Rabbi Anna Gerrard
Rabbi for the 3 Counties Liberal Jewish Community

The Gloucestershire Jewish community includes around 500 Orthodox Jews, with a significant number of elderly residents and visitors, especially in summer. The community is active through weekly services, social events, and virtual meetings.

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05 Breast Cancer Awareness Event – Jewish Community

We engaged with the community through:

- One-on-one discussions with leaders to identify gaps in care
- Event-based outreach, including educational health talks tailored to the community's cultural and religious context
- Feedback forms distributed at community events to capture views and priorities
- A focus on face-to-face trust-building sessions, including an upcoming coffee morning hosted by the community
- Specific questions focused on:
- Health education needs
- Perceptions of healthcare services
- Comfort and concerns during hospital admission
- Preferred ways to receive health information

What Did People Tell Us?

Key insights and needs shared by the community included:

- A desire for culturally appropriate and inclusive health education
- Concerns around genetic health risks, particularly in relation to breast cancer
- Interest in receiving targeted sessions on specific conditions, such as diabetes and dementia
- The importance of trust and familiarity when engaging with the NHS
- Need for reassurance that religious observance will be respected in care settings

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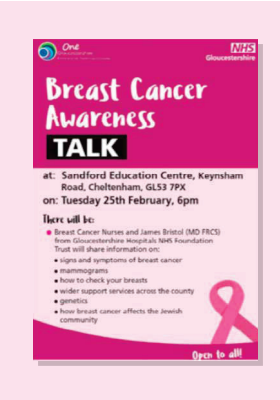
05 Breast Cancer Awareness Event – Jewish Community

What Did We Do?

Breast Cancer Awareness Session

Thank you to everyone who supported the Breast Cancer Awareness Talk for the Jewish community. The event was a success, with approximately 18 attendees and strong engagement throughout. It marked a significant milestone in building an ongoing relationship with the community.



The event was delivered in partnership between One Gloucestershire, Cheltenham Hebrew Congregation, GHFT, and the ICB. It was held at Sandford Education Centre, following a request for an evening session to accommodate working attendees. Refreshments were provided.

The session was structured in two parts:

- Breast Cancer in the Jewish Population – The Role of Genes
- Speaker: Mr James Bristol (GHFT)
- Breast Awareness and Screening Information Speaker: Jane Fide, Breast Care Nurse (GHFT)

Attendees were encouraged to ask questions throughout to ensure full understanding of the content. The session promoted open dialogue and allowed attendees to express concerns and share feedback in a safe, respectful environment.

Promotion and Community Involvement

A bespoke poster was created by NHS Gloucestershire ICB and circulated by the Chair of the Cheltenham Hebrew Congregation. The event was promoted across Orthodox and Liberal synagogues as a private event to encourage a comfortable and familiar atmosphere.

Feedback and Outcomes

- 16 attendees completed feedback forms, and the results have been compiled into a report to inform future planning.
- Feedback was overwhelmingly positive, with requests for further health education sessions on diabetes and dementia.
- Community leader Jenny has already been in contact to organise these follow-up events for the summer, showing a clear sign of trust and ongoing engagement.

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05 Breast Cancer Awareness Event – Jewish Community

Next Steps

- Organising further health education sessions on diabetes and dementia in collaboration with the community
- Hosting a community coffee morning, facilitated by Abigail Fisher, where senior GHT representatives will be present to hear feedback and build relationships
- Continuing to gather feedback and assess health priorities through future events and informal engagement
- Exploring opportunities for co-designed services that reflect the religious and cultural needs of the Jewish population

Conclusion

This work represents a significant step forward in building meaningful, sustainable relationships with the Jewish community in Gloucestershire. It has helped open lines of communication, increased understanding, and laid the groundwork for ongoing, trust-based collaboration.

We are proud of the progress made and committed to ensuring our services continue to meet the diverse needs of all communities. As we move forward, we hope to replicate this model of engagement with other groups across the county.

Together, we are shaping a healthcare system where it's okay to ask, and it's okay to share your specific needs.

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06 Update on Collaborative Community Engagement Work – Community Voices

Brief description:

As part of our commitment to listening, learning, and acting upon what matters most to our communities, we have undertaken a wide-ranging programme of engagement and involvement, placing particular emphasis on under represented groups across Gloucestershire. We recognise that each person's health needs are different, and we are committed to promoting equitable access to care by building trust and strengthening community relationships.

Who did we speak to?

Throughout the year, we engaged with a diverse range of communities and groups, including:

- The Hindu Community Group in Cheltenham
- Sahara Saheli and South Asian Elderly Women's Groups
- Active Gloucestershire's Walk and Talk participants
- Gloucestershire Action for Refugees and Asylum Seekers (GARAS)
- Communities in Forest of Dean
- SAMS – South Asian Men's Support Group

What and how did we ask?

We created inclusive, culturally sensitive spaces to listen deeply to people's experiences and views on health, wellbeing, and access to care. Through wellness talks, community health sessions, walking groups, outreach initiatives, and co-designed events, we asked:

- What are the barriers to accessing health information and services?
- What kind of support feels meaningful and relevant?
- How can we better tailor health engagement to individual and community needs?

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06 Update on Collaborative Community Engagement Work – Community Voices

What did people tell us?

We heard powerful, honest feedback that shaped our understanding:

"Communities need to be able to reach out to local health organisations to ask for health education, to enable them to support their families. Support to navigate and connect the dots with confidence, this helps reduce anxiety and helps us understand the health advice being given."

Community Group Participant

"Health organisations sometimes feel that signposting is enough, but the support does not end there... McMillian was for me, community engagement supports the patient's confidence to navigate services... My support helped me accept the changes to my voice and understand how to enjoy my life again."

SAMS Group Participant, reflecting on cancer recovery

"This is a safe space to express ourselves... When I retired, I realised that I was the 'foreign minister' and my wife the 'home minister'. We now share more, and I feel better supported with home life and health decisions. This space helps us become better able to support each other."

SAMS Group Participant

People told us they wanted:

Support that recognises personal, cultural, and health-specific journeys.

Clear, compassionate guidance to navigate complex health systems.

Continued opportunities to co-design local services that reflect their voices and values.

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06 Update on Collaborative Community Engagement Work – Community Voices

What did we do?

In response, we:

- Delivered tailored wellness talks, women's health sessions, and walking groups to foster connection and increase health literacy.
- Partnered with GARAS to bring health advice directly to refugees and asylum seekers in trusted, safe settings.
- Supported the SAMS group in offering culturally appropriate peer support and specialist signposting for South Asian men navigating complex health diagnoses.
- Facilitated community events in the Forest of Dean to ensure rural and seldom-heard voices are part of local health conversations.
- Captured and honoured lived experience stories, which now guide our service development.
- Committed to co-designing future services alongside communities, with a focus on tools that empower local change and sustainability.

This work reinforces that engagement is not a one-off activity, but a continuous relationship built on trust, relevance, and action. Our thanks go to all the individuals and communities who generously shared their time and voices with us.

Together, we are building a more inclusive, responsive health system where every person can say with confidence: "my wealth is my health."

Watch our Governors talk about their experience when they joined us at last year's Community Events

Find out more here:

www.gloshospitals.nhs.uk/get-involved

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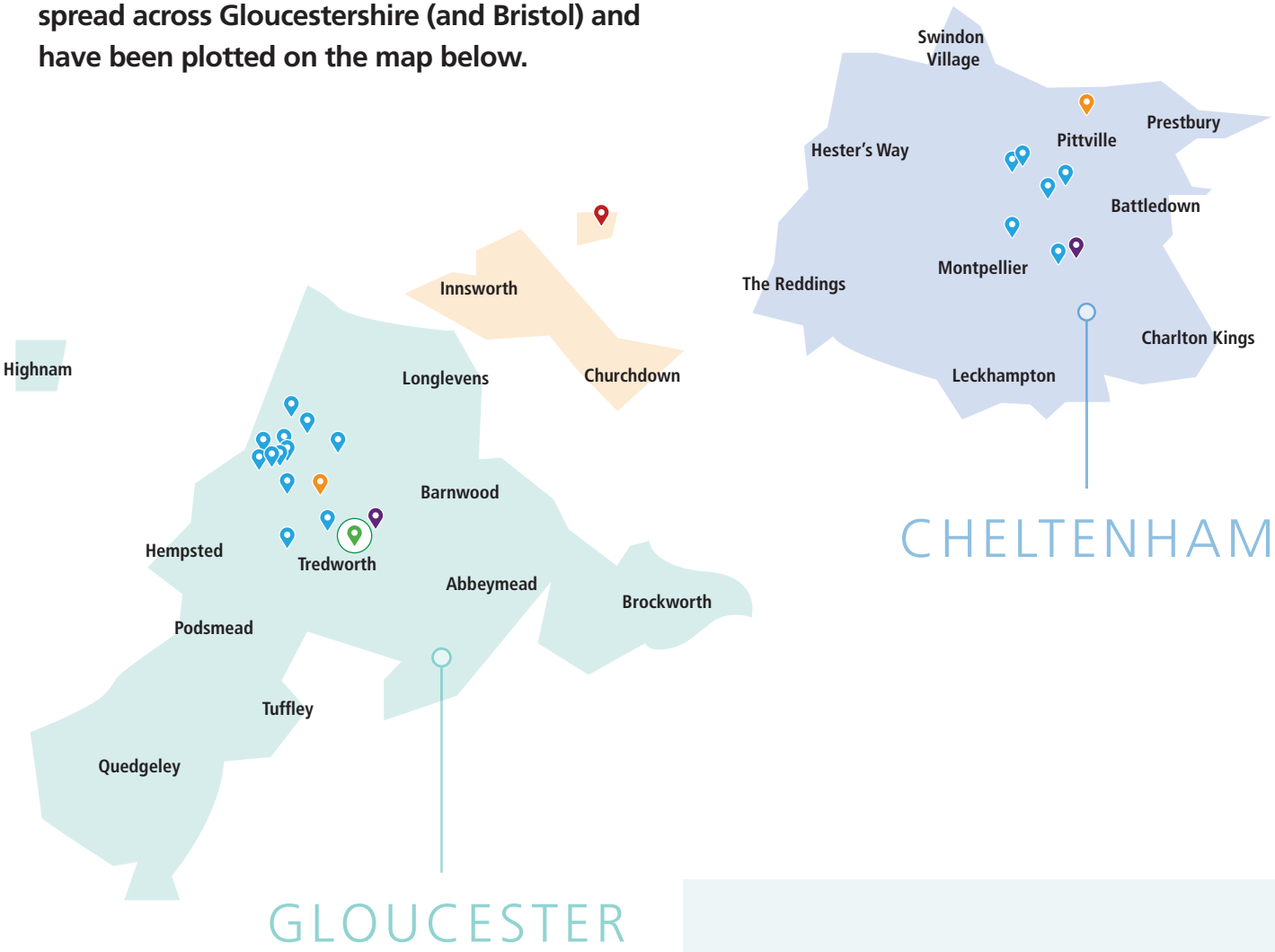
06 Update on Collaborative Community Engagement Work – Community Voices

Over the last 12 months, we hosted 47 engagement events in total. The events were spread across Gloucestershire (and Bristol) and have been plotted on the map below.



- 10 events hosted at this location
- 7 events hosted at this location
- 3 events hosted at this location
- 2 events hosted at this location
- 1 event hosted at this location

07 Inclusive Language Guide: Communication that Reflects Our Values

Brief description:

There is a power in words and language. At our Trust, this must reflect our values, beliefs, and the way we work together as a system. Language shapes experience and connection, and inclusive communication is essential to building psychological safety and mutual respect.

At Gloucestershire Hospitals NHS Foundation Trust, we understand the profound impact language has in building trust, connection, and inclusivity. Our communication must reflect our core values, fostering a workplace where everyone feels respected and valued.

In 2024, we proudly launched our first Inclusive Language Guide – a practical resource designed to help colleagues promote openness and understanding throughout our diverse workforce and communities. The guide supports improved communication, encourages honest dialogue, and helps prevent misunderstandings by celebrating cultural diversity and ensuring inclusivity in all interactions.

Who did we speak to?

We worked in collaboration with a wide range of internal and external partners, including diverse staff networks, patient representatives, local Integrated Care System (ICS) organisations, and equality specialists from Bradford District and Craven who bring expertise in areas such as race, gender, LGBTQ+, and disability. The Trust's Equality, Diversity and Inclusion (EDI) Council played a central role in the review process.

What and how did we ask?

We circulated a draft version of the guide and invited feedback through targeted emails, virtual workshops, and group discussions. Stakeholders were asked to review the guide for accessibility, practical relevance, and inclusivity, especially in clinical and public-facing contexts.

What did people tell us?

Participants emphasised the need for the guide to include real-life examples, be easy to understand and apply, and support the use of non-biased, respectful language in everyday conversations. They also encouraged clarity on inclusive terminology and how to challenge language respectfully.

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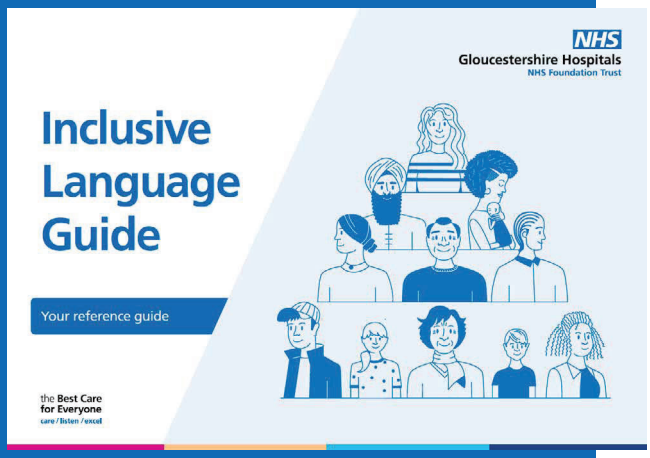
07 Inclusive Language Guide: Communication that Reflects Our Values

What did we do?

An early draft of the guide was submitted to the Trust's EDI Council for review and comment. Their insights informed several improvements to structure and tone. The guide was then shared with local ICS organisations for further review, with their feedback carefully considered to ensure the guide met the training needs of both clinical and non-clinical staff.

The final version was co-developed with our partners and reviewed thoroughly to ensure alignment with system-wide priorities. It is now embedded into staff induction programmes and communications training.

The Inclusive Language Guide has been well-received across the organisation and has become an essential reference point for staff, supporting communication that upholds dignity, safety, and equity in every interaction.



Find out more here:

www.gloshospitals.nhs.uk/inclusive-language-guide

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08 Introduction of the Patient Portal at Gloucestershire Hospitals

Brief description:

Introduced by Gloucestershire Hospitals, the NHS Patient Portal is to empower patients and improve the overall healthcare experience. This digital tool gives patients greater control by allowing them to access appointment letters, manage bookings, and communicate securely with care teams. The portal streamlines administrative processes and reduces reliance on paper letters, enhancing efficiency and sustainability.

It was developed to make healthcare more accessible, transparent, and user-friendly through technology patients already use, like smartphones or the NHS App. This is just the first step in a phased rollout, with more features planned to enhance patient engagement throughout 2025.

Who did we speak to?

We worked in collaboration with a wide range of internal and external partners, including diverse staff networks, patient representatives, local Integrated Care System (ICS) organisations, and equality specialists from Bradford District and Craven who bring expertise in areas such as race, gender, LGBTQ+, and disability. The Trust's Equality, Diversity and Inclusion (EDI) Council played a central role in the review process.

What and how did we ask?

We circulated a draft version of the guide and invited feedback through targeted emails, virtual workshops, and group discussions. Stakeholders were asked to review the guide for accessibility, practical relevance, and inclusivity, especially in clinical and public-facing contexts.

What did people tell us?

Participants emphasised the need for the guide to include real-life examples, be easy to understand and apply, and support the use of non-biased, respectful language in everyday conversations. They also encouraged clarity on inclusive terminology and how to challenge language respectfully.

09 Recruitment Support for Migrant Communities

Brief description:

The Gloucestershire Hospitals Community Engagement Team worked in partnership with local organisations to support refugees, asylum seekers, and migrant communities seeking employment within the NHS. Through workshops, tailored events, and direct engagement, the team helped individuals overcome barriers such as language difficulties, lack of confidence, and unfamiliarity with the NHS recruitment process. Key initiatives included the "Applying for Success" workshops and Walk and Talk events, which provided practical guidance, behind-the-scenes insights, and confidence-building opportunities. This ongoing work aims to ensure migrant communities are supported, included, and empowered to pursue careers within the NHS.

Who did we speak to?

We engaged with refugees, asylum seekers, and migrant communities, with a particular focus on those seeking employment opportunities within the NHS. This effort was supported through our collaboration with key partners, including the Gloucestershire Hospitals NHS Foundation Trust, the ICB's "We Want You" careers team, Gloucestershire Managed Services (GMS), and the Gloucestershire Action for Refugees and Asylum Seekers (GARAS).

What and how did we ask?

We sought to understand the specific needs and barriers faced by migrant communities in accessing NHS employment opportunities. This was done through direct engagement with individuals and groups via workshops and tailored events. We asked participants about their challenges in applying for jobs, including language barriers, lack of confidence, and understanding of the recruitment process within the NHS.

What did people tell us?

Participants expressed a strong desire for more tailored support in navigating NHS job applications, especially in relation to CV writing, application forms, and interview preparation. Many individuals, particularly those with foreign qualifications and work experience, shared challenges with having their skills and certifications recognized in the UK. There was also a consistent request for English language support and guidance on understanding NHS job roles and requirements. Additionally, the need for more opportunities to build confidence in the workplace and to integrate into local communities was frequently highlighted.

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09 Recruitment Support for Migrant Communities

What did we do?

To address these needs, we worked closely with the ICB's "We Want You" careers team, led by Charlie Presley, and GMS to provide practical support to migrant communities. A key initiative was the December and March "Applying for Success: Focus on HCSW Role" workshop, which was specifically designed for asylum seekers and refugees. The workshop covered vital application elements, such as CV writing and preparing supporting information, with a special focus on individuals who held overseas qualifications and were new to the UK workforce.

We also provided ongoing support through the tailored Walk and Talk event, organised in collaboration with GMS and Gloucestershire Hospitals Trust. This event aimed to help participants explore NHS roles, understand key recruitment processes, and build confidence in a supportive, engaging environment. The Walk and Talk provided a behind-the-scenes look at the GMS facilities, allowing participants to meet teams, ask questions, and gain an insight into daily hospital operations.

Moving forward, we are committed to continuing this partnership, ensuring sustained, practical support for migrant communities as they navigate the recruitment process. We will keep collaborating with GMS to offer additional opportunities for engagement, career development, and integration within the NHS workforce, ensuring that those facing barriers to employment are not left behind.

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10 FiveXMore Maternity Campaign and Stroud Community Engagement

Brief description:

Promoting equality, diversity, and inclusion (EDI) continues to be a key priority in creating a safer, more compassionate environment for staff, patients, and families within the Children's and Women's Division. Through a series of events and engagement activities, we have listened to our colleagues and communities to help shape a more inclusive culture and improve maternity care outcomes.

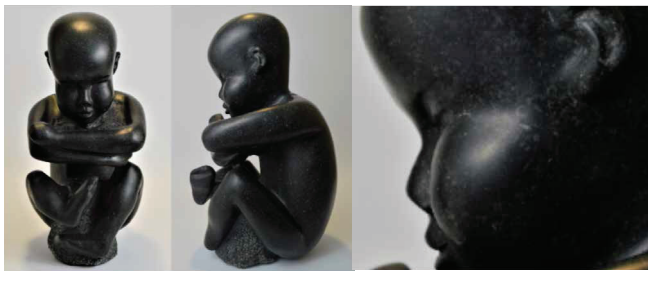
Who did we speak to?

We engaged with around 40 staff members from across the Children's and Women's Division during an in-person EDI workshop held on Monday 20 January at the Women's Centre, Gloucestershire Royal Hospital. We also collaborated with community organisations including the Stroud Motherhood Collective and Stroud Hospitals League of Friends to hear directly from mothers, birthing people, and families in the Stroud area via an online survey.

What and how did we ask?

At the EDI workshop, we facilitated a panel discussion with colleagues across the Trust, focusing on health literacy, communication barriers, and cultural perspectives in healthcare. We asked participants to reflect on how these factors affect patient experience and staff engagement.

In Stroud, we launched a co-designed online survey to find out what support matters most to local families during pregnancy and after birth. The survey was promoted through local networks and received 83 responses to date.



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10 FiveXMore Maternity Campaign and Stroud Community Engagement

What did people tell us?

Participants at the EDI workshop shared a range of experiences and insights. For example, we learned that cultural differences can significantly impact engagement with maternity care; some families may avoid antenatal clinics due to cultural or religious beliefs, while others may be unfamiliar with decision-making norms in the NHS. Internationally educated staff also reported challenges adapting to local expectations. The open dialogue generated rich discussions and valuable suggestions for improvement.

Survey respondents in Stroud highlighted the importance of accessible postnatal support, culturally appropriate care, and continuity during the perinatal journey.

What did we do?

We used the feedback from the EDI workshop to identify what's working well and where we can improve, particularly in communication and culturally competent care. As Lisa Stephens noted,

"I was pleased so many staff across the division not only attended but were so engaged in the session. The range of ideas that were shared was also impressive."

A highlight of the workshop was the introduction of a sculpture by Gloucester-based artist Deborah Harrison, inspired by the FiveXMore campaign, now on display at the Women's Centre. This piece helped spark meaningful conversations around Black maternal health, aligning with our broader work to tackle racial disparities.

Our Trust has partnered with Black Maternity Matters and the FiveXMore campaign to promote anti-racism learning among maternity staff. Staff involved in this collaboration are now applying their learning to inform inclusive, equitable maternity policies and practices. This is a vital step in improving outcomes for Black women and birthing people and fostering a more respectful and safe maternity experience.

In Stroud, we will use the survey responses to tailor interventions and support services that align with what families say they need most. This ensures community voice drives quality improvement.

Conclusion

Our EDI agenda is central to building the safety culture we all strive for. Events such as the January workshop have created a buzz of interest and innovation, with staff energized to lead positive change. By listening to staff and community voices, and responding meaningfully, we are actively shaping a more inclusive and equitable healthcare environment in the Children's and Women's Division.

www.gloshospitals.nhs.uk/improving-maternity-services

11 Iftar and Fasting Friends Initiative

Brief description:

Ramadan 2025 was a time of reflection, compassion and unity for colleagues and patients across our Trust. Through our Iftar and Fasting Friends Initiative, we enhanced awareness, accommodation and celebration of Ramadan, with active engagement from leaders, chaplaincy, and our wider hospital community. The initiative supported inclusivity and understanding through practical adjustments, education, and meaningful shared experiences.

Who did we speak to?

We spoke with Muslim colleagues, non-Muslim allies, line managers, members of the chaplaincy team (notably Imam Atique Miah), attendees at the Iftar events, and Trust-wide teams engaged in event planning and diversity initiatives.

What and how did we ask?

We gathered feedback through post-event surveys, informal conversations at the Iftar events, direct staff testimonials, and engagement via email with participants and managers. We asked about the impact of the events, the value of shared experiences, and suggestions for future initiatives.

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11 Iftar and Fasting Friends Initiative

What did people tell us?

Feedback was overwhelmingly positive and highlighted the emotional resonance and educational value of the initiative.

Participants also expressed deep appreciation for the inclusive approach, availability of prayer spaces, flexibility in working hours, and the opportunity to ask questions and learn in a safe, respectful space.

Key comments included:

"I found this a lovely event. It was wonderful to have the opportunity to share it with my Muslim colleagues and show my support for them in this way. I really hope the Trust continues to support these events."

"Brilliant event – please do it next year."

"I really enjoyed the event and the atmosphere of it, would really enjoy it again next year."

"It was amazing to learn about the personal experiences of those practicing Ramadan; what it means to them, their community and faith. It was an inspiring insight to how precious and important Ramadan is, beyond just fasting. It felt like we were adopted into the community for a brief moment and able to share in their joy of Ramadan."

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11 Iftar and Fasting Friends Initiative

What did we do?

To support and celebrate Ramadan 2025, we implemented a multi-faceted engagement plan:

- Created awareness through visible communications and resources across both sites.
- Partnered with Chaplain Atique Miah to provide tailored guidance and educational outreach to line managers and teams.
- Offered flexible working arrangements and adapted meeting times to support fasting colleagues.
- Organised two inclusive Iftar events attended by 360 colleagues at Blue Spa and Fosters Restaurant, where halal and vegetarian meals were provided, and all faiths were welcomed.
- Launched the "Fasting Friends" initiative, where non-Muslim colleagues fasted in solidarity and donated their meal savings to the Cheltenham and Gloucester Hospital Charity, supporting the Big Space Cancer Appeal.

Fostered a welcoming and informed environment where colleagues could respectfully engage with the meaning of Ramadan through talks, dialogue, and shared experiences.

The initiative not only strengthened cultural understanding and team cohesion but also demonstrated our Trust's commitment to equity, compassion, and community care.

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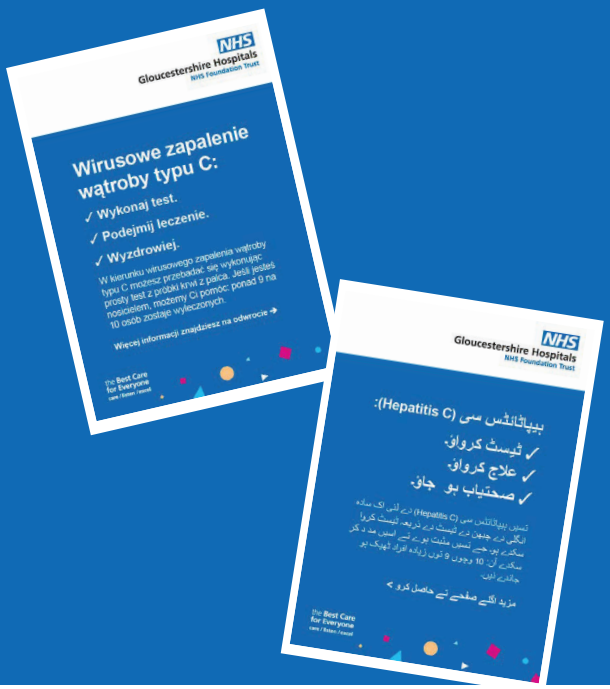
12 Bloodborne Viruses – Hepatitis C Screening Initiative

Brief description:

In collaboration with the Trust's Clinical Bloodborne Virus Team and the ICB Engagement and Experience Team, our Engagement and Involvement Team has developed and implemented a comprehensive plan to raise awareness about Hepatitis C (Hep C) and promote screening within diverse communities. This initiative aims to address cultural barriers and enhance access to testing and treatment services.



Who did we speak to?

- The Viral Hepatitis Nurse Specialist at the hospital
- The Service Development Manager (Countywide and Inclusion) at GHC, Co-Chair of the Race and Cultural Staff Network, and NHS Workforce Equality Standard Expert.
- Community members from Nigerian, Romanian (including Baltic nationalities), Egyptian, Ukrainian, and Polish backgrounds.
- The ICB Engagement and Experience Team who provided valuable data and analysis to inform our engagement strategies.

What and How Did We Ask?

- Collaborated closely with Trust's Clinical Bloodborne Virus Team to identify communities with higher prevalence of Hep C and discuss strategies for awareness and information dissemination.
- Engaged community group facilitators to leverage their connections with Ukrainian, Romanian, and Polish communities, seeking insights into effective communication channels and community meeting places.
- Worked closely with the ICB Engagement and Experience Team to analyse data on Hep C prevalence and identify target communities for engagement.
- Developed a stakeholder map to identify key community connections for sharing health information.

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12 Bloodborne Viruses – Hepatitis C Screening Initiative

What Did People Tell Us?

- Community leaders and members expressed a need for culturally sensitive information and accessible testing services.
- The importance of translated materials and engagement through community events was highlighted.
- Identified specific risk factors prevalent in these communities, including:
  - Sharing drug paraphernalia (needles, spoons, straws, filters, water).
  - Receiving tattoos or piercings with non-sterile equipment.
  - Needle stick injuries.
  - Living with someone infected with Hep C.
  - Having lived on the streets or been incarcerated.
  - Sharing personal items like toothbrushes or razors.
  - Receiving a blood transfusion before 1991.
  - Being born to a mother with Hep C.
  - Undergoing medical or dental procedures in countries with high Hep C prevalence.

What Did We Do?

- Developed and distributed information sheets detailing testing advice and symptoms associated with Hep C, emphasizing the message: "Get tested, get treated, get cured!"
- Translated the Hep C information leaflet into Polish and launched it during the Polish Day Celebration, engaging with members of the local Polish community.
- Shared testing information sheets, including advice on testing and symptoms of Hep C.
- Continued collaboration with the Bloodborne Virus Team and the The ICB Engagement and Experience Team to understand and address cultural barriers preventing individuals from seeking support and treatment.
- Utilised the stakeholder map to identify and connect with key community figures and organisations for effective dissemination of information.
- This ongoing initiative underscores our commitment to inclusive healthcare outreach and the importance of community collaboration in public health efforts.

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13 Engagement with Seldom-Heard Groups

Brief description:

The Gloucestershire Hospitals Engagement and Involvement Team participated in a series of Friendship Walks (a well-being initiative facilitated and organised by the Friendship Café Women's Well-being Group) in collaboration with The Cotswold Wardens and the National Forestry Commission.

These walks are designed to support women from seldom-heard and diverse communities, offering a safe and welcoming environment to connect, explore nature, and focus on their mental and physical well-being.

Inspired by the NHS 5 Steps to Well-being (Be active, Connect, Give to others, Keep learning, and Take notice) the walks also incorporate mindful photography and creative writing to encourage reflection and memory sharing.

Who did we speak to?

We engaged with women from a range of local community groups, many of whom face cultural or practical barriers to accessing nature and outdoor spaces. These included women from ethnically diverse backgrounds, many of whom are connected through the Friendship Café and other local support networks.

What and how did we ask?

We had informal, friendly conversations with participants during and after the walks, asking about their motivations for attending, their experiences during the walk, and how they felt it supported their well-being. We also gathered feedback on how the walks could be further developed to reach and benefit more women in the community.

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13 Engagement with Seldom-Heard Groups

What did people tell us?

Participants consistently described the Friendship Walks as a treasured opportunity to take time for themselves, relax, and feel rejuvenated. Many had never visited the locations before, such as the Asha Centre, Westonbirt Arboretum, and scenic Cotswold villages. They appreciated being more physically active in a social, non-judgemental setting. The chance to learn about nature, practice mindfulness, take photographs, and express themselves creatively through writing was particularly well-received. Women said the walks helped them feel more connected to others, to nature, and to their own well-being. The popularity of the walks is growing, with many asking for more frequent or longer sessions.

What did we do?

We supported the promotion and celebration of the Friendship Walks, sharing participant feedback with the organisers and local health and well-being partners. Based on input received, we are exploring ways to help extend the walks to new locations and to introduce additional creative elements, such as themed photography or storytelling sessions. With participants' consent, we are also using their photos and written reflections to showcase the impact of the initiative, helping to inspire more women to get involved and to demonstrate the value of culturally sensitive, community-led well-being activities.

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14 Cancer Care Patient Feedback on the NHS Information Bus

Brief description:

The One Gloucestershire Information Bus was conducted in January and February 2025 to engage with local communities across Gloucestershire about current and future cancer care services, especially regarding the planned new cancer build. This outreach was spearheaded by the Engagement and Involvement Team to capture patient feedback and identify service improvement opportunities.

Who did we speak to?

We engaged with over 448 individuals from a wide range of locations, including urban centres, rural communities, faith-based groups (e.g., Gloucester Muslim Committee and Hindu Temple attendees), and women's community groups at the Friendship Café. Minority ethnic communities, vulnerable groups, and the general public were all represented.

What and how did we ask?

Participants were invited to visit the One Gloucestershire Information Bus at various community locations to share their experiences and views on cancer care. We used Virtual Reality (VR) goggles to offer an immersive preview of the planned cancer facility, enabling informed feedback on its design and accessibility. QR code-based forms and one-on-one conversations were used to gather responses in real time.

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14 Cancer Care Patient Feedback on the One Gloucestershire Information Bus

What did people tell us?

On staff and care quality:
Oncology staff were consistently praised for their dedication, professionalism, and compassionate care during treatment.

On accessibility:
Significant issues were raised regarding poor parking, limited public transport (especially from the Forest of Dean), and the withdrawal of local services like the FOD chemotherapy van. There were calls to reinstate mobile services and improve pharmacy access for those reliant on public transport.

On service equity and inclusion:
Concerns were expressed about how cancer services support marginalised groups. Feedback emphasised the need for clearer communication, resources in multiple languages, and support for homeless individuals and those with complex health needs. Faith-based needs, such as multi-faith prayer spaces and ablution facilities, were highlighted.

Digital innovation feedback:
The VR goggles received overwhelmingly positive responses and successfully increased engagement. Virtual consultations and online follow-ups were also encouraged to ease travel burdens.

On community communication and collaboration:
Several attendees were unaware of the new cancer build until the tour. There were suggestions to use local noticeboards, social media, and community contacts such as Coleford Health Centre's practice manager to improve information dissemination.

On service design:
Patients requested better multidisciplinary team (MDT) support, more efficient interdepartmental communication, and assurance that the new cancer build would address waiting times and treatment logistics.

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14 Cancer Care Patient Feedback on the One Gloucestershire Information Bus

What did we do?

The Engagement and Involvement Team worked proactively with local groups, including minority and faith-based organisations, to ensure inclusive outreach. We used VR goggles to enhance the experience and encourage active feedback. Regular engagement sessions with local hubs and communities helped us stay informed on emerging issues and support continued dialogue. These insights are informing the planning of the new cancer build and service improvements, with a clear commitment to inclusivity and accessibility.

SPECIAL NOTES

The Engagement and Involvement Team remains committed to deepening ties with all community groups, using innovative tools like VR goggles to engage more effectively.

Strong collaboration with groups such as the Gloucester Muslim Committee and Friendship Café women's group helped surface unique community-specific health concerns.

Regular updates and partnerships with local community hubs are essential to understanding and responding to new and evolving health needs, especially among ethnically marginalised communities.

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15 Saluting Our Sisters Exhibition

Brief description:

Saluting Our Sisters is a compelling exhibition that celebrates the achievements and contributions of Black and minority ethnic women in Gloucestershire. Developed collaboratively by local councils, NHS bodies, community groups, and the University of Gloucestershire, the exhibition was launched during Black History Month and has since been showcased at International Women's Day events and community celebrations in Cheltenham and Gloucester. Now live online via the Hundred Heroines gallery, the project aims to uplift untold stories and inspire future generations.

Who did we speak to?

We engaged with staff and community members across the One Gloucestershire Integrated Care System (ICS), including NHS organisations, voluntary and community sector partners, and local authorities.

What and how did we ask?

We launched a social media campaign across the ICS, inviting nominations of inspirational Black and ethnic minority women who have made a positive impact in their communities. The campaign called on individuals to recognise women whose contributions deserved celebration and wider recognition.

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15 Saluting Our Sisters Exhibition

What did people tell us?

We received a strong and heartfelt response from across the ICS. Many people took the opportunity to nominate colleagues, friends, and family members whose resilience, leadership, and service have shaped local communities. The responses reflected deep admiration and highlighted the need for such recognition.

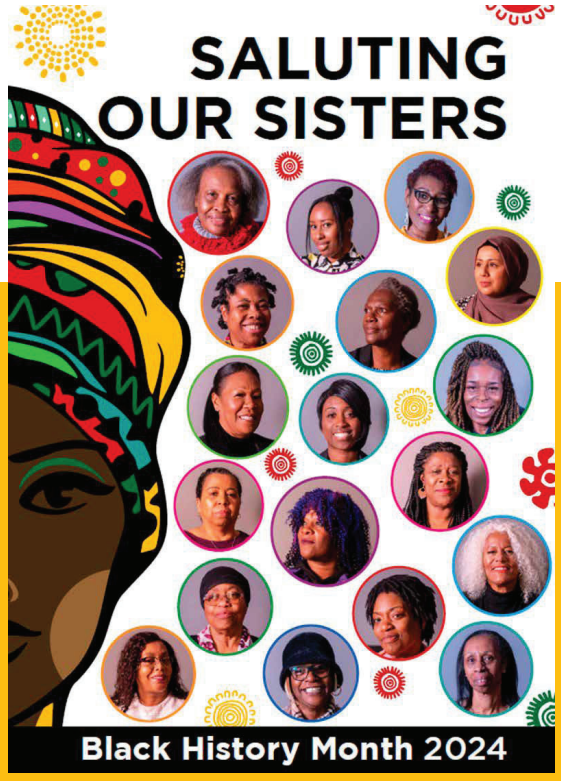
View the exhibition here:

Hundred Heroines

What did we do?

We curated the Saluting Our Sisters exhibition using the nominations received, showcasing the stories of women who were recognised for their contributions. The exhibition has since been featured at high-profile events, including the Lives of Colour Black History Month event, the All Nations BHM celebration, and several International Women's Day events. It has been warmly welcomed by the community and remains available online via the Hundred Heroines gallery.

Arts Diverse-City is equally thrilled to support this project and looks forward to incorporating the exhibition in the upcoming International Women's Day event in March 2025.



Other ways we involve and engage

Over the last year we have continued to strengthen and develop the range of ways we are able to engage and work with local people and colleagues. As an NHS organisation we also have a number of established approaches to ensure the voice of local communities are represented and we publish this on our website and through our social media:

www.gloshospitals.nhs.uk/about-us/get-involved/

We have continued to build our connections with our NHS and voluntary partners across Gloucestershire. There is a clear benefit to local people in health and social care working together on engagement and involvement opportunities, helping us to have more meaningful conversations and ensuring our voluntary and community sector have an active role.

Other ways we involve and engage

6.1 Get Involved Gloucestershire

In 2021 NHS partners launched 'Get Involved in Gloucestershire' which is an online participation space for people to can share views, experiences and ideas about local health and care services.

The new digital platform will be a central point for the NHS and local people to find out and directly get involved in shaping local services. The experiences shared through the platform will help inform and influence the decisions local NHS organisations make.

Further information about Get Involved in Gloucestershire and free registration can be found here:

getinvolved.glos.nhs.uk

6.2 Governors

An important way local people can directly get involved with the Trust is as Member and staff through our Council of Governors. We have 22 public, staff and appointed governors who represent the views and interests of Trust members and the local community, to ensure our Trust reflects the needs of local people.

Our governors ensure we listen to the views of patients and people who live locally, along with our staff and other interested parties. They hold us accountable and ensure we can make improvements to our services, and the information we provide.

The Council of Governors meet six times a year to provide feedback on developments and decisions at our hospitals. These meetings are open to the public, who are welcome to attend.

Further information about Governors can be found here:

www.gloshospitals.nhs.uk/about-us/governors

6.3 Members

As a Foundation Trust, we are accountable to local people and we actively promote the benefits of becoming a member and how to stand for election as a governor.

Members are our staff, our patients and members of the public who either have a general interest in healthcare or are interested about a specific condition or speciality. Members are regularly invited to get actively involved with the Trust to develop services which will best suit the needs of local people.

For more information and to become a Member visit:

www.gloshospitals.nhs.uk/about-us/get-involved/support-our-trust/join-our-foundation-trust/

Watch our Governors talk about their experience when they joined us at last year's Community Events

Find out more here:

www.gloshospitals.nhs.uk/about-us/support-our-trust/join-our-foundation-trust/

Other ways we involve and engage

6.4 Patient Experience

Our patient experience matters to us. Our Trust's strategy has a commitment to create a culture where patients really are at the heart of everything we do and that a patient centred care is embedded across the Trust.

We know from international evidence that outstanding patient experience improves patient safety and clinical effectiveness and also improve the experience of NHS colleagues.

As a Trust we produce an Annual Patient Experience Report which focuses on all our patient experience initiatives, including Friends and Family, compliments, comments and complaints and projects that have happened across the organisation this year.

This can be read at:

www.gloshospitals.nhs.uk/about-us/reports-and-publications/reports/

6.5 One Gloucestershire People's Panel

As part of our One Gloucestershire approach to involvement, we have supported the recruitment of over 1,000 local residents to join the People's Panel. The Panel is made up of individuals whose anonymous feedback is used to shape health and care services at both a countywide and local level.

Importantly, the Panel includes people from CORE20 priority areas, communities that experience greater health inequalities than elsewhere in Gloucestershire or England. While we continue to hear from actively engaged individuals, the Panel helps us better understand the views of those who may not usually share what matters to them.

Panellists are invited to complete regular online surveys (with postal options available) on a range of health and wellbeing topics. Recent surveys have focused on non-medical support for wellbeing and helped inform our approach to working with VCSE organisations and local communities. We also contributed to the national conversation on the 10-Year Plan for Health with a local survey that will shape Gloucestershire's response when the Plan is published in 2025

6.6 Patient and colleague stories

Patient and colleague stories are regularly presented at the beginning of Trust Board meeting. The stories provide an example of the lived experience of patients and colleagues to highlight examples of excellence and where there are areas for improvement.

www.gloshospitals.nhs.uk/about-us/reports-and-publications/reports/

6.7 Our Annual Members Meeting

Our Annual Members Meeting is where the Trust shares key highlights and achievements, and reflect on the previous year's performance, and where we share some future developments planned for the year ahead.

You can watch Annual Members Meeting again at:

YouTube GlosHospitalsNHS

Other ways we involve and engage

6.8 Healthwatch Gloucestershire

The Trust works closely with Healthwatch Gloucestershire (HWG) and they are actively involved in our work and plans, including attendance at Trust Board, Partnership Involvement Network and a number of service projects, including the Covid vaccination programme.

More information about Healthwatch can be found here:

www.healthwatchgloucestershire.co.uk/

6.9 Maternity and Neonatal Voices Partnership

Gloucestershire Maternity and Neonatal Voices Partnership is made up of volunteers who represent the voice of women and families from all communities and cultures to inform improvements in local maternity care. The partnership is directly involved with the Trust's Maternity and Midwifery services and provides an important independent voice in shaping our services.

www.glosmaternityvoices.nhs.uk/

6.11 Social Media

Social media continues to evolve and can bring closer involvement and engagement with a wider range of people than traditional approaches alone. The Trust has evolved its engagement and involvement, embracing face-to-face activity with social media, with a far wider reach. This includes our Facebook Live events, live streaming Q&A sessions with staff, and listening to individuals' experiences of services.

We have several social media channels that anyone can follow and these are outlined below:

Twitter:
www.twitter.com/gloshospitals

Facebook:
https://www.facebook.com/gloshospitalsNHS

YouTube:
www.youtube.com/c/GlosHospitalsNHS

LinkedIn:
https://www.linkedin.com/company/gloucestershire-hospitals-nhs-foundation-trust/

What will we be doing this year?

Over the past year, we have developed an engagement plan with our partners to ensure that together, we are able to attend as many key local events and celebrations, as well as being part of supporting community programmes.
We are always exploring new ways to connect with our communities to help gain a deeper understanding of priorities, ensuring what we all do remains responsive to local needs.

What will be doing this year?

1. **Maternity Improvement Journey**

   Find out more here

2. **In the coming year, the Community Engagement and Involvement Team will support the Research and Innovation (R&I) department to strengthen patient involvement, particularly through the new Patient Participation, Engagement and Involvement (PPIE) Group. We will help identify patients from under-represented communities to join this group, which will contribute to Trust research projects and work closely with the Director for Research, Innovation and Genomics and the Academic Services Manager.**

   Additionally, we will support the development of the Trust's new 5-year Research and Innovation Strategy.

3. **Continue the Collaborative Partnership with Mindsong to create Playlist for other local Gloucester community groups.**

4. **Refugee Week 2025**

5. **Collaborative work to develop GHT Health Inequalities Strategy**

6. **LGBTQ+ Engagement and PRIDE Tour Public Engagement Development**

7. **Cultural Health Cancer Education and Careers Session, Cervical Screening Awareness Week Gynaecological Cancer Awareness Month**

8. **Develop and continue to work with community groups to support Migrant journey to NHS career**, to include GARAS, Cheltenham Welcomes Refugees and the newly established Homeward Horizon which is a refugee peer support group and GMS.

If you want to find out more about the activities mentioned above, make sure you join the 'Get Involved in Gloucestershire' www.getinvolved.glos.nhs.uk platform where you can also share your views, experiences and ideas about local health and care services across the county.

You can also visit the Trust website to find out how to get involved in supporting the hospitals:

www.gloshospitals.nhs.uk/about-us/get-involved/

Report to Board of Directors			
Date		10 July 2025	
Title		Annual Equality Report 2024/25	
Author / Sponsoring Director / Presenter		**Author:** Coral Boston EDI Lead **Presenter:** Maria Smith – Associate Director of Education Learning and Culture **Sponsor:** Claire Radley - Director for People & OD	
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 paper presents the Annual Equality, Diversity, and Inclusion (ED&I) Report for 2024/5024 to the Board. The report has been scrutinised by the EDI Steering Group, the People and OD Delivery Group and People and OD Committee. Challenge was received in the following areas:

- To ensure that language was consistent throughout the report, ensuring that terms were not being used interchangeably.
- That there were clear staff and patient sections rather than a mix throughout.
- To be reporting on achievements made against our set priorities.
- What the next steps are from the progress

With amendments made accordingly, the Report is recommended to the Board by People and OD Committee.

NHS Trusts are required to publish an annual Equality Report in compliance with the Public Sector Equality Duty. This report must be accessible for download from the Trust's website.

The report details:

- Context of our organisation – our mission, vision and values and how this links to the Equality
- Equality, Diversity & Inclusion (EDI) agenda
- Overview of legal and regulatory frameworks
- Summary of progress against our equality objectives in the last 12 months (March 24 -April 25)
- An overview of previous activities and planned activities for the year ahead to improve our services
- Patient experience
- Colleagues experience and support

Future Plans: Our strategic approach for the coming year focuses on creating an inclusive environment where all members of the Trust feel valued, empowered, and actively involved in promoting equality, diversity, and inclusion.

This is supported by a comprehensive development plan, aligned with the 6 High Impact Actions from the NHS England EDI Improvement Plan. The strategy includes clear goals and targeted actions aimed at addressing ongoing challenges, strengthening accountability, building on the progress achieved so far, and clear monitoring of progress.

The appendices of this report contain:

Equality Delivery System Report: An in-depth analysis of our performance against the Equality Delivery System (EDS) standards, providing a clear picture of our current standing and areas where we need to make improvements.

Gender Pay Gap and Ethnicity Pay Gap Report:
The Gender Pay Gap Report provides analysis of our organisation's pay disparities between male and female employees. This report highlights key findings, including the current gap in average hourly pay and bonuses, while also examining the factors contributing to the gap, such as the distribution of roles across different levels and specialities. It outlines both the progress made and the challenges that remain in achieving gender equality in the workplace. The report serves as a valuable tool for tracking progress and setting future goals to ensure gender equity within our company

WRES and WDES Reports:
These reports present key indicators related to race and disability within our workforce. They include concise narratives that explain the data and outline our planned actions to address identified concerns, ensuring we are taking targeted steps to improve diversity and inclusion in these areas.

The report is also presented to the Board for assurance and is set to receive additional support from the communications team to ensure it is effectively communicated and accessible. This step is crucial for engaging with our stakeholders and ensuring transparency in our ED&I efforts.

All reports will be available on the Trust website.

Conclusion
The Report highlights our significant achievements in 2024/25 and outlines our plans for the upcoming year to keep building a culture where everyone feels a sense of ownership and shared responsibility for advancing equality, diversity, and inclusion.

Achievements in 2024/25: A detailed overview of the progress made in various areas of ED&I, showcasing the initiatives that have been successfully implemented and the positive impacts they have had on the Trust.

Implications and Future Action Required

Once approved by Board, this report will be formatted and made ready for publication by the Communications Team. It will be published on the Trust internet.

Risks or Concerns

There are no risks or concerns with the report.
The risk associated with EDI is risk 154: The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher levels of discrimination, leading to low morale, poor health and wellbeing.

Financial Implications
Nothing to report.
Recommendation
• Note Content of the report • Endorse the outcomes of the annual report • Approve publication of this report
Enclosures
Paper: Annual Equality Report 2024/25

Equality Annual Report 2024 - 2025

Subheadings: Arial Bold 14pt, black

Main body text: Arial Regular 12pt, black

Notes: Arial Regular 10pt, black

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Introduction

This report reflects not just our compliance with the Equality Act 2010, but our ongoing commitment to recognising what we do well and where we need to improve. Both in how we support our patients and how we care for our people. It brings together the data required under the Public Sector Equality Duty and highlights the Equality, Diversity, and Inclusion (EDI) work we've been leading across our Trust.

Each year, we publish this report to share how we're doing and where we're heading. It allows us to track progress, compare data from previous years, and understand the real impact of our actions. Through this, we can identify where inequalities exist and take meaningful steps to support those who are underrepresented or disadvantaged. Ensuring everyone who works with or receives care from us can thrive.

As we look ahead to 2025–26, we have set clear EDI priorities focused on improving the day-to-day experience of our people. These are:

- Recruitment and EDI
- Anti-discrimination
- Allyship and Leadership Practices

We know there's still work to do. We're committed to ensuring every staff member have the tools, confidence, and support to put EDI into practice in everything they do. Our goal is to build a culture where everyone feels they belong and where fairness, respect and inclusion are not just talked about, but genuinely lived.

Over the last year, we've taken important steps forward. From strengthening our staff networks and delivering tailored training, to listening through national surveys, group discussions and one-to-one conversations, we've worked with purpose to support staff across our Trust.

EDI is part of who we are, not a separate project, but a value that runs through our teams, our decisions, and our future. We have collaborated across departments, connected with communities, and opened powerful conversations — sometimes within our own walls, and sometimes with our System partners.

We have challenged assumptions, elevated voices that need to be heard, and held ourselves accountable as leaders. Our focus on EDI is not just about meeting standards, it's about shaping a better, more compassionate organisation for everyone.

Coral Boston
Equality, Diversity & Inclusion Manager

Executive Foreword

We have made considerable progress in our cultural journey this year, reflected in our much-improved staff survey results. Our collective efforts and dedication to create a more inclusive workplace are leading to improvements, but we also know there is much more to do. We continue to seek and reflect on feedback, engage with staff, patients and service-users with wide-ranging backgrounds and experiences, and focus on the issues that have the biggest impact. Undoubtedly, the more our staff feel able to be themselves at work, the better care they are able to provide.

This report highlights evidence of our commitment to Equality, Diversity, and Inclusion, describing the tangible steps we have taken and the progress we are making. It sets out our achievements and serves as a foundation for the exciting ambitions we have for the coming year.

Claire Radley,
Director for People & OD

Equality Annual Report Contents

What do we mean by Equality, Diversity, and Inclusion

Equality

A culture that embraces a wide range of ideas, experiences, and practices can lead to an environment where differences are both respected and celebrated. This inclusivity benefits not only us as individuals but also the diverse communities we serve. By valuing and acknowledging various perspectives, we foster a richer and more dynamic workplace that promotes innovation and excellence in our work. This approach enhances our ability to address the unique needs of our community, ultimately creating stronger, more meaningful connections, leading to a better quality of life.

Diversity

Diversity is the fact that there are many different people in our workplaces and communities, many of whom have different backgrounds, social positions, and lifestyles. We encourage everyone to recognise, respect and value the differences between individuals within our workforce and amongst our service users.

Inclusion

Inclusion is the act of ensuring that all staff can access and enjoy the benefits of working for the Trust including, but not limited to, employment opportunities, flexible and agile working, training and development opportunities, team and Trust-wide activities and ensuring that no person or persons is excluded, especially those from disadvantaged groups ensuring a positive experience for all.

The Equality Act 2010 and the Public Sector Equality Duty (PSED).

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions. These are to:

- Eliminate discrimination, harassment, and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and people who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

We are required to do this by:

- Removing or minimising disadvantages suffered by people due to their protected characteristic.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
- The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include steps to take account of disabled person's disabilities.

- Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard to the need to tackle prejudice and promote understanding.

The Protected Characteristics covered by the Equality Act 2010 are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

Progress made 2024/2025.

We have continued to support staff in the trust by carrying out a few activities.

Our key areas of focus for Equality, Diversity, and Inclusion (EDI) over the next 12 months are closely aligned with both our Trust Strategy and the national EDI Improvement Plan. We are committed to driving meaningful change by focusing on priority areas that will make a real difference to the experiences of our staff and the communities we serve.

Our priority objectives include ensuring equal opportunities in recruitment, career progression, and promotion for all. We are taking active steps to embed inclusion into our recruitment processes. One example being the introduction of Inclusion Champions on interview panels for roles at Band 8a and above. This is a significant step forward in our efforts to create fair and equitable processes at all levels of the organisation.

We continue to use national frameworks such as the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) to better understand and address disparities. These reports, published alongside this document, provide valuable insights by comparing the experiences of Ethnic Minority and White staff through the WRES, and of disabled and non-disabled staff through the WDES.

We are using these insights not only to inform our planning but to hold ourselves accountable. They guide our actions and help us identify where we must do better. Our commitment is not just about meeting targets. It is about creating an inclusive culture and working towards levelling the playing field.

Progress on our objectives

Report to the Public Board				
Date	10 July 2025			
Title	Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training for 1 April 2024 – 31 March 2025.)			
Author **Director/Presenter**	Dr Shyam Bhakthavalsala, Guardian of Safe Working Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO			
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

1. A total of 389 exception reports have been raised from 1 April 2024 to the 31 March 2025m, which includes 21 ERs reported as 'immediate safety concern'.
2. No fines have been levied during that period.
3. A total of £2922.56 was paid to junior doctors because of exception reporting of additional hours worked.
4. In addition, 80 hours have been given as time off in lieu due to additional hours worked and reported to GOSW.
5. A new resident doctor's forum was elected in November 2024 and meetings have been taking place regularly since.

Recommendation

That the Board accepts the report for assurance and information.

Enclosures

Annual Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training.

Annual Report of the Guardian of Safe Working Hours (GOSW for Doctors and Dentists in Training

For Presentation to Public Board Thursday, 10 July 2025

1. Executive Summary

1.1 This annual report covers the period of 1st April 2024 to 31st March 2025.

1.2 During this period, there were 389 exception reports logged, 21 of which have been reported as an immediate safety concern. Most exception reports are related to extended working hours and have been closed with additional payment or time off in lieu.

1.3 0 fines were levied.

2. Introduction

2.1 Under the 2016 Terms and Conditions of Service (TCS) for Junior Doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the Board of compliance with safe working hours' limits. The Terms and Conditions have been updated in 2019, with further requirements being monitored.

2.3 The structure of this report follows guidance provided by NHS Employers.

High level data (March 2025)

Number of doctors / dentists in training (total):	496
No. of trust doctors	225
Total Resident doctors	496
Amount of time available in job plan for guardian:	1PA
Administrative support:	4Hrs

Time allocated in job plans for Educational supervision: 0.25/0.125 PAs (first/additional trainees to maximum 0.5 SPA)

3. Junior Doctor Vacancies as of March 2025

These figures vary from month to month and do not include gaps due to maternity leave, sickness, etc. However, they can worsen the impact of acute/long term sickness, etc on rotas leading to more exception reports.

Department	**Additional training and trust grade vacancies**
ED	3 x Reg
Surgery	Senior fellow surgery x 1
General Medicine	Trust doctor Care of the elderly x 2 Trust Reg in Acute 1
Women's & Children's	Obs & Gynae 2 x Reg

4. Medical Agency and Bank for Junior Doctors

4.1 This data is supplied by Finance.

4.2 The total expenditure on agency and bank locum cover, across all divisions, over this period was £20303793. This also includes the cost of safely covering resident doctor rotas during their industrial action in June 2024.

Monthly breakdown of medical agency and bank spend by division - 1 April 2024-31 March 2025

Month	Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Med	Agency	401,745	396,969	318,972	396,969	318,972	394,493	366,400	341,279	307.167	327,319	472,449	544,239	4,586,973
Med	Bank	922,678	846,801	514,511	846,801	514,511	490,601	537,176	411,113	545,645	703,867	527,769	585,977	7,447,450
Surg	Agency	131,680	12,806	66,256	108,050	66,256	51,527	68,313	85,901	35,771	96,571	106,249	74,903	904,283
Surg	Bank	450,585	359,180	483,553	359,180	483,553	439,684	573,042	402,948	407,652	355,291	352,915	532,340	5,199,923
D&S	Agency	34,783	29,171	47,622	29,171	47,622	34,792	20,724	106,632	39,129	53,254	42,897	93,771	579,568
D&S	Bank	93,624	60,388	80,918	60,388	80,918	74,213	43,098	43,826	72,884	98,380	56,948	28,694	794,279
W&C	Agency	32,792	2,942	0	0	0	-3,484	22,100	20,531	5,794	69	-64	-34	80646
W&C	Bank	0	0	0	89,250	89,148	82,220	66,018	86,112	96,411	52,019	63,056	86,437	710,671
Total	**Agency**	601,000	441,888	432,850	534,190	432,850	477328	477,537	554,343	387,861	477,213	621531	712879	**6151470**
Total	**Bank**	1,466,887	1,266,369	1,078,982	1,355,619	1,168,130	1,086,718	1,219,334	943,999	1,122,592	1,209,557	1,000,688	1,233,448	14,152,323
Total		2,067,887	1,708,257	1,511,832	1,889,809	1,600,980	1564046	1,696,871	1,497,342	1,510,453	1,686,770	1622219	1946327	**20,303,793**

5. Additional Cost

5.1 A total of £2922.56 was paid to junior doctors because of exception reporting of additional hours worked in the last year.

5.2 A total of 80 hours was given as time off in lieu as a result of exception reporting of additional hours worked.

6. Exception Reports

6.1 A total of 389 exceptions have been reported during the period 1 April '24 – 31 March '25 including 21 exceptions reported as immediate safety concern. This contrasts with 439 reports with 22 ISCs for the previous year.

6.2 The following exception reports were raised across specialties:

Exceptions Raised				
Specialty	***Working Hours***	***Educational Opportunities***	***Service Support Available***	***Of which, no. of ISCs***
A&E	5	0	0	0
Acute Medicine	2	0	0	0
General Medicine	178	7	23	9
General Surgery	22	4	12	8
Gastroenterology	0	0	2	0
Respiratory	9	0	0	2
Surgical	3	12	0	2
Anaesthetics	2	0	0	0
Cardiology	3	0	1	0
Obs & Gynae	10	0	0	1
ENT	61	0	0	0
Oncology	4	0	0	0
Vascular	1	0	0	0
T&O	12	0	0	0
Haematology	1	0	0	0
Intensive therapy	1	0	0	0
Max Fac	1	0	0	0
Renal	13	0	0	0
SUB-TOTALS	**328**	**23**	**38**	**21**
TOTAL EXCEPTION REPORTS inc. ISCs = 410				

7. Fines Levied

7.1 For the period 1 April 2023 to 30 March 2024, no fines have been levied.

8. Issues Arising

8.1 There were 21 ERs with immediate safety concerns, 8 of which related to hours or pattern, 2 to inadequate educational opportunities and 11 relating to service support, including inadequate time for handover.

8.2. There does not appear to be a recurring pattern and an analysis of ISCs against clinical incidents reported through Datix relating to staffing did not identify any direct correlation.

9. Actions Taken to Resolve Issues

9.1 As GOSW, I would follow up all exception reports raised as an immediate safety concern with a view to escalating to the medical director's office where necessary. I would also review exception reports to identify themes and patterns and those which appear stalling at the local level. Trainees can also contact me by email if they feel their concerns have not been addressed. Any exception reports relating to educational matters are referred to the Director of Medical Education, Dr Preetham Boddana, for oversight or follow up when necessary.

9.3 Where there have been persistent issues relating to hours or service support, I have met with the relevant Clinical Leads/Rota coordinators to discuss options to resolve issues. DME has also been involved in such discussions, where educational issues have also been raised by trainees in the same specialty.

10. Post Graduate Doctors Forum

10.1 The Resident Doctor's forum (previously Junior doctors forum) meets every other month and is a useful forum for juniors to raise any issue of concern and keep informed of current business issues within the Trust. Though there had been a gap in these meetings due to delays in appointing a new chair following changeover of doctors, they have now resumed regularly and are well attended.

10.2 As GOSW, I would attend these meetings whenever possible. I would also get regular updates from RDF chair and would discuss any concerns as appropriate.

10.3 There were unspent monies raised previously through GOSW fines – these are now being utilized for purchasing new furniture and coffee pods for the doctor's mess.

11. Changes to Resident Doctor's contract

11.1 Several changes have been suggested to the current process of exception reporting in the new resident doctors' contract with potential for more fines.

11.2 It is suggested that these changes are implemented by August, however NHS Employers are still working on details regarding the exact nature of changes and how some of the recommendations can be met. Further information is awaited from NHS Employers.

12. Summary

11.1 389 exception reports have been raised from the beginning of April 2024 to the end of March 2025.

11.2 No fines have been levied during that period.

11.3 The overall rate of exception reports has dropped slightly, though there has been a larger number of reported ISCs. No specific themes or patterns have been identified on further review.

11.4 A total of £2922.56 was paid to junior doctors because of exception reporting of additional hours worked in the las year.

11.5 In addition 80 hours have been given as time off in lieu due to additional hours worked and reported to GOSW.

Author: OBJ **Dr Shyam Bhakthavalsala, Guardian of Safe Working**
Paula Baudry, Governance and Business Lead

Presenting Director: OBJ **Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**

Date: **25/6/2025**

Recommendation
For assurance
To approve

Appendices:
Link to Rota rules factsheet: OBJ
Rota rules at a glance | NHS Employers

Link to exception reporting flow chart (safe working hours):
Safe-working-flow-chart-orange (nhsemployers.org)

KEY ISSUES AND ASSURANCE REPORT
Quality and Performance Committee (QPC) May and June 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.

Overall Summary

The Quality and Performance Committee meeting highlights a trust making **significant progress** in several key areas, particularly in reducing nurse vacancies, improving emergency department flow, and achieving strong infection control rates. However, **persistent challenges** remain in certain clinical specialties, data quality, and compliance-related issues, requiring continued attention.

Items rated Red

Item	Rationale for rating	Actions/Outcome
National Maternity Review	The CEO provided an update on the National Maternity review work, distinguishing it from a national inquiry.	A fuller Board update will be provided – with further detail of expectations
Overdue National Patient Safety Alerts: Red	Two national alerts, including one for Maternity, were noted as **overdue**. This indicates a critical safety and compliance concern.	QPC to be updated at future meeting
Non-RTT (Referral to Treatment) Waiting Times-	An **increase** in non-RTT waiting times was noted, particularly in midwifery, trauma, and acute medicine, although efforts are being made to address these through validation and efficiency checks.	More detailed reporting of non RTT specialities to feature in Planned Care Improvement Board.
Data Quality Issues (Paediatrics & Non-RTT)	**Significant data quality issues** were noted for paediatrics and non-RTT patients over a year, which are currently being addressed.	Project underway with medical leadership on Data quality.
Cancer Performance.	**Remains challenging**, particularly in urology, gynaecology, and upper GI, as the trust is **below trajectory for 62-day performance**. There had been improvement in 28-day performance.	All actions are included in the Integrated performance report exception reporting – updated positions are reported to Trust Board directly from the COO
Diagnostic Performance:	A **reduction in diagnostic performance** was noted, particularly in neurophysiology, ECHO, and cystoscopy, due to resource issues. Neurophysiology is specifically affected by workforce issues (maternity leave and consultant retirement). Cystoscopy was identified as challenged with physical estate being a key issue, though a bid for more procedure rooms has been approved and works started.	

Other areas flagged in IPR	Histopathology and Pharmacy Manufacturing	**Issues were flagged** in these areas, progress regarding clear plans and actions to resolve them noted
Category 3 Pressure Ulcers.	Concern was expressed over an **increase** in Category 3 pressure ulcers, with ongoing work in training and validation.	Update to be provided at next QPC
Children's Nursing Recruitment	Recruitment in children's nursing **remains a challenge**.	Divisional oversight ongoing
Non-participation in National Audits.	The trust **did not participate** in two national audits last year (Emergency Medicine for older people, Samba audit) due to departmental priorities and staffing levels.	Noted by QPC
Water Safety Management:	While the trust received **good compliance** in an independent audit, **outstanding surveys** and the need for external review were highlighted. Crucially, issues related to procurement and compliance audits (e.g., HTM November 2024) have not been received by the Water Safety Group, and there are **fluctuating statuses of Responsible Persons**.	A deeper dive into water safety, including a significant case from 2022, was proposed. The Water Safety Group is tasked with providing assurance to the Quality and Performance Committee.
Level 3 Safeguarding Training (Children):	This remains a **persistent challenge**, with delays in the national training program and consideration of alternative providers.	
Never Event	The committee were formally briefed regarding the occurrence of a **Never Event** involving a patient who had the wrong side of metalwork put into their elbow during surgery. The executives are overseeing the actions and investigation. The patient did not come to harm however, it is concerning as is the second event of this type in a short timescale therefore rapid learning is required.	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Integrated Performance report: Patient Flow & Waiting Times	**Patients Waiting Over 52 Weeks: Significant improvement** with a reduction from 125 in March to 93 in April, despite being flagged as red. This shows positive progress, but the issue is not fully resolved. **Emergency Department (ED) Performance:** Performance remained largely flat, with a	

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
ERF: Elective Recovery Fund

	focus on reducing patients waiting over 12 hours. While 12-hour trolley waits have been **halved** over the past year, and lost ambulance hours **reduced** significantly (from 111 to 52 per month), ongoing challenges include the need to discharge patients earlier and the impact of infection prevention and control. **Non-Criteria to Reside (NCTR)** The number of NCTR patients has **remained static**, with a focus on reducing this number to below 100 by July. The trust is an outlier for length of stay post-discharge ready date (10.3 days vs national 6 days). **Specialist Weight Management Service Wait List:** While efforts are being made to improve first appointments and patient flow, concerns were raised that the service "felt closed for many patients". A new capacity model and engagement workshops are part of the strategy.	All actions are included in the Integrated performance report exception reporting – updated positions are reported to Trust Board directly from the COO
Cancer deep dive	QPC were provided with an overview of **cancer performance** for 2024-2025, highlighting the three headline standards: 28-day, 31-day, and 62-day. The 62-day performance showed a slight decline compared to the previous year, with specific improvements noted in urology and gynaecology. **Notable achievements** include Gloucestershire ICB being the 4th best performing ICB in the country for FDS (Faster Diagnosis Standard) performance in April 2025.	The focus for 2025-2026 includes achieving a minimum of 80% for the 28-day standard by March 2025 and sustaining a minimum of 75% for the 62-day standard. Key areas of focus include urology, gynaecology, skin, and haematology diagnostics.
Maternity and Neonatal oversight	**Obstetric workforce** plans were discussed as a live issue with mitigation plans **Neonatal staffing** highlighted as an ongoing issue with mitigation plans **Maternal outcome inequalities** were discussed and improvement plans	Ongoing monitoring via internal and external processes
Winter Planning look back and look forward	The ICB Director of system flow shared learning from 24/25 and the committee discussed areas for forward planning for 25/26	Winter plan on forward planner

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Monitoring Experience:	**Transgender Patients:** The trust is working on monitoring the experience of transgender patients considering changing guidance and will report back to relevant committees. This is an ongoing action. **Friends and Family Test Scores: Amber** A recent **drop** was noted, indicating a need for deeper analysis to understand the reasons. **Perception of Cleanliness: Amber** Concern was expressed about the **perception of cleanliness**, though the integration of patient experience into cleanliness audits is noted.	The newly formed experience forum will be monitoring the delivery of the issues discussed
Mandatory Training Compliance for Medical Staff in Training.	**Low compliance** was highlighted, affecting overall rates,	For discussion via the People and Organisational Development Committee.
Care Quality Commission (CQC) Compliance:	Positive progress in compliance with the Section 31 notice was also noted, with the aim to be fully compliant by July. However, regulatory anxiety about the pace of progress was expressed.	QPC requested an update at the next meeting
Child Protection Medical Assessments	Recommendations from work undertaken are with community paediatricians for work plan development. Risk assessments need aligning with ICB colleagues and is in progress.	The action remains open until further updates.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Quality Account	The Committee received and made final comments regarding the Trust Quality Account	Recommended to Trust Board for approval
Annual Safeguarding Report	The Committee received the report and were assured of multiagency working and systems and processes to safeguard vulnerable adults and children.	Ongoing improvement actions regarding safeguarding level 3 training and system working with child protection medicals noted for ongoing updates to QPC
Care Quality Commission (CQC) Compliance:	The provisional CQC report for medicine and oncology indicated a **"good" rating" for** Cheltenham General Hospital with no 'should-do' or 'must-do' actions.	
Nurse Staffing Levels:	**Significant improvement** has been made, with a reduction in whole-time vacancies across inpatient wards, children's wards, and the emergency department, attributed to	

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	successful recruitment campaigns. The focus is shifting to support and retention.	
Mortality Data:	Mortality data is now **within the normal range**, attributed to improvements in coding, with ongoing work to maintain this.	
Falls: Green	A recent **drop in falls** was noted, attributed to improved risk assessment processes.	
C-section Infection Rates	The trust is **approaching one of the best centres** in the West of England for C-section infection rates.	
Enhanced Care Team:	A new enhanced care team has been **established** to reduce reliance on temporary workforce and improve quality of care.	An update is pending for July QPC
Interpreting Services:	**Successful procurement** of interpreting services, with a trial showing a 30% increase in usage in maternity.	More detail on actual numbers requested by QPC
Infection Prevention Control Rates:	The trust has the **lowest rates of reportable infections across the Southwest**, including zero MRSA bacteraemia cases for the year. While E. coli is above threshold and C. diff remains a priority, overall performance is strong.	
PALS and Face-to-Face Services	**Improvements** in the Patient Advice and Liaison Service and the return of face-to-face services were noted.	
SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.		
Governor Observations included recognition of all work related to safer nursing and midwifery staffing and enquired about wider staff groups. Governor support also offered to engage with health inequalities work.		

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	10 July 2025
Title	Integrated Performance Report (IPR)
Author / Sponsoring Director/ Presenter	Alan Sheward- Chief Operating Officer (COO) Mark Pietroni– Medical Director (CMO) Matt Holdaway- Chief Nurse (CN) Claire Radley- Director for People & OD (DoP&OD) Karen Johnson- 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

To note: whilst technically outside the period being reported, NHS England published their Urgent and Emergency Care Plan 2025/26 in June confirming the 7 key priorities NHS providers must focus and deliver consistently. (#1, Cat2 response times at 30 minutes; #2 Maximum handover of 45 minutes (with a normal handover time of 30mins); #3 78% 4hour performance (combined); #4 90% 12 hour performance; #5 reduced MH waits in ED (less than 24 hours); #6 reduction in patient over 21days from Discharge Ready Date (DRD); #7 improved 4hr performance for Paediatrics – (95% <4 hours)

May proved to be another busy month with increased attendances of 14097 (+739) with a mean daily attendance of 454. The departments achieved improvements in almost all key areas.

4 Hour performance increased by 2% to 63%, having remained static for the previous 12 months with just marginal improvements not exceeding 0.5%. 8-hour performance improved by 2.5% from the previous month, as did the proportion of patients ready to move forward in their treatment within an hour. Triage times improved marginally. Paediatrics 4hour performance also improved in-month from 59% to 65%.

12 hour performance increased to 90.3%, sustaining modest but steady improvement. This key indicator linked to delay related harm is one of the 7 priorities. published this month.

The Department saw 192 additional ambulances in May, but saw hours lost to offload delays fall to just 35 hours average per day in month. This means the average handover period fell from 46 minutes per ambulance to 33 minutes.

Handover delays decreased by 721 hours this month due, in part, to improved discharges and system flow. This illustrates the achievement of another one of the seven priorities mentioned earlier, which has shown consistent improvement over the past six months.

Patients with no criteria to reside remained at 133 over the target of 87 (at 133) but the volume of discharges for longest stay patients increased in the 7 and 21+ day environments. This indicator is now recorded and reported as patients with a discharge ready date in the IPR Pack.

PLANNED CARE

RTT

The total number of RTT incompletes decreased from 68,509 in March to 67,389 in April. Much of this improvement has been driven by the Validation Sprint, which has already resulted in 1,425 additional clock stops, helping shift cases from the long-wait category. However, this process also contributed to a minor dip in RTT performance, slipping from 69.66% in March to 68.98% in April, largely due to the prioritization of removing long waits.

The Trust's performance against the rest of the Southwest region remains favorable, particularly in
relation to RTT performance and 52 weeks as a % of incompletes; May month-end performance for 52 weeks places GHFT 10th best in the country. May month-end position has been finalised with a total of 78 reportable breaches (compared to 93 in April). Of the 78 breaches, 11 of these breaches directly relate to patients the Trust hasn't been able to treat due to national shortages, namely 8 corneal graft and 3 PFJ patients. Effectively the Trust achieved 67 breaches in month. The Divisional split was 2 for Medicine with the remainder being for Surgery. There were no breaches for W&C & D&S.

DM01
In May 2025, diagnostic performance worsened with a 4.41 percentage point rise in breach rates, reversing early-year improvements. Several key modalities saw significant deterioration, particularly in cardiology, cystoscopy, and flexi sigmoidoscopy, while a few areas demonstrated strong improvements.

- Total RAG Breach Rate↑ 4.41 pts (from 21.49% in April to 25.90% in May).
- Worst Performing Modality: Cardiology – Echocardiography (↑ 13.84 pts to 66.76%).
- Best Recovery: Barium Enema (↓ 15.53 pts to 0.92%).
- Notable Deteriorations: Flexi Sigmoidoscopy (↑ 13.07 pts), Cystoscopy (↑ 6.21 pts), Sleep Studies (↑ 7.88 pts)

CANCER
62 Day reportable backlog is 155 as of end of April - most of this cohort is held by Urology.
The unvalidated 62 Day standard for May is currently 68.6% which is a held position from the previous month.
An unvalidated 28 Day standard for May is currently at 82.6%, which is continued compliance with the national standard, and meets the new ask of 80% FDS achievement

Finance
At the end of month 2 the Trust is reporting a year-to-date deficit position of c£10.6m which is £2k adverse to plan. This position is utilising underspends in corporate areas and slippage in reserves to mitigate emerging pressures in

- Nursing staffing costs
- Medical staffing costs
- Financial sustainability delivery

Financial sustainability delivery remains the largest area of concern at this stage with c50% of the planned value being either red rated or unidentified. Failure to deliver our planned sustainability requirements will lead to the non-delivery of the financial position and the utilisation of Trust cash balances which are needed in order to pay our commitments (both revenue and capital related). Non delivery of the financial position may also lead to regulatory intervention.

Capital expenditure and at the end of month 2 amounted to c£1.8m against the planned expenditure of c£5.8m. Any schemes in the programme still do not have an approved business case and there are concerns around in year deliverability due to the slow start to some schemes. Further work is being undertaken on digital schemes to understand the impact of software as service schemes.

Against the use of resource metrics the Trust is delivering against the level of agency spend as a % of pay.

Workforce

The workforce section reflects the Workforce Performance Metrics that reflect where there has been deterioration in performance. This month this is being seen in Appraisal and Bank use. The supportive narrative reflects the areas/services which are contributing to this position together with the recovery actions in train to realise improved performance against target.

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 (IPR)

Integrated Performance Report (IPR)

May 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

Where a metric has shown improvement, entering **special cause variation**, the metric will be moved to watch measures and removed from the slide deck.

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-25	May-25
Quality of Care, Access & Outcomes	Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes	*0%*	47.3%	36.7%
		Proportion of patients spending more than 12 hours in an emergency department	*<10%*	11.1%	9.7%
	Elective Care	Total elective activity undertaken compared with 2019/20 baseline		111%	106%
		Total diagnostic activity undertaken compared with 2019/20 baseline		146%	142%
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	*No Target*	161	160
		Total patients waiting over 62 days to begin cancer treatment compared with baseline	*<=6%*	8.05%	7.98%
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	82%	83%
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	283	291
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		109.00%	104.70%
	Primary Care	Proportion of patients discharged from hospital to their usual place of residence	*No Target*	97.47%	0.00%
	Safe Care	Summary Hospital -level Mortality Indicator	*No Target*	0.000	
		Clostridium difficile infection rate per 100,000 bed days	*104*	25.7	30.6
		E. coli bloodstream infection rate per 100,000 bed days	*71*	21.5	17.5

Watch Measures

			Target	Apr-25	May-25
Watch Measures	Urgent Care	Total hours lost to ambulance handovers		1820	1099
		Average ambulance handover time	*< 40 minutes*	34	19
	Elective Care	78ww RTT	*0*	1	0
		65ww RTT	*0*	3	3
		52ww RTT	*0*	94	75
		Short notice (within 72h) cancellation rate – total	*<9%*	9.3%	8.7%
		Short notice (within 72h) cancellation rate – for clinical reasons	*<3%*	2.3%	2.0%
		Angiogram Waiting List Position		293	288
		Histopathology 10-day reporting	*70%*	56%	56%
	Flow	G&A Occupancy - CGH	*92%*	88%	89%
		G&A Occupancy - GRH	*92%*	95%	94%
		Daily Average of boarded patients	*0*	4	3
	Safe Care	VTE Assessment within 14 hours (%)		92%	91%
		VTE assessment completed - excluding short stay (%)		96%	96%
		Number of Category 2 pressure ulcers acquired as inpatient		15	19
		Smoking Status Compliance (%)	*100%*	97.10%	97.12%
		Severe Harm from Patient Medication Errors	*0*	0	

UEC: Performance

(Standard: a min of 78% of patients seen within 4 hrs by March 26)

Highlights

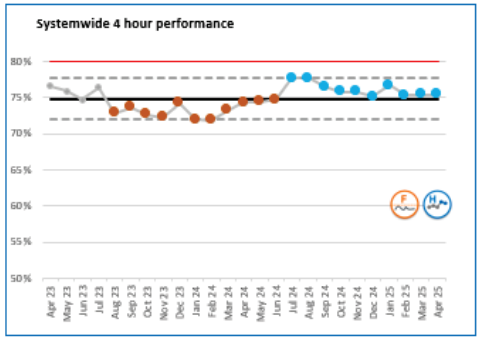
- Improvement in 4 hour Trust position to 62.7%
- 12 hour improvement at 90.3% in May

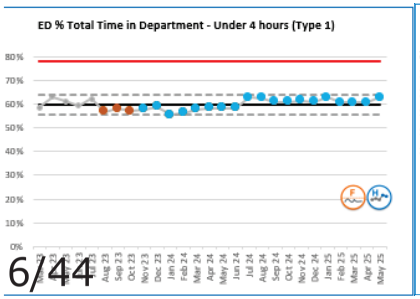
Areas of concern

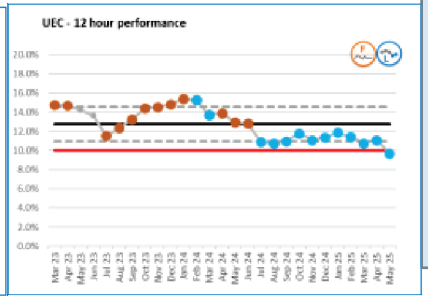
- Non admitted and Paediatric performance
- Response to specialty expected patients

Looking forward

- Review of footprint to take place which would allow for pitstop space to be utilised differently (pilot TBD).







Technical Analysis

Improvement in month against the 4hr performance trajectory, although noted deterioration in the last 10 days of the month. Contributed to the overall system position being achieved and delivering 77.3%.

Planned Actions

CVOF work in place to address streaming opportunities and direct access pathways under the SDEC pillar.

Work to test a change of use to the pitstop space is being considered and a pilot being scoped.

Paediatric options appraisal being developed to improve overall paed performance
Escalation processes being reviewed with action cards to support flow.
UTC business case being developed.

UEC: Performance

(Standard: a min of 78% of patients seen within 4 hrs by March 26)

Highlights

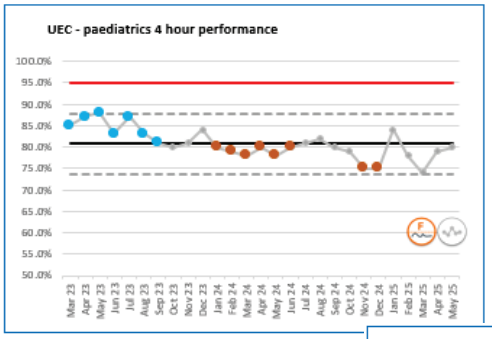
Ongoing collaboration between W & C and Medicine to review the Paediatric model.

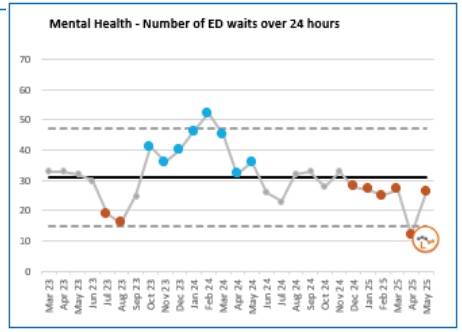
Areas of concern

As per last slide

Looking forward

Focus on escalation route for mental health only patients who have prolonged length of stay within the ED through system engagement





Technical Analysis

There is variation in the delivery of 4 hour performance for Paediatrics which is acknowledged across a number of months. Felt to be driven by the staffing model and number of Paediatric Emergency Medicine Consultants.

Planned Actions

UEC improvement plan ongoing, focus planned for Paediatrics working with Women and Children's.
Clear focus on achieving a further reduction in all domains.
Work with system about Mental Health provision in the community and confirm clear escalations.

UEC: Average Handover Time

(Standard: a min of 78% of patients seen within 4 hrs by March 26)

Highlights

The Trust continues improvement in ambulance handover times; down to 33 minutes in May.

Strong start to June with current average of 31 minutes.

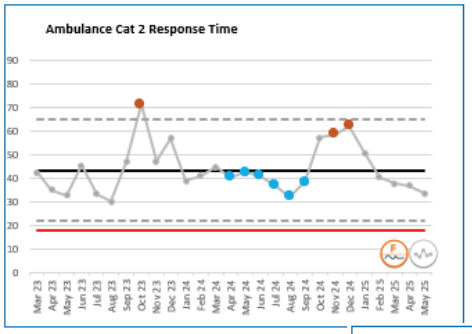
Areas of concern

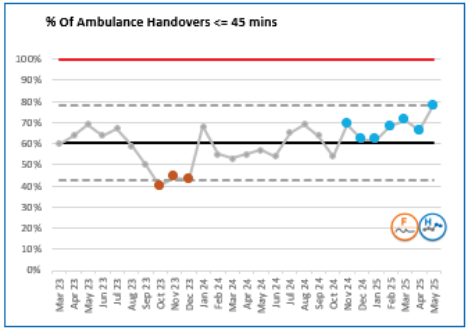
Consistency and continued improvement of time to handover.

Paramedic Pin off challenges in a number of SDEC areas

Looking forward

Continued focus through mandated support, UEC improvement plan and system priorities.





Technical Analysis

As above, an improvement has been noted in May and has continued into June. This continues to be monitored.

Planned Actions

•Further plans to relocate HALO, introduce Cinapsis into CGH and set up SWAST/Trust Working Group through summer are also expected to improve performance.

•Initiatives such as MAP potentially supporting an improvement in reducing handover times (see later slide). Ambition to roll this out across more wards within medicine.

Elective: 45 Week Wait

Highlights

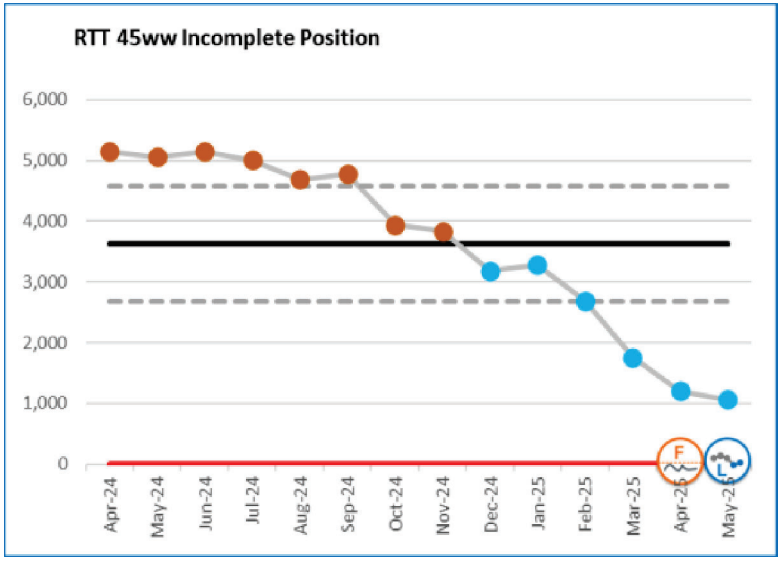
The trend of reducing long waiting patients continues, particularly against the metrics of 45 and 52 weeks Incomplete RTT.

Areas of concern

The most challenged areas remain T&O & Spinal (319 combined); ENT (138) & Dermatology (110) due to volume. Other areas include Urology due to cancer demands & Cardiology due to complexity.

Looking forward

Focus remains on reducing both 45/52 week breaches, recognising that 65 and 78 week breaches will still occur for T&O and Ophthalmology due to the national shortage of graft material / equipment.



Technical Analysis

The unsubmitted May month-end position should be finalised imminently with an anticipated position around 1,080. This a reduction of approx 100 on last month, with reductions being made consistently across most specialties. The specialty to see a rise was Dermatology moving from 89 to 110 (+21) as a likely impact of 2ww demand.

Planned Actions

Use of ISPs will continue for appropriate patients to be transferred, together with referral avoidance schemes. In particular, transfers of ENT patients to Health Harmonie; Oral Surgery patients to Oral Surgery Ltd together with imminent introduction of digital OMFS referral system, and T&O to Nuffield for hips & knees. In addition, the validation sprint via the Patient Access Team / ECH will continue until end of June. Waiting list scrutiny and booking in order will continue.

Cancer: % Patients seen within 62 Days (with trajectory)

Standard: 85%

Highlights

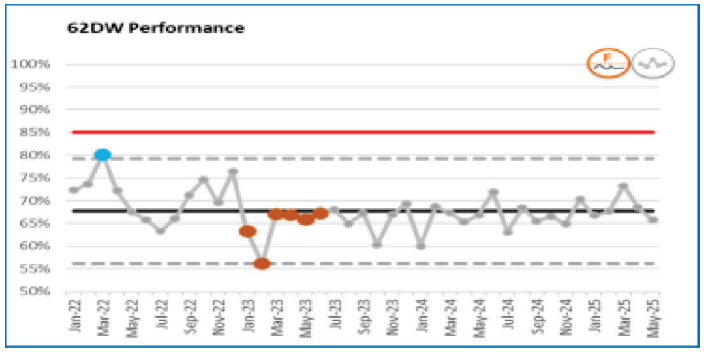
Achievement of 85% by Breast, Head and Neck and Skin.

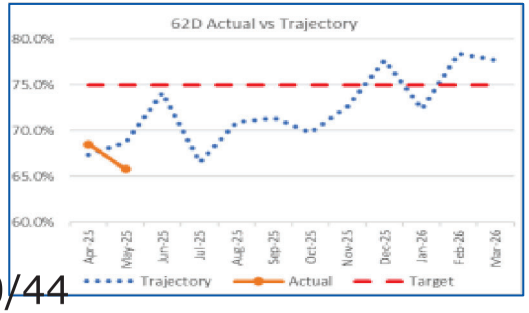
Areas of concern

Validated 62 Day standard for April is currently at 68.7% and so we will miss this target. A new 25/26 trajectory of recovery has been created against the national ask of achieving a minimum of 75% 62 Day performance by March-26.

Looking forward

Trajectory has been submitted to ICB for recovery of 62Day at a sustained position of 75% by March-26. Recovery plan shown with plotted actual performance





Technical Analysis

This is slightly above our recovery trajectory of 67.3% but 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; Areas of focus include Urology, Gynaecology, Dermatology and LGI
- Radiology recovery plan underway with review of capacity and demand and outsourcing solutions
- Cancer Project manager within Pathology supporting ongoing recovery
- Review of Cancer Alliance funding for 25/26 with focus on operational delivery against this standard

Cancer 62 Day Backlog Position

Highlights

Dramatic reduction in Skin backlog from over 60 to 9 as of 16/06

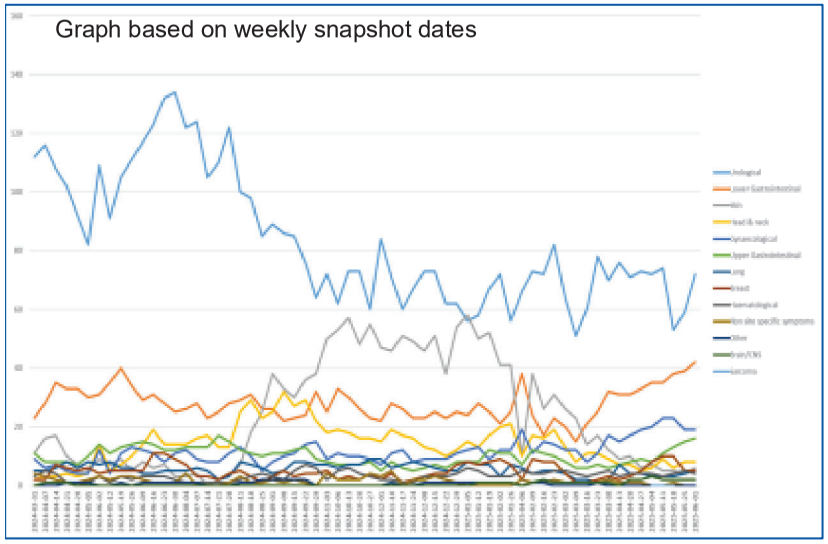
Areas of concern

Current backlog of patients waiting longer than 62 days is at 7% of our PTL size

Urology continues to be our largest contributor to the backlog however over the past few months Lower GI has seen an increase in their figures due to treatment capacity delays and late IPT"s in

Looking forward

Sustained backlog recovery of no more than 6% of our PTL expected March-26



Technical Analysis

62 Day reportable backlog is 155 as of end of April

Most of this cohort is held by Urology as demonstrated by the graph however it had decreased significantly compared to this time last year – 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

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

Cancer: Faster Diagnoses Standard (FDS) % with trajectory

Standard (80%): Improve performance against the 28 day FDS to the 80% ambition by March 2026

Highlights

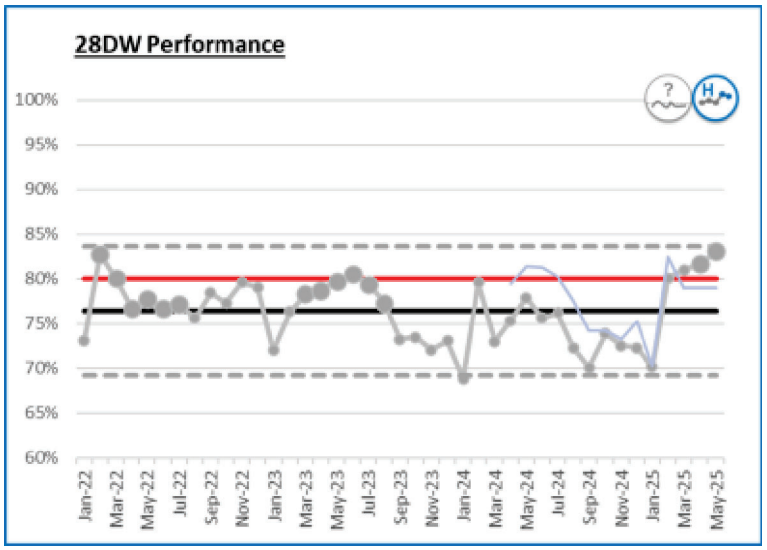
Over the past few months Skins FDS performance has increased from 40% in Nov-24 to 92% in May 2025

Areas of concern

Urology 28 day continues to be below target
While we have met the overall target for 28 day, when looking at the split between diagnosis of cancer and ruling out of cancer, the percentage of patients diagnosed before day 28 dramatically drops to 48% in May 2025

Looking forward

Recovery and sustained achievement of the FDS standard is expected by March-26, however, is dependent on all services which support the cancer pathways supporting the actions agreed.



Technical Analysis

Unvalidated 28 Day standard for April 2025 is currently at 82.1% and we are likely to meet this target.
Skin FDS recovery trajectory in progress however sustainability is dependent on procurement support, additional capacity and Tele dermatology business planning

Planned Actions

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.

Cancer Waiting Times Performance for the last 3 months

Please Note – May is unvalidated

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Mar-25	Apr-25	May-25	Mar-25	Apr-25	May-25	Mar-25	Apr-25	May-25	Mar-25	Apr-25	May-25
Acute leukaemia												
Brain/CNS	100.0%	100.0%	100.0%	63.6%	100.0%	50.0%	100.0%	100.0%	100.0%			
Breast	98.8%	96.9%	97.0%	97.4%	96.9%	96.1%	98.3%	97.3%	93.2%	92.4%	90.3%	91.0%
Gynaecological	97.5%	96.1%	97.8%	76.6%	65.1%	72.7%	94.7%	91.1%	83.3%	78.3%	43.8%	55.2%
Haematological	100.0%	100.0%	93.8%	47.4%	35.7%	26.3%	100.0%	100.0%	100.0%	78.6%	64.7%	67.4%
Head & neck	95.8%	94.5%	96.1%	78.5%	76.7%	80.8%	95.3%	100.0%	90.9%	71.4%	86.5%	90.0%
Lower GI	94.8%	91.9%	94.9%	79.0%	78.0%	70.1%	86.6%	80.9%	91.1%	71.2%	38.5%	45.7%
Lung	93.3%	97.4%	97.6%	96.4%	96.3%	97.2%	97.2%	82.4%	92.0%	74.2%	39.1%	63.0%
Other							100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sarcomas							100.0%	100.0%	100.0%	57.1%	0.0%	50.0%
Skin	97.1%	95.2%	93.2%	86.6%	91.8%	92.7%	88.7%	91.6%	87.8%	91.9%	88.9%	86.7%
Non site specific sympto	96.8%	87.1%	93.8%	59.3%	35.5%	65.6%						
Testicular	100.0%	92.9%	100.0%	83.3%	87.5%	85.7%				100.0%		100.0%
Upper GI	98.6%	99.1%	97.5%	89.2%	89.3%	92.1%	98.2%	95.0%	100.0%	83.9%	85.1%	81.8%
Urological	91.9%	91.3%	90.7%	43.1%	48.2%	54.7%	92.5%	90.4%	60.0%	43.7%	53.5%	33.1%
Trust Total	96.5%	94.8%	95.3%	80.5%	80.9%	82.2%	94.6%	93.1%	86.1%	73.2%	68.5%	65.8%

Diagnostics: Performance Trend

Highlights

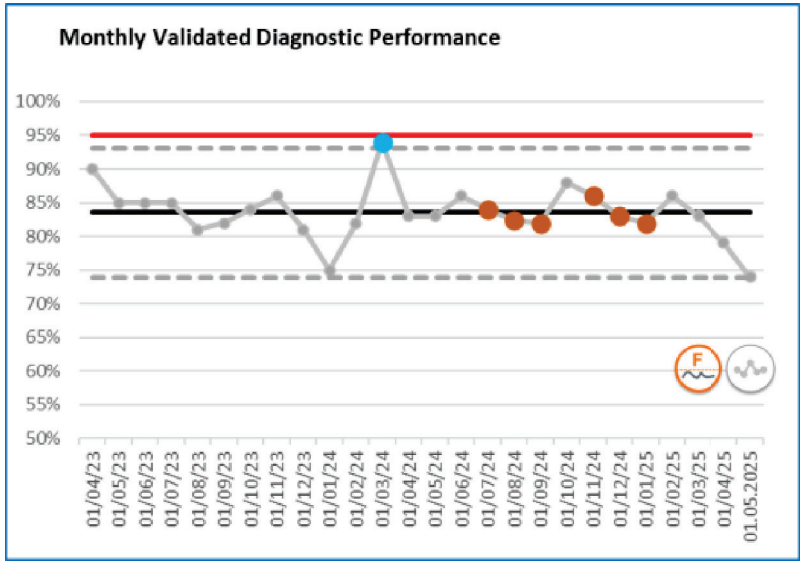
The M2 aggregate diagnostic performance is 25.9% breach performance which is a 4.4% deterioration on the previous month. The total waiting list has increased in month, from 14,526 in April to 14,571 in May.

Areas of concern

ECHO, Flexi Sigmoidoscopy and Sleep Studies have significantly deteriorated in month. The Audiology waiting list has grown by 500 patients in-month (the largest increase)

Looking forward

An ECHO recovery plan has been generated as part of an overall Cardiology improvement plan. Mandated support is being revised within Medicine division to support delivery. A Cystoscopy recovery plan is urgently required.



Technical Analysis

May 2025 saw the worst diagnostic backlog breach rate in over a year— performance is trending away from recovery. Urodynamics has delivered a zero-breach performance in May but inconsistent recovery actions are unlikely to sustain this position into June and July. Barium Enema has recovered by 15.53% delivering a zero-breach position in line with predicted recovery performance.

Planned Actions

- Neurophysiology recovery plan presented June 2025 at ECPB (Dec '25 recovery trajectory).
- MRI performance improvement July 2025 onwards (operationalisation of new machine).
- ECHO recovery plan refreshed – driven improvement through mandated support.
- Cystoscopy recovery plan urgently required – action for Surgical Division to submit to July ECPB.

Diagnostics: Performance Trend

DM01 Performance	Month													
Modality	2024-04-01	2024-05-01	2024-06-01	2024-07-01	2024-08-01	2024-09-01	2024-10-01	2024-11-01	2024-12-01	2025-01-01	2025-02-01	2025-03-01	2025-04-01	2025-05-01
Audiology - Audiology Assessments	83.78%	81.97%	82.15%	91.13%	98.39%	98.65%	98.15%	99.09%	99.25%	99.18%	98.75%	98.58%	99.38%	98.98%
Barium Enema	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	72.60%	75.46%	81.28%	83.55%	99.08%
Cardiology - echocardiography	59.25%	66.04%	75.61%	53.96%	48.19%	38.72%	72.50%	63.51%	53.85%	25.20%	52.83%	49.97%	47.08%	33.24%
Colonoscopy	43.83%	46.37%	50.06%	60.41%	59.98%	57.12%	61.76%	65.62%	61.79%	71.87%	71.03%	71.93%	67.16%	72.55%
Computed Tomography	99.90%	99.37%	100.00%	99.95%	100.00%	99.94%	99.89%	100.00%	98.89%	96.75%	96.50%	93.44%	92.83%	91.28%
Cystoscopy	38.36%	38.19%	33.46%	36.23%	29.09%	33.21%	44.44%	53.55%	61.31%	49.07%	69.40%	52.26%	45.18%	38.97%
DEXA Scan	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Flexi sigmoidoscopy	55.41%	53.83%	57.93%	64.19%	63.71%	68.97%	58.15%	60.29%	64.85%	67.65%	80.30%	85.83%	74.47%	61.40%
Gastroscopy	83.03%	82.74%	83.66%	89.92%	85.87%	84.29%	87.02%	85.43%	87.41%	84.85%	87.48%	85.98%	86.10%	80.38%
Magnetic Resonance Imaging	97.27%	97.54%	98.40%	100.00%	99.89%	96.43%	96.64%	97.71%	96.48%	93.87%	94.67%	82.91%	77.59%	76.09%
Neurophysiology - peripheral neurophysiology	36.21%	40.95%	49.25%	52.84%	54.12%	40.49%	48.24%	30.70%	31.88%	29.65%	42.18%	46.82%	40.88%	43.82%
Non-obstetric ultrasound	96.96%	95.99%	99.40%	96.84%	97.42%	95.27%	98.67%	99.15%	98.75%	99.85%	99.73%	99.87%	99.68%	99.93%
Respiratory physiology - sleep studies	83.85%	98.47%	98.55%	99.15%	98.14%	94.19%	100.00%	100.00%	96.67%	98.88%	98.10%	98.93%	98.26%	90.38%
Urodynamics - pressures & flows	86.92%	75.00%	69.23%	52.94%	41.67%	52.83%	71.43%	44.78%	41.07%	78.33%	66.67%	91.84%	76.09%	100.00%

Discharge Ready Summary

Highlights

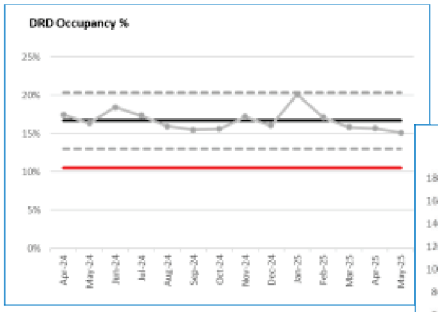
Continued reduction sustained over the past 3 months with a significant reduction in bed days lost for patients with a DRD.

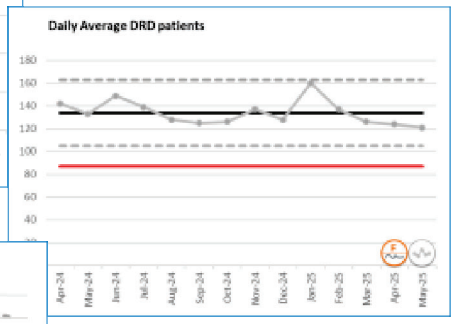
Areas of concern

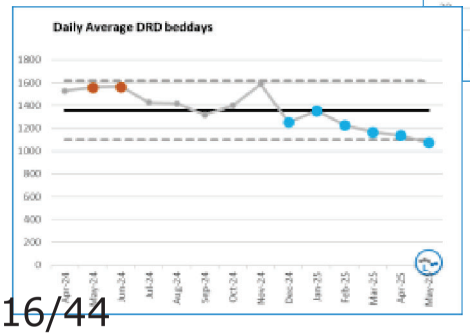
No concerns, improvements are ahead of trajectory as part of this years planning. Will need to be maintained.

Looking forward

Expecting the bed days lost to take a further significant reduction related to specific work focusing on 21+ days DRD with plan to then bring that further down.







Technical Analysis

All three measures show positive trends sustained over the past 3 months. However, percentage of beds occupied still remains higher than national target of 10.5% and the number of DRD patients remains higher than the 87 within the operational plan. The new UEC plan sets out a 0 tolerance on DRD LOS of over 21 days so this may need to be added to the IPR pack. Currently we have 6 patients who meet that delay, although 4 have a plan in place for imminent discharge.

Planned Actions

This work forms a key part of the UEC portfolio system improvement plan with a specific focus on care coordination and the review of current discharges processes and timelines. Internally the focus in on referrals to the transfer hub being sent prior to a patient have a DRD and then a focus on pathway 1 which we know is a quicker pathway, but also has better longer term outcomes for our patients. Alongside this sits work around TTOs and D/C summaries being done prior to the day of discharge to avoid unnecessary delays along with a need to minimise deconditioning within our beds further.

Delay Related Harm Summary

Highlights

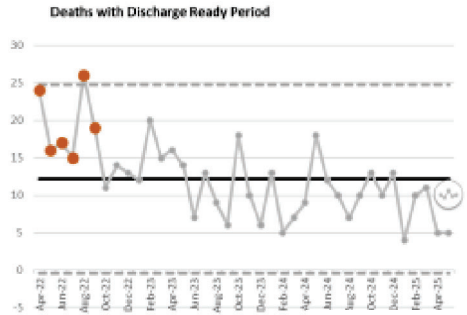
Sustained improvement in the number of deaths whilst DRD, linked the overall reduction in days delayed.

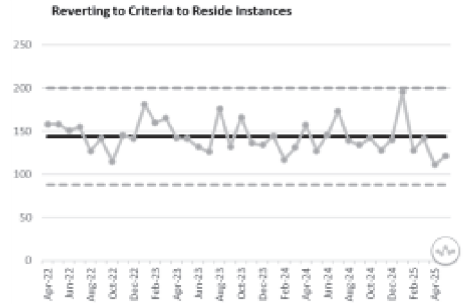
Areas of concern

Still a significant number of patients becoming unwell and therefore meeting the criteria to reside after having an initial DRD.

Looking forward

Further reduction in days lost DRD should also see these figures reduce, although there will remain to be cases of deterioration until we are same day next day in terms of pathways 1-3.





Technical Analysis

Overall, both deteriorations and deaths remain below the average since we started recording in 2022. The past months improvement has been sustained within the number of deaths, but patients becoming unwell has seen a slight deterioration. There have been no external factors such as IPC outbreaks which may have influenced this, so represents potential delay related harm.

Planned Actions

Ongoing work underway to improved delays within the DRD patient group. Need to undertake further analysis of the patient groups to understand the impact on known palliative/EOL patients within the deaths component, supporting need for targeted work on the CHC process and EOL pathways. There is also consideration needed on the number of patients who become CTR within 24hrs of being determined DRD, as this may indicate internal decision-making elements to the data returns, rather than true delay related harm.

Quality & Safety Metrics

Quality of Care: FFT Positive Response

Highlights

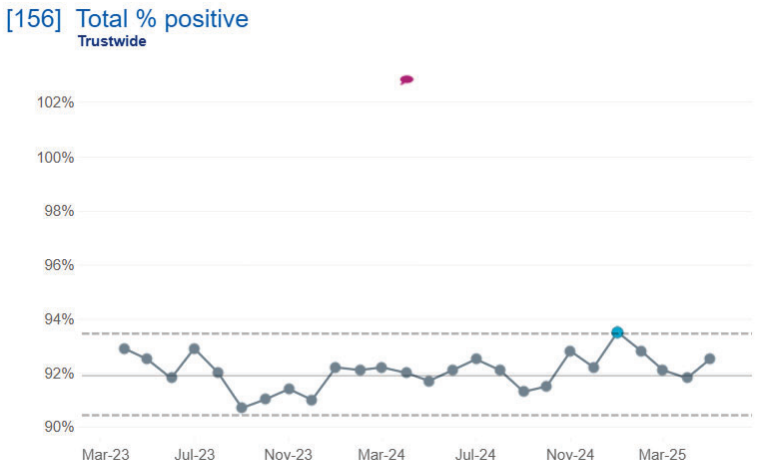
Increases in score for ED overall and specifically GRH and outpatients

Areas of concern

Maternity score decrease on last month, reported positive experience of Maternity Ward affecting this overall score

Looking forward

We would hope to see our scores in maternity to increase slightly to maintain position.



Technical Analysis

The overall Friends and Family Test (FFT) score has increased slightly from 91.8% in April to 92.5% for May. This is as a result of a increase in score notably for ED and Outpatients. We have a high number of responses from these care types. Score is above average and higher than our score for the same time last year.

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. To work with maternity team to understand the decrease in score through a review of the comments.

PALS

Highlights

Maintenance of closure rate with 46.4% closed in same day and 64.2% closed in one day

Areas of concern

Currently carrying additional workload due to ongoing work in Maternity

Looking forward

June is already appearing a heavy month in terms of cases, annual leave and sickness so the expectation is that this level is may not be maintained but expecting the target of 75% to be met.

Technical Analysis

The PALS team have maintained closing concerns in 5 working days at 86% for May which is above the target of 75% . The team have continued to work hard to close cases more quickly and the revised triaging criteria of cases has been working well. An additional member of the team is now trained and carrying a caseload along with designated specialties. The drop-in service is now open x3 days/week improving access.

Planned Actions

A review of KPI's in light of deep dive is ongoing including reviewing the alignment of issues recording in Datix.
Workload distribution continues to be reviewed to support PALS staff and improve experiences of patients.
Work to provide an accessible service continues and following feedback we are trialling a mobile number to enable our Deaf BSL patients to make contact with the team.

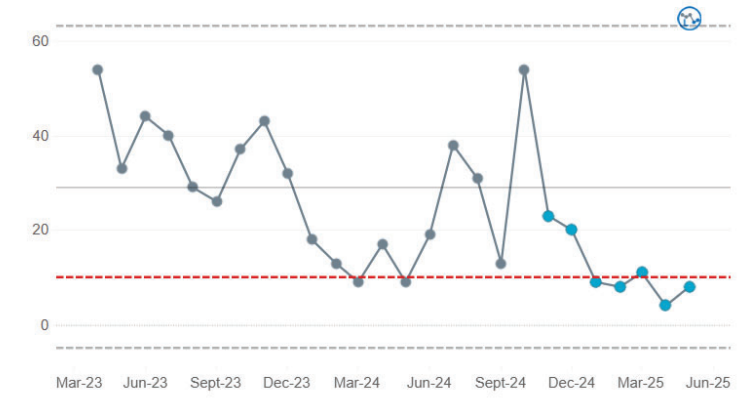
Patient Care: Mixed Sex Breaches

Highlights
Mixed sex accommodation breaches remain low and are an exception

Areas of concern
Delays in transferring out of Critical Care and Recovery create MSA breaches

Looking forward
Expected to remain within limits of expected performance.

[148] Number of breaches of mixed sex accommodation
Trustwide



Technical Analysis
The most recent 3-monthly 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.

Infection Control: *C. difficile*

Highlights

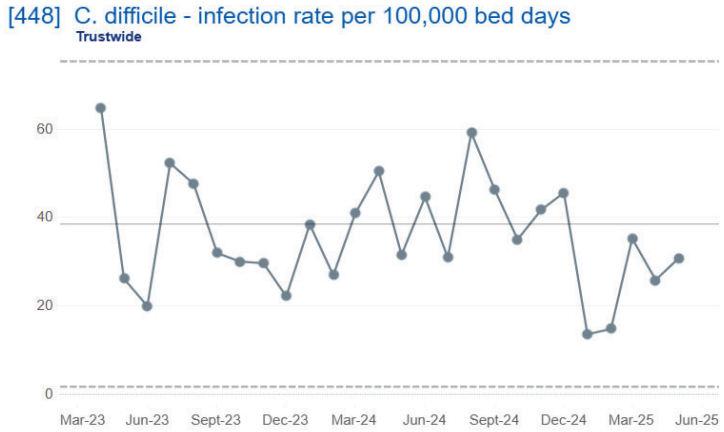
The annual CDI threshold for 2025-2026 is yet to be set by NHS England

Areas of concern

Ward cleanliness- no report to ICC for 2 meetings. FR assessment needs escalating for some areas- but no agreement from GMS on how to get changed. Change to enhanced pods showing issues with cleaning methods of floors. Inappropriate use of anti-motility drugs- system wide issue.

Looking forward

We aim to continue to reduce the burden of CDI on our patients across the Trust and system, we are awaiting our new improvement threshold for 2025/26.



Technical Analysis

For 2025-26 we have had 13 trust apportioned cases of *C. difficile.* Nationally and across the South-West region there has been an increase in the number of *C. difficile* cases. Model hospital data benchmarking ICBs for rates of CDI per 100,000 age-sex weighted populations (12 months rolling to quarter ends) states Glos ICB is in the lowest 25% and the best in the SW compared to our ICB peers

Planned Actions

The Trust *C. difficile* reduction plan for 2025/2026 focuses on actions to address cleaning; equipment and environment, antimicrobial stewardship, timeliness of stool sampling, prompt isolation of patients and optimising management of patients with *C. difficile*. 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 supports 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.

Safety Priority: Pressure Ulcers Cat 3

Highlights

No new cases of Category 3 pressure ulcers recorded. Data has been re-processed for the previous 12 months as IPR did not align with Datix.

Areas of concern

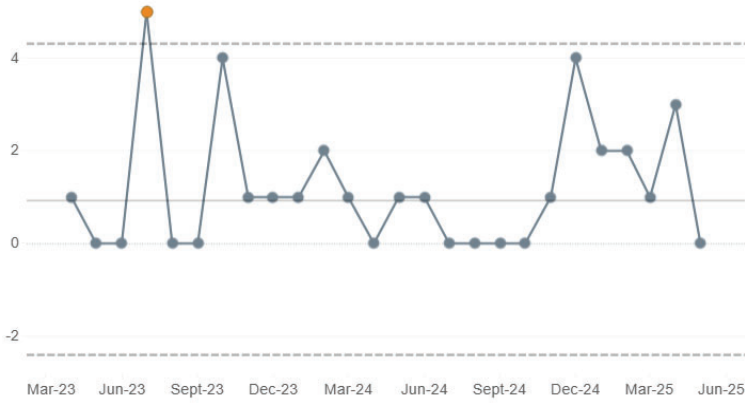
These serious pressure ulcers have remained a challenge for the Trust, whilst numbers appear low our ambition is to have zero cases and over the last couple of months cases are on upward trajectory.

Looking forward

Implementing lessons learned can contribute a downward trajectory of factors within our control

[267] Number of category 3 pressure ulcers acquired as in-patient

Trustwide



Technical Analysis

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.

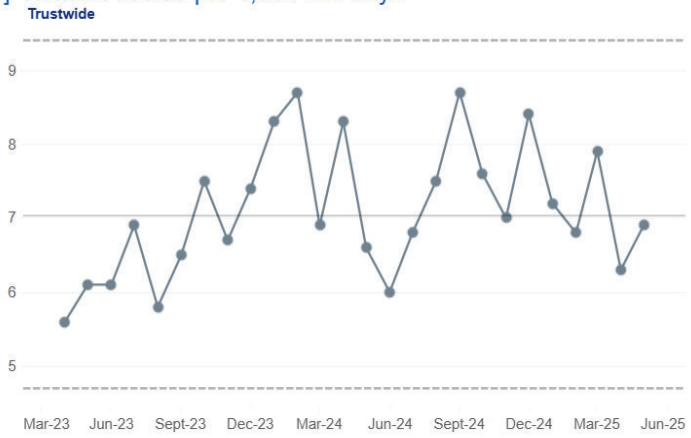
Safety Priority: Patient Falls

Highlights
Number of falls with in the trust remain static and number of falls of injurious falls also remains static

Areas of concern
Falls remain a challenge for the Trust, due ot the acuity of the patients, increased controls on the use of enhanced care and the length of time for discharge due to capacity in community services

Looking forward
Implementing lessons learned can contribute a downward trajectory of factors within our control

[112] Number of falls per 1,000 bed days



Technical Analysis
The previous 12 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
Improvement focus is on specialist review of patients who have fallen twice during admission, if appropriate. 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.

Maternity Care: Postpartum Haemorrhage >= 1,500 ml

Highlights

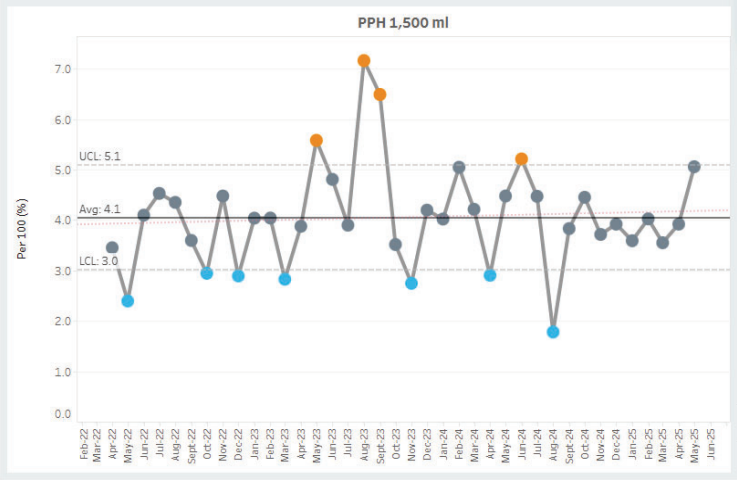
Detection and escalation of maternal and fetal deterioration is one of the areas of improvement for the Trust and this has been identified as one of the Trust Safety **Priorities.**

Areas of concern

Overall Massive Obstetric Haemorrhage (MOH) rates have decreased.

Looking forward

The QI work continues with oversight reported to the **Maternity Delivery Group**.



Technical Analysis

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.

Mortality – SHMI National Data

Highlights

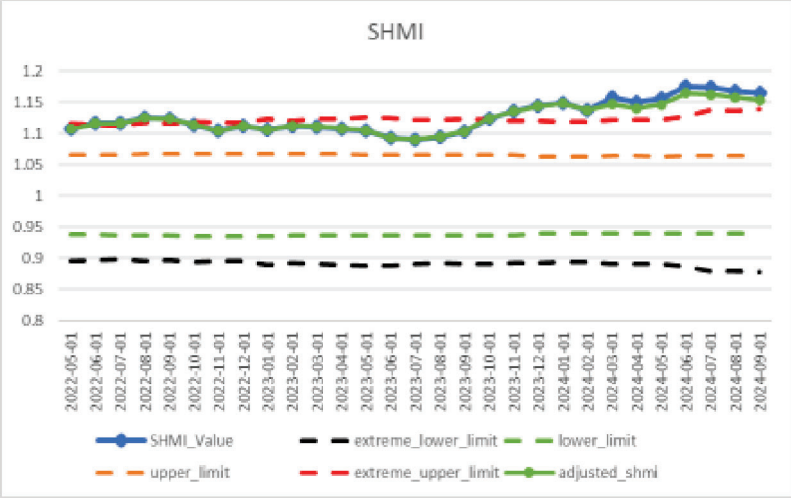
Latest SHMI (NHS Digital) = 1.15, continuing to fall

Areas of concern

Nil

Looking forward

SHMI is predicted to be in the normal range in Q4 due to this improved data quality.



Technical Analysis

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.

Planned Actions

Data quality improvement in action.

PSIRF Learning Responses

Highlights

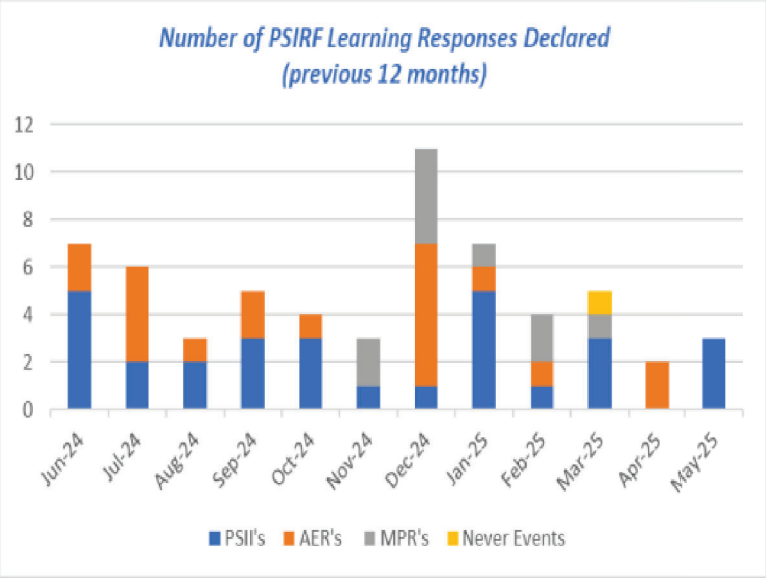
60 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 5 per month. 3 New PSII's were declared in May 2025.

Areas of concern

Timeframes within which learning responses are completed. 50% of MPR's/AER's and 25% of PSII's were completed within required timescales in May 2025.

Looking forward

Resource and Capacity within Divisions and the Patient Safety team will be addressed through implementation of the Quality Governance Framework.



Technical Analysis

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

Planned Actions

Implementation of the Quality Governance Framework

Complaint Performance 2024/2025

Highlights

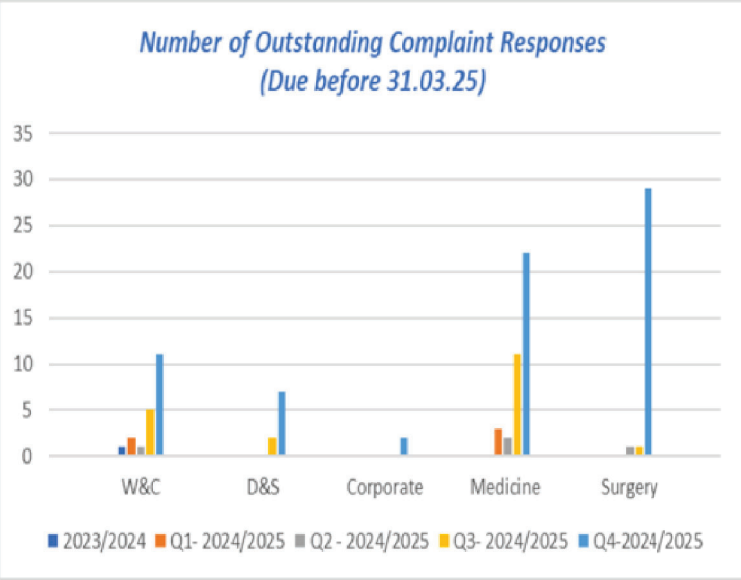
Number of Complaints in backlog (responses due before 31.03.25) continues to reduce.

Areas of concern

Response timeframes of complaints received after 31.03.25

Looking forward

Backlog to be cleared by July 2025



Technical Analysis

As at 30.05.25 85% of the complaints in the backlog (responses due before 31.03.25) have had a response. (Figure 1)

The collaboration and focus of the Complaint Department and Divisional leads on clearing the backlog has become an embedded, business as usual, approach.

Planned Actions

Clear Backlog by July 2025.

Complaint Performance 2025/2026

Highlights

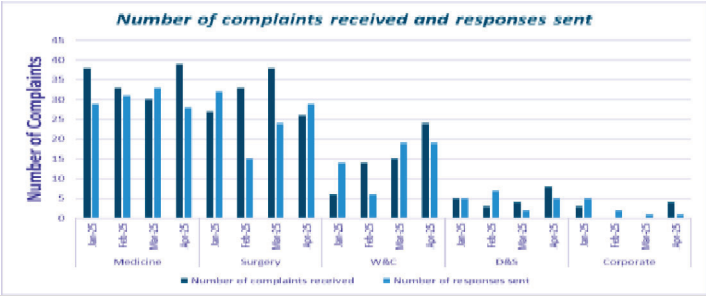
There is Trust wide commitment to improve response timeframes. The collaborative approach to clearing the backlog, will continue; ensuring the required sustainable improvement through 2025/2026.

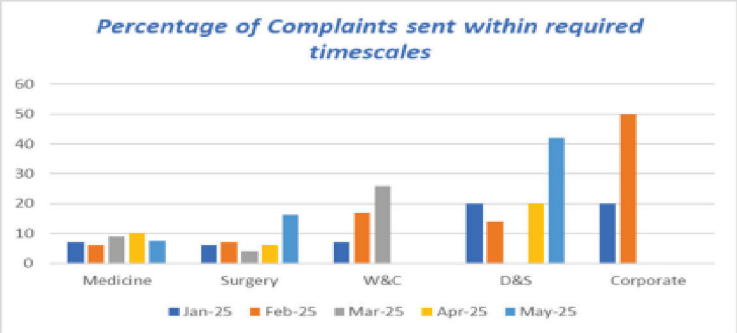
Areas of concern

Whilst the response rate (figure 2 below) continues to require improvement, progress is evident and is expected to continue month on month.

Looking forward

The progress made with the backlog is providing increased capacity for focus on more recently received complaints and ultimately implementation of the new Complaint Response Framework.





Technical Analysis

Figure One shows the number of complaints received by each Division (last five months added for context) alongside the number of responses sent in that month

Figure Two shows the percentage of responses sent within required timescales (last five months added for context).

Planned Actions

Planned Actions:

Ongoing QI approach to improving "how" we respond, the "quality" of response and timeframes within responses are provided.

Use of Resources Metrics

Financial Metrics

Highlights

Revenue position is £2k adverse to plan.
Agency spend is 1.8% of paybill.
FSP is £16k adverse to plan.
Capital spend is £4m behind plan.
The Trust is holding 20 days operating cash.

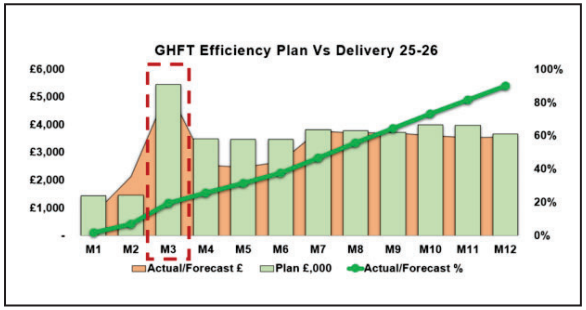
Areas of concern

Medical and Nursing budgets are overspent. This has been mitigated in M2 but requires action moving forward.

Looking forward

FSP targets are significantly higher in M3-M12. Only 7% of the FSP target is in M1-M2. A focus on delivering FSP is essential to maintain the revenue position and to ensure cash balances are held at sustainable levels..

	Metric		Month 12			Month 1			Month 2		
			Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	Ytd £'000s	0	67	67	-5,266	-5,473	-207	-10,580	-10,582	-2
		Forecast £'000s	0	0	0	0	0	0	0	0	0
	Agency spend as % of pay		3.2%	2.5%	-0.7%	3.2%	1.6%	-1.6%	3.2%	1.8%	-1.4%
	FSP	Ytd £'000s	37,389	37,389	0	1,435	762	-673	2,899	2,883	-16
		Forecast £'000s	37,389	37,389	0	41,775	41,775	0	41,775	41,775	0
	Capital vs budget plan	Ytd £'000s	45,972	43,427	-2,545	958	927	-31	5,797	1,763	-4,034
		Forecast £'000s	45,972	43,427	-2,545	57,092	57,092	0	54,941	55,754	813
	Nos days operating cash		5	20	15	5	22	17	5	20	15
	BPP - nos invoices paid in 30 days		95%	99%	4%	95%	98%	3%	95%	98%	3%
	Bank spend (incl locum) spend as % of pay		-	8.2%	-	-	9.3%	-	-	9.1%	-



Risks

The Trust financial position is faced with significant risks including:

- FSP delivery. There remains £4.4m unidentified schemes at M2 with a further £17.6m rated as high risk of delivery.
- Pay award which is above planning assumptions. There has been no notification that the additional cost of c.£8m will be funded.
- Industrial action in response to pay award
- Delay in capital schemes starting due to lack of approved business cases and ability to deliver approved schemes

M2 Revenue Position

Highlights

The Month 2 in month position is £5.4m which is £0.2m favourable to plan. The plan is £5.6m. The YTD position is £10.6m deficit which is £2k adverse to plan. The plan is £10.6m deficit.

Areas of concern

Whilst the YTD position is in line with plan, there are underlying pressures including FSP shortfall £348k, Medical staff £432k, Nursing £392k.

Looking forward

The Trust and ICS are reporting breakeven positions in line with plan for 2025/26.
An internal forecast is being prepared to quantify the level of risk facing the Trust.

Summary I&E Position (Trust only)	Current Month Budget	Current Month Actual	Current Month Variance	YTD Budget	YTD Actual	YTD Variance	YTD Variance excluding Pass-through, donated assets & IFRIC 12
	£000	£000	£000	£000	£000	£000	£000
Income	(65,313)	(66,522)	(1,209)	(130,500)	(132,598)	(2,099)	(299)
Pay	42,490	42,593	102	84,740	85,655	915	915
Non Pay	28,193	29,063	870	56,340	58,679	2,340	(614)
(Surplus)/Deficit	**5,370**	**5,134**	**(236)**	**10,580**	**11,736**	**1,156**	**2**
Donated Assets/Impairments	**0**	**(13)**	**(13)**	**0**	**(1,154)**	**(1,154)**	
Adjusted (surplus)/deficit	**5,370**	**5,121**	**(249)**	**10,580**	**10,582**	**2**	**2**

Technical Analysis

The income and non pay variances are driven by pass through drugs & devices costs and income which neutralise each other. The outstanding pressure is within pay.
Donated Assets, impairments and IFRIC 12 adjustments are technical NHS accounting adjustments that remove the costs from the reported position for the Group.

M2 Pay

Highlights

Pay is overspent by £915k driven by nursing overspend of £365k and medical staff overspend of £334k.

Areas of concern

Medical overspend has increased in month. This is analysed further in the Medical Pay slide.
The nursing run rate has improved in month but remains overspent.

Looking forward

If run rate continues at current levels pay budgets will be c£2m overspent by the end of 2025/26.

Summary Pay Position (Trust Only)	M2 YTD Plan £000s	M2 YTD Actuals £000s	M2 YTD Variance £000s
Infastructure	13,903	13,376	(527)
Medical & Dental	25,681	26,016	334
Nursing	33,484	33,849	365
Other Clinical Staff	12,723	12,348	(374)
Total (excl reserves)	**85,790**	**85,589**	**(202)**
Reserves (FSP & Other Staff)	**32**	**12**	**(20)**
Divisions (FSP target & vacancy factor)	(1,083)	54	1,137
Adjusted (Surplus)/Deficit	84,740	85,655	915

Summary Pay Position	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Total
Infrastructure	(636)	47	37	(0)	(0)	26	(527)
Medical & Dental	(25)	(59)	316	(30)	157	(24)	334
Nursing	83	(50)	1,232	(647)	(166)	(87)	365
Other Clinical Staff	12	(373)	(20)	(0)	1	5	(374)
Other Staff Sub	89	264	180	(20)	416	189	1,117
YTD Variance	(477)	(171)	1,744	(696)	407	109	915

Technical Analysis (further info on following slides)

Nursing overspend of £365k, of which £1.2m is within Medicine.

Medical staffing overspend of £334k of which £316k is within Medicine and £157k is within Surgery.

Infrastructure underspend of £527k, of which £636k is within corporate, primarily CIO (£387k).

Planned Actions

Divisional forecasts are being developed with mitigations.

M2 Nursing Pay

Highlights

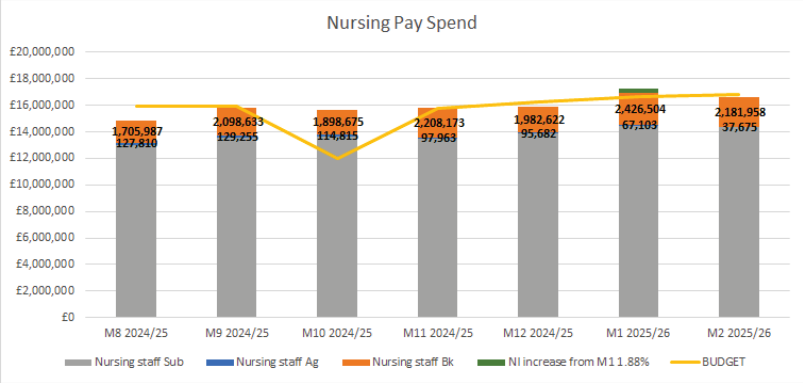
- The Month 2 YTD nursing position is £365k overspent. YTD spend is £33.8m against a budget of £33.4m.

Areas of concern

Nursing spend within Medicine division is £1.2m overspent. Underspends in the other clinical divisions are offsetting this which is not sustainable.

Looking forward

If run rate continues at current levels pay budgets will be c£2m overspent by the end of 2025/26.



Technical Analysis

Of the total nursing overspend, £1.2m is within Medicine. The drivers of the Medicine overspend include wards/areas that are staffing to rosters that are above funded levels totalling £0.2m. Sickness and vacancy cover is at a higher than average level which combined with the unfunded element of maternity cover totals £1m.

Planned Actions

Chief Nurse is working with Medicine Division to identify actions to mitigate the overspend.

M2 Medical Pay

Highlights

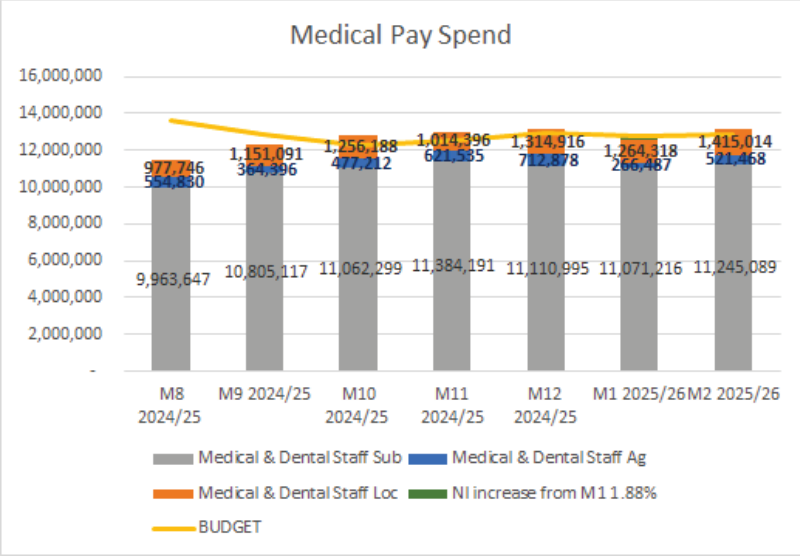
Medical staffing budgets are £334k overspent YTD. This includes a pressure of £92k for providing medical staff on ward 6b.

Areas of concern

Medicine division is £316k overspent YTD. Surgery division is £157k overspent YTD. D&S, W&C and corporate areas are underspent.

Looking forward

Medical staffing is forecast to overspend by c.£3m by the end of the financial year if current run rate continues.



Technical Analysis

Pressure within Medicine is driven by unfunded 6b cover and deanery pressures as a result of rotations into posts without budget.

Pressure within Surgery includes £70k that should be funded by Cancer Alliance funding and ERF once agreed. The remaining pressure is due to sickness expected to end M6.

Planned Actions

- Ensure Cancer Alliance funding is allocated to cover medical staffing costs incurred in Surgery.
- Seek clarification from Deputy COO/GICB about allocation of ERF slippage and/or redirection of funding streams.
- Escalate funding requirement of ward 6b to Executive level.

M2 Non Pay

Highlights

M2 YTD non pay position is overspent by £2.3m which reduces to £600k underspend once IFRIC12 and pass through pressures are removed.

Areas of concern

Non pass through drugs are overspent in month. This needs to be aligned with activity to understand if this is related to ERF, productivity improvements or price increases.

Looking forward

FSP delivery is a real risk to the non pay position with the phasing of targets increasing from Q1.

Non Pay	YTD Variance			
	Divisions	Corporate	Reserves/ Central	YTD Variance
YTD Variance	3,697	496	-1,853	2,340
Drivers of variance				
IFRIC12 & donated assets		1,154		1,154
Pass through drugs and devices	2,717		-954	1,763
Non delivered FSP	200			200
Clinical supplies in divisions	-91			-91
Central reserves*			-499	-499
Release of 3% productivity reserve			-400	-400
Non Passthrough drugs	404	-4		401
VAT benefit M2		-332		-332
Other	467	-322	0	145
Total YTD Variance	3,697	496	-1,853	2,340

*includes Variable API expenditure budget

Technical Analysis

After removing pass through drugs and IFRIC 12, the main pressure area is non delivered FSP. All divisions have a pressure as a result of this and this is expected to increase in future months when the targets increase.

Planned Actions

Action is needed to identify further FSP schemes and ensure delivery of those already underway.

M2 Income

Highlights

The income position is £2.1m favourable to plan. This includes £1.8m accrual for pass through drugs & devices income overperformance.

Areas of concern

Private Patient income is below plan in all divisions except for Surgery.

Looking forward

Commissioning income will be monitored as the year progresses to manage underperformance against out of county API contracts.
Private Patient income is monitored at the Private Patient Sub Committee.

Income	M2 YTD Plan £000s	M2 YTD Actuals £000s	M2 YTD Variance £000s
HEE Income	(2,986)	(3,341)	(354)
Other Income from Patient Activities	(3,179)	(3,496)	(317)
Other Operating Income	(4,495)	(4,946)	(451)
PP Overseas and RTA Income	(1,021)	(925)	96
SLA & Commissioning Income	(118,818)	(119,891)	(1,073)
Total Income	(130,500)	(132,599)	(2,100)

Technical Analysis

Income favourable/over performance of £2.1m. This includes £1.8m accrual for pass through drugs & devices income overperformance. HEE income is (£354k) above plan and is covering pay costs. CDC income is also above plan and matching costs (£138k)

Planned Actions

Out of county API commissioner contract income is calculated using coded activity which means that the M2 position is reliant on estimates due to being so early in the year. The M3 position will include a catch up once coding of activity is complete.

M2 Capital Position

Highlights

As a of the end of May (M2), the Trust had goods delivered, works done or services received totalling £1.8m, against a planned spend of £5.8m, equating a variance of £4.0m behind plan.

Areas of concern

- There are many schemes in the programme without an approved business case.
- There are potentially issues around in year deliverability due to slow start to schemes.
- There are some potential issues around the capitalisation of some Digital costs

Looking forward

As at M2, the Trust is reporting a breakeven forecast in line with plan. Internally, the Trust have agreed to overcommit the programme by £0.8m in anticipation of slippage within the programme.

in £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	1,897	694	1,202	9,963	9,963	0
DIGITAL - IFRS16	0	0	0	101	101	0
MEDICAL EQUIPMENT	689	195	493	5,795	5,795	0
MED EQUIP - IFRS16	43	0	43	2,268	2,268	0
ESTATES	2,312	627	1,684	20,240	20,240	0
ESTATES - IFRS16	86	38	48	499	499	0
SLIPPAGE RESERVE	598	0	598	0	0	0
OVERCOMMITMENT OF PROGRAMME	0	0	0	(813)	0	(813)
Total Charge against Capital Allocation (incl. IFRS 16)	**5,623**	**1,554**	**4,069**	**38,053**	**38,866**	**(813)**
NAT PROG: CIR FUNDING	0	0	0	9,710	9,710	0
NAT PROG: CONST STANDARDS FUNDING - DIAGNOSTIC	0	0	0	2,119	2,119	0
NAT PROG: DIGITAL DIAGNOSTICS	0	0	0	336	336	0
NAT PROG: CANCER FUNDING	0	0	0	2,916	2,916	0
IFRIC 12	88	88	0	533	533	0
DONATIONS VIA CHARITABLE FUNDS	86	121	(35)	1,274	1,274	0
Total Expenditure against Additional Funding	**174**	**209**	**(35)**	**16,888**	**16,888**	**0**
Gross Capital Spend Total	**5,797**	**1,763**	**4,034**	**54,941**	**55,754**	**(813)**
Gross Capital Spend Total	**5,797**	**1,763**	**4,034**	**54,941**	**55,754**	**(813)**
Less Donations and Grants Received	(86)	(121)	35	(1,274)	(1,274)	(0)
Less PFI Capital (IFRIC12)	(88)	(88)	0	(533)	(533)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	59	59	0	353	353	0
Total Capital Departmental Expenditure Limit (CDEL)	**5,682**	**1,613**	**4,069**	**53,487**	**54,301**	**(813)**

The commentary is based on the gross capital spend. The position against CDEL differs as per the table in that adjustments are made for donations, grants and IFRIC 12 spend.

Technical Analysis

The Trust submitted a gross capital expenditure plan for the 25/26 financial year totalling £57.1m. This consists of: £38.1m against the system capital allocation, £17.2m of planned national programme funding, £1.3m of planned donations from charitable funds and £0.5m of PFI Lifecyle spend. The only change since the plan is the decision to not proceed with bidding for constitutional standards funding for the UTC (£2.2m)

The capital programme variance is driven by: a) Delay in Estates schemes whilst assessing additional BS regulations on projects and project interdependencies. b) Digital Upgrade implementation costs that were in plan in one month rather than phased over its delivery timeframe.

Planned Actions

The delivery profile of the capital programme is significant back-ended and therefore accurate and frequent forecasting throughout the year will be vital to ensure that any mitigation measures can be appropriately agreed and put in place in a timely fashion.

There is a push to get most of the outstanding business cases completed so that schemes can continue to delivery.

Cash Flow

Highlights

- 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.

Areas of concern

- Non delivery of FSP schemes will impact upon the level of cash held which may mean that the Trust needs to take additional actions if red rated scheme delivery is not improved

Looking forward

- The Trust has developed a cash management strategy
- The Trust is exploring national funding routes for its capital expenditure

	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	Apr 26 £'000	May 26 £'000	Jun 26 £'000	Jul 26 £'000	Aug 26 £'000	Sep 26 £'000
Opening Balance	**42,357**	**46,602**	**23,310**	**29,731**	**41,109**	**36,573**	**30,813**	**37,295**	**30,030**	**28,625**	**25,576**	**33,801**	**28,532**	**36,036**	**30,061**	**28,800**	**36,078**	**31,475**
Receipts																		
SLA Income	58,808	59,529	71,806	63,249	63,249	63,249	63,249	63,249	63,249	63,249	63,249	63,249	62,415	63,142	64,179	63,249	63,249	63,249
Other NHS	18,121	2,825	3,401	15,283	2,215	2,015	21,883	2,155	2,371	4,321	17,757	2,313	17,771	2,578	2,745	15,283	2,215	2,017
Other Non-NHS	2,241	1,742	1,733	2,317	1,896	1,787	2,260	2,720	2,527	6,751	4,470	8,233	2,320	1,643	1,694	2,217	1,792	1,869
VAT	2,628	2,499	2,961	2,841	3,218	2,166	1,935	2,479	2,095	2,989	1,688	2,214	2,628	2,455	2,961	2,841	3,218	2,166
Total Receipts	**81,797**	**66,595**	**79,901**	**83,690**	**70,578**	**69,217**	**89,326**	**70,603**	**70,241**	**77,310**	**87,164**	**76,009**	**85,133**	**69,818**	**71,579**	**83,590**	**70,474**	**69,301**
Payments																		
Payroll - Direct payments	(25,024)	(25,293)	(25,856)	(25,894)	(26,248)	(25,931)	(26,235)	(25,880)	(25,891)	(27,214)	(26,977)	(26,895)	(25,024)	(25,293)	(25,861)	(25,894)	(26,248)	(25,931)
Payroll - On costs	(18,505)	(20,023)	(19,604)	(19,670)	(19,566)	(19,566)	(19,606)	(19,586)	(19,595)	(19,583)	(19,570)	(19,572)	(18,505)	(20,023)	(19,606)	(19,670)	(19,566)	(19,566)
Payables	(29,821)	(41,422)	(25,283)	(24,254)	(25,922)	(22,215)	(31,883)	(29,193)	(22,913)	(30,172)	(28,161)	(27,527)	(29,897)	(29,681)	(24,536)	(28,252)	(25,885)	(22,189)
Capital Payables	(4,204)	(3,149)	(2,737)	(2,495)	(3,378)	(3,160)	(5,121)	(3,208)	(3,258)	(3,390)	(4,230)	(2,353)	(4,204)	(796)	(2,837)	(2,495)	(3,378)	(3,217)
Loan Principle & Interest	0	0	0	0	0	(1,167)	0	0	0	0	0	(1,142)	0	0	0	0	0	(1,167)
PDC Payments	0	0	0	0	0	(2,938)	0	0	0	0	0	(3,790)	0	0	0	0	0	(2,938)
Total Payments	**(77,552)**	**(89,887)**	**(73,480)**	**(72,313)**	**(75,114)**	**(74,977)**	**(82,844)**	**(77,868)**	**(71,646)**	**(80,359)**	**(78,938)**	**(81,279)**	**(77,629)**	**(75,792)**	**(72,840)**	**(76,311)**	**(75,077)**	**(75,008)**
Net Cashflow	**4,245**	**(23,292)**	**6,421**	**11,377**	**(4,536)**	**(5,760)**	**6,482**	**(7,265)**	**(1,404)**	**(3,049)**	**8,226**	**(5,269)**	**7,504**	**(5,975)**	**(1,262)**	**7,279**	**(4,603)**	**(5,707)**
Closing Balance	**46,602**	**23,310**	**29,731**	**41,109**	**36,573**	**30,813**	**37,295**	**30,030**	**28,625**	**25,576**	**33,801**	**28,532**	**36,036**	**30,061**	**28,800**	**36,078**	**31,475**	**25,768**
Number of days operating cash held	20	10	13	18	16	13	16	13	12	11	15	12	16	13	13	16	14	11

Technical Analysis

- It is currently assumed that financial sustainability target identified in the plan is achieved
- Trust held 20 days operating cash (c£2.3m per day) at the end of April – at the end of March 2026 this would be equivalent to 12 days.

Planned Actions

- Discuss the cash management strategy with TLT
- Complete a capital cash funding request to NHSE

Workforce

Workforce Performance Indicators

Performance Indicator	Target	Apr 24	May 24	June 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Turnover	**13%**	10.58%	10.35%	10.55%	9.95%	9.94%	10.03%	9.41%	9.36%	9.30%	9.04%	8.78%	8.95%	8.71%	8.54%
Vacancy	**8%**	6.11%	6%	6.82%	7.24%	7.43%	7.48%	7.51%	7.37%	7.67%	7.25%	7.41%	7.21%	7.30%	7.34%
Sickness	**5%**	4.28%	4.31%	4.32%	4.35%	4.34%	4.34%	4.28%	4.29%	4.57%	4.85%	4.32%	4.19%	4.37%	Too early for data
Appraisal	**90%**	80%	80%	80%	82%	82%	81%	81%	81%	82%	81%	81%	82%	82%	82%
Essential Training	**90%**	86%	86%	87%	87%	88%	88%	88%	89%	89%	89%	90%	90%	90%	90%
Agency (FTE & % of establishment)	**2%**	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%)	94 (1.2%)	59 (0.7%)
Bank (FTE & % of establishment)	**6.5%**	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%)	651 (8.0%)	581 (7.1%)

Workforce - Appraisal

Highlights

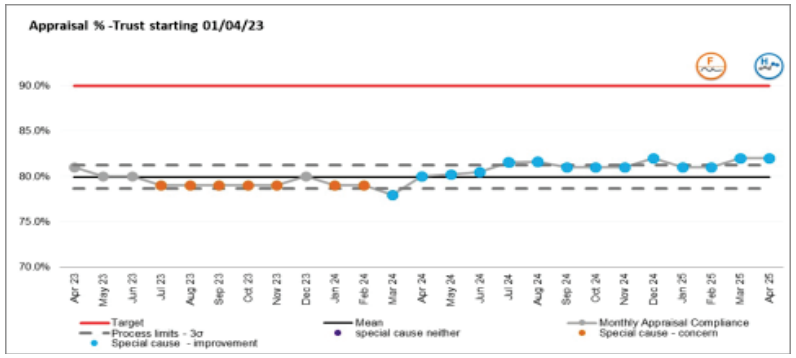
- Appraisal Policy confirmed and uploaded to the Policy Library.
- Targeted engagement sessions with specific services (Digital & MaxFax) piloted the planned action described last month Intention to conduct a research-based approach to improving Appraisal quality with new launch

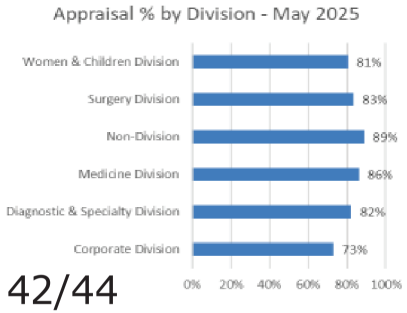
Areas of Concern

- Low compliance in Corporate and A&C staff group needs focus
- Intensive training demand for new process requires human resourcing

Looking forward

- Internal Audit of Appraisals planned from July 2025
- Further engagement sessions needed in low scoring cost-codes.





Appraisal % by Staff Group	
Add Prof Scientific and Technical	79%
Additional Clinical Services	85%
Administrative and Clerical	75%
Allied Health Professionals	80%
Estates and Ancillary	78%
Healthcare Scientists	80%
Medical Staff - Consultants	90%
Medical Staff - SAS	79%
Nursing and Midwifery Registered	85%

Technical Analysis

Organisational target is 90% for appraisal compliance. Current compliance of 82% remains consistent with the previous month. Estates and Ancillary are the most improved staff group with a compliance of 78% (previously 76%) turning a downward trend seen in the previous quarter. Medicine and Surgery Divisions have seen a minor decrease this month. Medical Staff – Consultants remains the only staff group to meet the 90% compliance target.

Planned Actions

New Appraisal Process and Paperwork Launch planned for July.
In-depth Analysis of Compliance & 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.

Workforce - Bank

Highlights

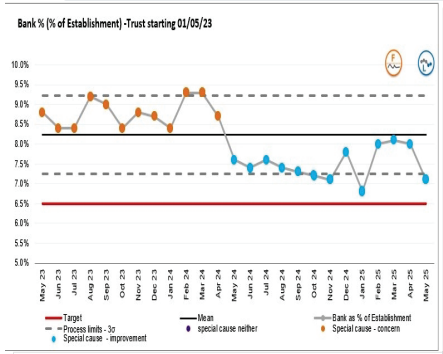
- RN/HCSW WTE use for M1 & M2 is lower in FY 25/26 in comparison to both previous FY.
- M1 saw a reduction from FY 24/25 of 56 WTE & M2 31 WTE.
- Overall bank use for all staff groups is down in year on year comparison

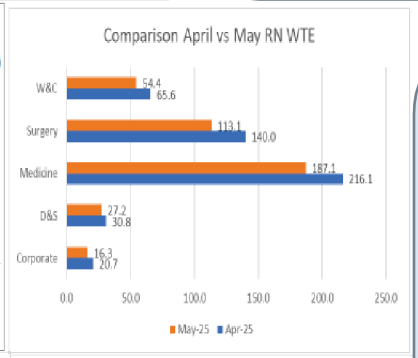
Areas of concern

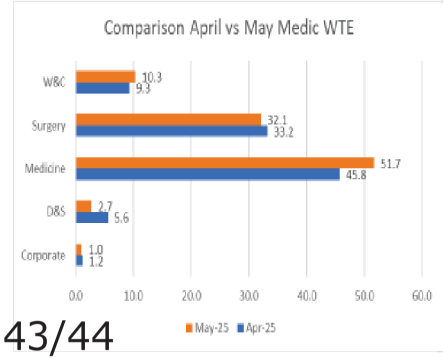
- The Trust target of 6.5% has not been achieved in month 2.
- Overall WTE and £ use of bank is not yet at the trust reduction target of 15% in M2

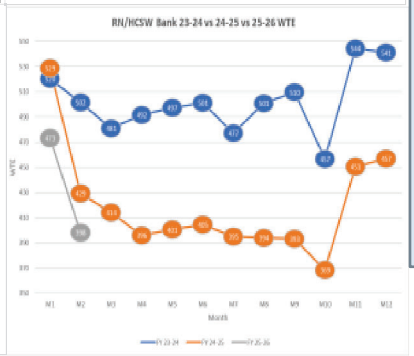
Looking forward

- As the trend of FY23-24 and 24-25 is broadly similar, and FY 25-26 appears to be following that trend, it is reasonable to assume that M3 will also see a reduction in WTE use for FY 25/26.









Technical Analysis

- The Trust has seen a reduction in temporary RN/HCSW Staffing from 473 WTE in April 25 to 398 in May 25.
- In comparison with M2 of the 2024/2025 FY, there has been a reduction of 31 WTE RN/HCSW use.
- Medicine is the highest user of Bank & Locum staff.
- ED, COTE, Stroke and Acute Medicine are the highest users of temporary staffing in Medicine.
- A year-on-year WTE comparison of RN/HCSW temporary staffing use shows the significant improvements achieved throughout the FY.

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.

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Thank you

Report to the Board of Directors				
Date	10 July 2025			
Title	Quality Account 2024/2025			
Author /Sponsoring Director/Presenter	Deputy Director of Quality – Suzie Cro Head of Quality – Debra Ritsperis 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

Purpose

Please find attached our **FINAL Quality Account** for members to be assured we have met our regulatory requirement and published on 30 June 2025.

Background

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts.

Our Quality Account is our annual report to the public about the quality of services we deliver. The primary purpose of our Quality Account is to assess quality across all of the healthcare services we offer. It allows us (leaders, clinicians, governors and staff) to demonstrate our commitment to continuous, evidence-based quality improvement, and to explain our progress to the public.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what we are doing well and where improvement is needed. But, crucially, they also look forward, explaining what we have identified as our priorities for improvement over the coming year.

Guidance

There is no guidance this year from NHS England (last guidance January 2023 (link).

The processes for producing Quality Accounts remain the same as previous years, with the following exceptions to NHS providers:

- NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2022-23.

- There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS foundation trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.
- Integrated care boards (ICBs) have assumed responsibilities for the review and scrutiny of Quality Accounts. ICBs must clarify with providers where they are expected to send their Quality Account. Our Account will be sent to the ICB Chief Nurse and then will be presented to Quality Committees.

Production Timeline

Date	Requirement
1 April 2025	Request all sections to be completed
6 June 2025	Final Draft sent to HOSC, Health Watch and ICB for comments and statement to be attached.
10 June 2025	Final Draft to Quality Delivery Group (QDG) for approval
16 June 2025	HOSC, Health Watch and ICB for comments and statement to be received
18 June 2025	Trust Leadership Team (2025-6 priorities sign off)
26 June 2025	Q&P Committee to receive final account (approved)
27 June 2025	Trust Board to receive Quality Account (approval)
30 June 2025	Publication on Trust website send to NHSE and ICB Chief Nurse

Publishing requirements for the 2024/5 Account

The NHS.uk website no longer allows NHS organisations to upload reports. Therefore, just as last year, we were asked to:

- Upload our Quality Account to an appropriate page on our organisation's website (so that it is clearly visible and easily accessed by members of the public) Quality Account 2024–2025
- We have forwarded the link of the webpage as requested to the following email addresses: QUALITY-ACCOUNTS (NHS ENGLAND) england.quality-accounts@nhs.net

Our Quality Priorities for the coming years 2025-2026

- We must identify **at least three priorities** and we have chosen to report on the following

priorities

- We have indicated in our 2024/5 Quality Account how our priorities were decided through learning from the PSIRF process and who was involved in the decision-making process.
- QDG will receive a plan and updates as to how we are to achieve this improvement over 2025/6
- We will measure our improvement through clear indicators/metrics.
- Our governance arrangements for the Quality Account is that QDG will receive regular progress reports throughout the year.
- Our Quality Strategy describes our processes for delivering the Trust's strategic objectives for Quality and provides the framework for deciding on our priorities.

Table of Quality Priorities for the years 2025-2026

Priorities	Focused on	Metrics/ improvement we want to achieve
1. Patient Safety Incident Response Plan - safety priorities	Continuing our improvement work within the 8 safety priorities and linking them to the transformation work within the organisation.	To continue the work started in 2024/2025 with a focus on our learning and improvement.
2. Outpatient transformation	Improving how outpatient care is delivered, with the goal of providing more patient centred and more efficient services.	Decrease in the number of hospital appointment cancellations. Decrease in numbers of patients who do not attend their appointments (with a focus on health inequalities).
3. Clinical Vision of Flow	Improving how we minimise wait times, reduce bottlenecks across all services and improve the quality of care delivered to our patients	Decrease the number of patients waiting greater than 12 hours in the Emergency Department
4. Fire prevention and safety	To safeguard the lives and wellbeing of patients, staff and visitors by minimising the risk of fire and ensuring safe evacuation in case of a fire.	Compliance with our training targets across all our hospital sites
5. Maternity service improvements	Removal of the CQC conditions (S31) on our registration with focused improvement in the Safety Plan	All 8 conditions on our CQC registration removed

	priority for maternity – prevention and detection of deterioration.	
6. Emergency Department service improvements	Getting care right in the emergency department is crucial because timely and effective treatment can be the difference between life and death.	- Ambulance offloads - Duration in the department

Table of improvements made for the Quality and Safety priorities during 2024-2025 years.

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
Pressure Ulcer Prevention	Hospital acquired pressure ulcers	Pressure Ulcer risk assessment rate for in-patients improved by 25% from 61% – 87% in 12 months. Pressure Ulcer Improvement Group reestablished with revised Terms of Reference. Pressure Ulcer Business Intelligence Platform established to demonstrate rates and real time data for pressure ulcer occurrence. Annual quality summit planned for July 2025. Testing the use of Hot Debriefs to align with the Patient Safety Incident Framework.
Falls Prevention	Patient falls	Compliance of falls risk assessments for in-patients has remained at 75%. The incidence of in-patient falls remains at an average of 7 per 1000 hospital bed days. Falls prevention masterclass offered to staff, preceptor and falls-link nurses. Annual quality summit identified 3 areas for improvement (developing Datix to collect falls information, enhancing debriefs after falls and

		developing the electronic patient record). Revitalised Falls Steering Group.
Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	Risks and incidents where delays in recognition and/or escalation of deterioration during pregnancy and/or delivery have or could have affected the safe care and outcome for mother or baby.	The compliance for the Maternity Obstetric Early Warning score to be repeated when raised (amber alert) improved from 63% in May 2024 to 90% in March 2025. Compliance with NICE guidelines for fetal heart monitoring improved from 60% to 95% for risk assessments on admission, and 80% to 90% for hourly risk assessment. Accurate assessment and escalation compliance reached 100%. Hourly intrapartum peer reviews improved from 76% to 98%.
Safer Staffing	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	All in-patient wards and departments have had a review calculation of the care hours per patient day. Those areas where acuity and dependency has increased or decreased will have budgets amended. Similarly, areas requiring more training time allocation such as the Emergency Department, Paediatrics and Neonates will have similar budget amendments.
Organisational Culture	Risks or incidents where team / department or organisational culture is impacting on behaviours, standards or safe delivery of services/ care.	Working on a Staff Experience Improvement Programme which included implementation of 3 key projects (Just and Restorative Culture, Report, Support and Learn and Antidiscrimination practices). Improving our safety culture by ensuring staff understand new ways of working with level 1 training for Essentials for Patient Safety at 91% across the Trust. Staff survey results demonstrating and increase to 65.8% in the question about staff feeling secure at raising concerns about unsafe clinical practice from 2023 results at 63.49% (increase of 2.34).
Digital Systems Improvement	Risks and incidents related to the introduction	The allocation to the correct consultant on the digital Communicator platform was identified to have weaknesses in its design. New “unexpected result”

	and use of digital clinical systems.	and “cancer” alert codes have been implemented to alert the reporter 9 times as a safety net. A dashboard report has been implemented for unacknowledged radiology alerts so that Teams have oversight of their results. Local governance processes are being identified for all unacknowledged alerts.
Clinical Vision of Flow (admission and discharge)	Risks and incidents related to impeded patient flow from assessment to discharge, including delays to discharge, excluding clinical complications.	The improvements are measured in hours lost to handover delays, reduced from nearly 6000 in Oct 23 to under 2000 in March 25. Improvements for patient experience include the reduction of patients who spend over 12 hours in the emergency department from 18,000 in March 2024 to 15,000 per month in March 2025. Additional improvements include a streaming nurse in minors and a review of Pitstop process and location in majors.
Communication	Risks and incidents that relate to communication between staff and patients and their families	The 3 components of Martha’s Rule have been implemented into all adult, paediatric and maternity areas. 1. Patients/ or their families/carers are being asked, at least daily, about how they are feeling. 2. All staff are able to refer to clinicians if they are concerned a patient is deteriorating. 3. There is an escalation route available to patients, their families and carers advertised across the specialties.

Recommendation

The Board of Directors are to be assured the annual 2024-2025 Quality Account has been approved by the Quality and Performance Committee on 26 June 2025 and published in line with statutory with regulations.

Enclosures

Published Quality Account 2024-2025: Quality Account 2024–25

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Account

2025 – 2026

Our Quality Account 2024/25

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements.

Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Table of Contents

Part ONE: Foreword by the Chief Executive

I am pleased to introduce our Quality Account and I hope that you enjoy reading about some of our highlights from 2024-2025. Over the past year, our two main hospital sites - Cheltenham General Hospital and Gloucestershire Royal Hospital - as well as our community-based services, have continued to evolve to meet the needs of our patients and local communities.

This year, we have made positive steps forward in developing a number of our key services for our patients and local community. One of our most exciting achievements has been the opening of the new Hyper-Acute Stroke Unit at Cheltenham General, providing specialist care to stroke patients at a critical time in their recovery. This is a development that will help further improve Stroke care for local people and build on the success we saw in year where our Trust had the quickest access time in the South West to get access to life saving thrombolysis for someone suffering a stroke.

Timely access to services is a key element of quality and safety and during the year our teams delivered a significant reduction in the number of patients waiting over a year for treatment – from over 2,800 at the start of the year to 94 by the end of the financial year. This work continues and we aspire to be a place where local people have some of the best access times for elective care in the country. We started the new financial year strongly and are currently in the top ten trusts in the country for reducing our longest waiting patients and we want to go further.

From an Urgent and Emergency Care perspective, historically we have experienced significant delays at the front door – particularly at our busiest times. This has resulted into ambulance handover delays and waits for beds. This continues to be a significant area of focus for us as a Trust and in year we saw a number of improvements that should give us hope and confidence that we can continue to change some of those issues that have been stubborn for some time. These improvements include a reduction in ambulance handover delays from 3600 hours per month to under 2000 hours per month during the year and almost eliminating patient boarding on wards – a process where patients waiting for a bed are placed on the wards in corridors which does not deliver the quality of care we aim for.

We have also seen some improvement in patients waiting longer than 12 hours in ED, and to make real inroads into this it is a priority for us this year given long delays contribute to greater harm for our patients. Our hope and expectation is that in doing this, we improve timely access to urgent and emergency care and we reduce delay related harm. Whilst we can see positive steps forward, we know there is more for us to do and we are committed to making the improvements our patients and the local community expect through our Clinical Vision of Flow programme.

Encouragingly, more colleagues are recommending our Trust as both a place to work and a place to receive care compared to 2023. While this is a positive step forward, we know there is much more to do and fully acknowledge our latest results build on a poor baseline from the staff survey in 2022. As our culture continues to evolve, we remain responsive to the changing needs of our workforce, ensuring we build a supportive, inclusive and thriving

environment for all our staff – in full knowledge that it is these types of cultures that deliver the safest care.

We also want to acknowledge the challenges we have faced. In January 2025, the Care Quality Commission published its delayed report on our maternity services, following an unannounced inspection in March 2024. The report rated our maternity services 'inadequate' for the second time – a disappointing outcome, but one we are meeting with determination and action. While we recognise that there is still more to do, we are making progress and remain committed not only to providing safe, high-quality maternity care but also being open and transparent in the quality of care we are providing. We are determined to ensure that maternity care at our Trust is something we can all be proud of.

We are also focussing heavily on improving complaint response times – an area that has been below standard for some time. This cross-divisional effort is focussed on not only ensuring we respond in a timely way and ensure people get the answers they need, but most importantly we pick up the learning from when we get things wrong.

Having worked in the NHS for over 20 years, I know that we can only do what we do if we work in partnership with patients, partners and the local community. Both in terms of listening to their experience and using their insight to help drive forward improvements. This continues to be a priority for us and later this year we will launch our new Trust strategy which will focus heavily on our role in the community – as an employer, a healthcare provider and a good partner so we can make the biggest difference to the people of Gloucestershire.

The NHS remains challenged, but our passion and purpose remain undiminished. The privilege of working in the NHS comes with great responsibility and we are committed to ensuring that our hospitals remain places where patients receive outstanding care and staff feel valued and supported.

I would like to thank all those who contribute to our shared mission - staff, volunteers, partners and the wider Gloucestershire community. Everything we achieve is a result of a collective effort; together, we will continue to meet challenges with innovation, compassion and determination.

Finally, I can confirm that, to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represents a true picture of the Trust's activities and achievements in respect of quality.

Thank You

It serves for me to thank you, the reader, for everything that you have brought to the Trust whether as a colleague, a governor, a partner, a public member or a patient.

Finally, I can confirm that, to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represents a true picture of the Trust's activities and achievements in respect of quality.

Kevin McNamara
Chief Executive

Part TWO: Priorities for improvement and statements of assurance from the board

Looking forward our priorities for 2025/2026

We continue to develop our priorities using a range of information and sources (safety, experience and clinical effectiveness data) with consultation from staff, senior leaders and our Executives. We have reviewed our performance, incidents, the learning that has taken place and how we want to take this to the next level in our Trust. We continue to experience pressure across the organisation during 2024/2025 but during this time we retained our cohesive approach to quality, safety and risk. For next year, 2025/2026, we have chosen to continue to focus on our Patient Safety Incident Response Plan (PSIRP) local safety priorities. For next year, in addition to the safety priorities, we have chosen to report on the Trust priority improvement programmes of work. Each programme will have an element of quality (safety, experience and clinical effectiveness) within them.

In September 2025, we will begin again our structured approach to reviewing the data for 2026/2027. The purpose will be to check that we are focusing on the right things by reviewing our themes and trends.

Table: Priorities for the years 2025/2026

Priorities	Focused on	Metrics/ improvement we want to achieve
1. Patient Safety Incident Response Plan - safety priorities	Continuing our improvement work within the 8 safety priorities and linking them to the transformation work within the organisation.	To continue the work started in 2024/2025 with a focus on our learning and improvement.
2. Outpatient transformation	Improving how outpatient care is delivered, with the goal of providing more patient centred and more efficient services.	Decrease in the number of hospital appointment cancellations. Decrease in numbers of patients who do not attend their appointments (with a focus on health inequalities).
3. Clinical Vision of Flow	Improving how we minimise wait times, reduce bottlenecks across all services and improve the quality of care delivered to our patients	Decrease the number of patients waiting greater than 12 hours in the Emergency Department
4. Fire prevention and safety	To safeguard the lives and wellbeing of patients, staff and visitors by minimising the risk of	Compliance with our training targets across all our hospital sites

Priorities	Focused on	Metrics/ improvement we want to achieve
	fire and ensuring safe evacuation in case of a fire.	
5. Maternity service improvements	Focused improvement in the Safety Plan priority for maternity – prevention and detection of deterioration: Meeting all of the objectives of our maternity transformation plan, including all regulatory requirements.	All 8 conditions on our CQC registration to be achieved
6. Emergency Department service improvements	Getting care right in the emergency department is crucial because timely and effective treatment can be the difference between life and death.	- Ambulance offloads - Duration in the department

Introduction to the Patient Safety Incident Response Framework

On 1 March 2024 Gloucestershire Hospitals NHS Foundation Trust introduced a new way of working and implemented the Patient Safety Incident Response Framework (PSIRF). This framework sets out the National Health Service's (NHS) approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The framework is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract.

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy. PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The patient safety incident response system, developed from the framework, integrates **four key aims:**

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

Patient Safety Incident Response Framework Policy

Our Trust Patient Safety Incident Response Framework policy exists to provide our structured approach to respond to patient safety incidents, focusing on learning and improvement rather than blame. This approach aims to enhance patient safety by fostering a culture where incidents are viewed as opportunities for learning and systemic improvements.

Patient Safety Incident Response Framework Policy

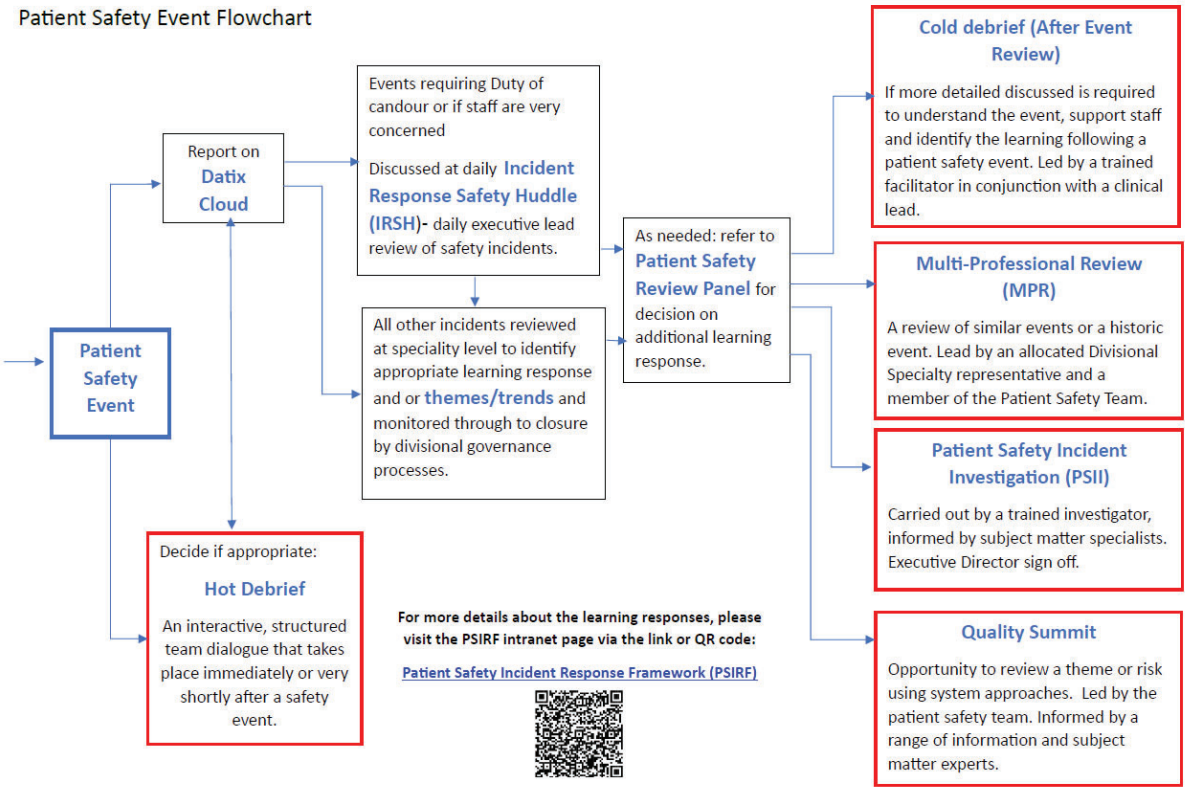
Learning Responses

Part of the Patient Safety Incident Response Framework philosophy is that our response to a safety incident should be proportionate to the opportunity to learn. To enable this, there are a number of learning responses that we may use to understand how and why something occurred, and ultimately so that we may learn and improve. Information about these learning responses and how they can be used, can be found below.

Hot debrief
Cold debrief (After Event Review)
Patient Safety Incident Investigation
Multi-Professional Review
Quality Summit

Patient Safety Event Flowchart
We have developed a Patient Safety Event Flowchart to demonstrate how our system works in practice.

Picture: Patient Safety Event Flowchart



Patient Safety Response Plan

Our Patient Safety Incident Response Plan sets out how we intend to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. We developed 8 safety (quality) priorities and last year we chose to write about them in our Trust Quality Account.

Link – Patient Safety Response Plan

Looking back - progress against our local safety priorities 2024/2025

Our Quality Account is an important way for us to report on the quality of our services we provide and show our improvements to our services that we deliver to our local communities. The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provide. The priorities, detailed in this report, form a key element of the delivery of the Trust's objective to provide the "Best Care for Everyone". Below is a summary of progress over the year and in the next section we provide more information about each priority and its relationship with PSIRF.

Table: Summary of our Patient Safety Incident Response Plan local safety priorities and the improvements made in 2024-2025

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
Pressure Ulcer Prevention	Hospital acquired pressure ulcers	Pressure Ulcer risk assessment rate for in-patients improved by 25% from 61% – 87% in 12 months. Pressure Ulcer Improvement Group reestablished with revised Terms of Reference. Pressure Ulcer Business Intelligence Platform established to demonstrate rates and real time data for pressure ulcer occurrence. Annual quality summit planned for July 2025. Testing the use of Hot Debriefs to align with the Patient Safety Incident Framework.
Falls Prevention	Patient falls	Compliance of falls risk assessments for in-patients has remained at 75%. The incidence of in-patient falls remains at an average of 7 per 1000

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
		hospital bed days. Falls prevention masterclass offered to staff, preceptor and falls-link nurses. Annual quality summit identified 3 areas for improvement (developing Datix to collect falls information, enhancing debriefs after falls and developing the electronic patient record). Revitalised Falls Steering Group.
Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	Risks and incidents where delays in recognition and/or escalation of deterioration during pregnancy and/or delivery have or could have affected the safe care and outcome for mother or baby.	The compliance for the Maternity Obstetric Early Warning score to be repeated when raised (amber alert) improved from 63% in May 2024 to 90% in March 2025. Compliance with NICE guidelines for fetal heart monitoring improved from 60% to 95% for risk assessments on admission, and 80% to 90% for hourly risk assessment. Accurate assessment and escalation compliance reached 100%. Hourly intrapartum peer reviews improved from 76% to 98%.
Safer Staffing	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	All in-patient wards and departments have had a review calculation of the care hours per patient day. Those areas where acuity and dependency has increased or decreased will have budgets amended. Similarly, areas requiring more training time allocation such as the Emergency Department, Paediatrics and Neonates will have

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
		similar budget amendments.
Organisational Culture	Risks or incidents where team / department or organisational culture is impacting on behaviours, standards or safe delivery of services/ care.	Working on a Staff Experience Improvement Programme which included implementation of 3 key projects (Just and Restorative Culture, Report, Support and Learn and Antidiscrimination practices). Improving our safety culture by ensuring staff understand new ways of working with level 1 training for Essentials for Patient Safety at 91% across the Trust. Staff survey results demonstrating and increase to 65.8% in the question about staff feeling secure at raising concerns about unsafe clinical practice from 2023 results at 63.49% (increase of 2.34).
Digital Systems Improvement	Risks and incidents related to the introduction and use of digital clinical systems.	The allocation to the correct consultant on the digital Communicator platform was identified to have weaknesses in its design. New “unexpected result” and “cancer” alert codes have been implemented to alert the reporter 9 times as a safety net. A dashboard report has been implemented for unacknowledged radiology alerts so that Teams have oversight of their results. Local governance processes are being identified for all unacknowledged alerts.
Clinical Vision of Flow (admission and discharge)	Risks and incidents related to impeded patient	The improvements are measured in hours lost to handover delays, reduced from nearly 6000 in Oct 23 to

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
	flow from assessment to discharge, including delays to discharge, excluding clinical complications.	under 2000 in March 25. Improvements for patient experience include the reduction of patients who spend over 12 hours in the emergency department from 18,000 in March 2024 to 15,000 per month in March 2025. Additional improvements include a streaming nurse in minors and a review of Pitstop process and location in majors.
Communication	Risks and incidents that relate to communication between staff and patients and their families	The 3 components of Martha's Rule have been implemented into all adult, paediatric and maternity areas. 1. Patients/ or their families/carers are being asked, at least daily, about how they are feeling. 2. All staff are able to refer to clinicians if they are concerned a patient is deteriorating. 3. There is an escalation route available to patients, their families and carers advertised across the specialities.

1. Quality priority - Pressure ulcer prevention

Background

Pressure ulcers are recognised as one of the top 10 harms in the NHS, and over the years, there have been a number of approaches to investigating these, the most recent being the Serious Incident Framework which classified higher-grade pressure ulcers as Serious Incidents and subject to Root Cause Analysis investigations. However, it became clear that the resources deployed in conducting these investigations were not proportionate to the outcomes in terms of reduction of harm. So, in 2022 NHS England brought in a new approach, known as Patient Safety Incident Response Framework. Patient safety incidents are “unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients” (NHS England 2022, p2).

Local Experience prior to PSIRF

We had a well-established governance structure for reporting and investigating pressure ulcers for several years, but in common with many other organisations the time and effort expended on conducting these investigations, particularly by the Tissue Viability Nurses, was heavy and was diverting resources away from direct clinical care.

For many years, our Pressure Ulcer Steering Group, met monthly to review all the new Datix incidents that have been reported that month for Category 3, 4, unstageable, suspected deep tissue Injuries, and multiple Category 2s. Ward Managers conducted Root Cause Analysis Investigations and then developed specific actions to prevent recurrence.

Implementing Patient Safety Incident Response Framework

Over the last year we have been focused on implementing PSIRF as this aims to look at pressure ulcer incidents through a systems-wide lens. Under the previous system, patient safety management was focussed on identifying root causes for why things happened. It focused on ‘work as prescribed’, how things should be done according to policy or procedure. It often resulted in actions such as requiring staff to undertake training, reflections or re-reading policies, which gives the impression of blame either intentionally or unintentionally.

Our new Patient Safety Incident Response Framework approach accepts that risk is inevitable and looks at the whole system, or the bigger picture, to reduce the likelihood of incidents recurring. It focuses on ‘work as done’ and how work really takes place. The approach empowers everyone to make meaningful changes that can lead to genuine safety improvements.

In April 2024, awareness events were held across the organisation, ensuring everyone was aware of the new patient safety agenda because the approach encourages all staff at all levels and grades to be involved. It is no longer restricted just to senior staff or team leads as was previously the case with Root Cause Analysis investigations.

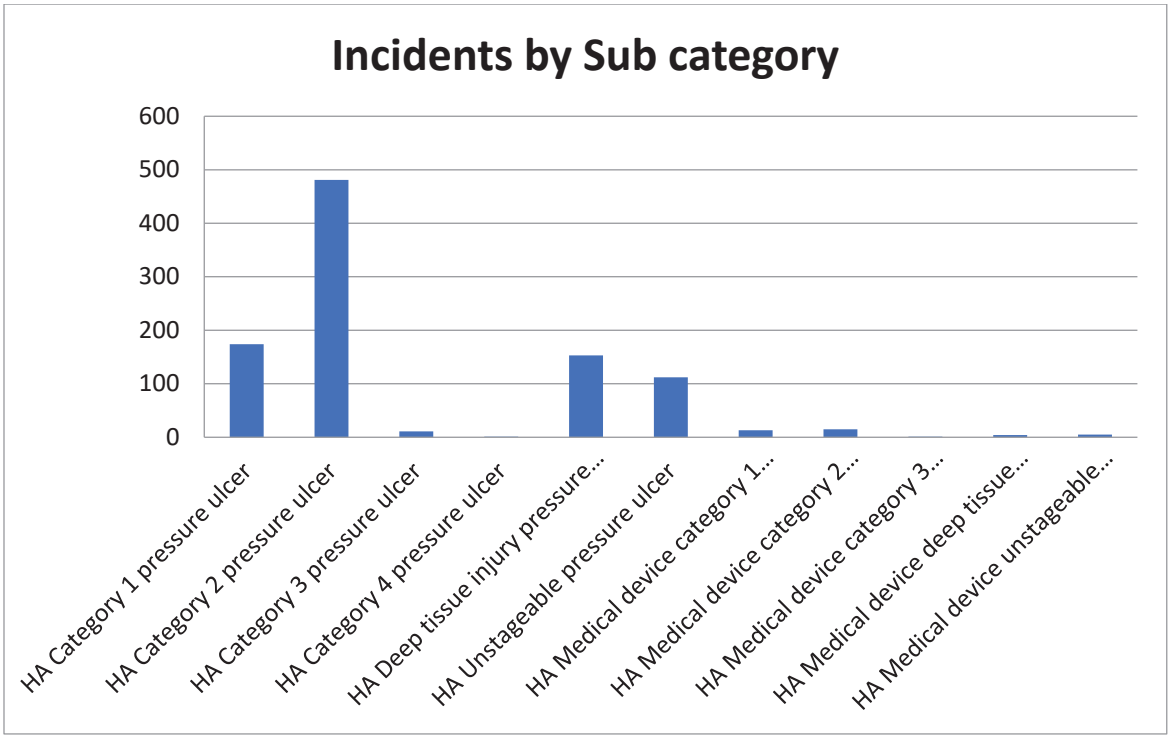
An essential tenet of the Patient Safety Incident Response Framework approach and the Trust risk management strategy is the concept of reducing harm to “As Low As is Reasonably Practical”, which acknowledges that eliminating harm completely is not achievable or realistic. As Low As is Reasonably Practical considers the human factors in any incident without attributing blame to any individual or team. It aims to look at care as expected and compare it with care as delivered and identify any learning from the difference.

How we have performed and what we have learnt in 2024/25

Our focus from learning from harm from pressure ulcer this year has been our implementation of the Patient Safety Incident Response Framework as this was a new way of working. Within PSIRF there are different learning responses that can be employed. Local incident investigation may be sufficient to identify the contributing factors and the learning response required. However, if the elements of the incident are not well understood, then other approaches (such as Hot Debrief, After-Event Review, or Multi-Professional Review), might be used. A key difference with this approach, compared with the historical Root Cause Analysis approach, is that these meetings do not require a lead or manager in attendance and this non-hierarchical approach is designed to support honesty and openness and the best opportunities for learning about ‘work as done’.

The following table demonstrates the number of hospital acquired pressure ulcer safety incidents we reported onto the safety reporting system Datix.

Graph: Total number of pressure ulcer incidents reported by sub category 2024/25



Our learning responses have been that most cases have been reviewed by the Tissue Viability Nurse Team to check the grading of the pressure ulcers (grade 2 and above) and then supporting the clinical ward teams with wound care advice and with developing clear prevention plans for further deterioration of the ulcer (or new ulcers).

In addition, we have:

- Analysed our data to understand our issues and to make improvements to preventing pressure ulcers.

- Updated the Pressure Ulcer Prevention and Management Policy. These clinical guidelines based on the best available evidence provide a framework for healthcare professionals to make informed decisions, improve patient outcomes, and reduce healthcare costs. They are developed through a rigorous process that includes reviewing scientific evidence, expert opinions, and feedback from stakeholders.

- Analysed our data from the silver Quality Improvement project (this was a questionnaire developed and sent to staff in order to understand current knowledge and key challenges at ward level). We developed an improved method of learning through simulation and gamification.

- Implemented further Electronic Patient Record changes which enabled extra opportunities for staff to document their pressure ulcer prevention care.

- Continued to implement Pressure Ulcer Prevention simulation pilot and this is now integrated into tissue viability training and the evaluation will be ongoing.
- Collaborated with Gloucestershire Health and Care Trust and the Gloucestershire Integrated Care Board to share information and ideas in our pressure ulcer prevention.
- Agreed with the senior nursing team that the Tissue Viability Nursing Team team will review all hospital acquired pressure ulcers at grade 2, 3 and 4.

- Improved our compliance with pressure ulcer risk assessment from 61.75% in 2023/2024 to 87% in 2024/25. **This is an improvement of 25%.**

  Table: Percentage of completed pressure ulcer risk assessment on adult wards by quarter

Metric	End of year average 2023/24	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of year average 2024/25
Compliance with completion of: pressure ulcer risk assessment	61.75%	87.3%	87.5%	88.8%	88.5 %	87%

Although the Patient Safety Incident Response Framework is still a relatively new change in our organisation, and there still will be challenges to work through, our initial observations and reflections are very positive and encouraging. So far, the Patient Safety Incident Response Framework appears to be a really positive shift in how we manage patient safety incidents related to hospital acquired pressure ulcers and has the potential for meaningful change to enable pressure ulcer prevention.

Plans for improvement 2025/26

We will:

- Host a Quality Summit in July 2025.

- Relaunch the Pressure Ulcer Steering Group as the Pressure Ulcer Prevention Improvement Group.

- Launch the most appropriate learning responses for pressure ulcers, as determined by our pilot.
- Continue to develop our in-hospital pressure ulcer dashboard, with the

Business Intelligence Team, which will include data for pressure risk assessments within the first 6 hrs of an admission. The dashboard also identifies the number of pressure ulcers with categories, the role of the health care worker reporting and the length of stay when a pressure ulcer developed.

- Develop an Emergency Department pressure ulcer dashboard (as they have a different process as they use the Adison screening tool and if required start using the Surface, Skin inspection, Keep moving, Incontinence/moisture and Nutrition and Hydration bundle).

Picture: Communications for Pressure Ulcer Prevention Quality Summit

Pressure Ulcer Quality Summit 31 July 2025

Save the date: Quality Summit for Hospital Acquired Pressure Ulcers, 31 July 2025

Join us for the Gloucestershire Hospitals Quality Summit on 31 Jully 2025 at Sandford Education Centre, Cheltenham General Hospital. This event is an exciting opportunity to collaborate with healthcare professionals from Gloucestershire Hospitals to tackle key issues identified from investigating hospital acquired pressure ulcers.

As a healthcare professional, your expertise and input are crucial in driving forward quality improvement initiatives that will directly enhance patient care and support your colleagues. Together, we will explore the issues arising from HAPUs in depth with staff who carry out the work thereby ensuring we are looking at the issues as ‘work as done’ rather than how it is envisaged. We will also be learning about improvements in the past year relating to hospital acquired pressure ulcers and the proposal for investigating hospital acquired pressure ulcers using hot debriefs.

This summit offers an exciting platform to address these challenges head-on and work towards tangible improvements in patient care. Don’t miss this chance to be part of a collaborative effort that will make a real impact!

For further information and details visit the Gloucestershire Hospitals website

2. Quality Priority - Falls prevention

Background

Patient falls are amongst the most common adverse incidents reported in hospital. Of those patients who experience a fall, some suffer moderate to severe injuries that reduce mobility and/or independence and may increase the risk of premature death. We fulfil our duty to manage the risks associated with falls as far as reasonably practicable by ensuring safe systems of working through effective risk assessments, controlling hazards and personalised care planning. We aim to provide a consistent and safe approach across the trust, in the identification, assessment of risk, and the prevention and management of falls for all adult inpatients.

How we have performed and what we have learnt in 2024/5

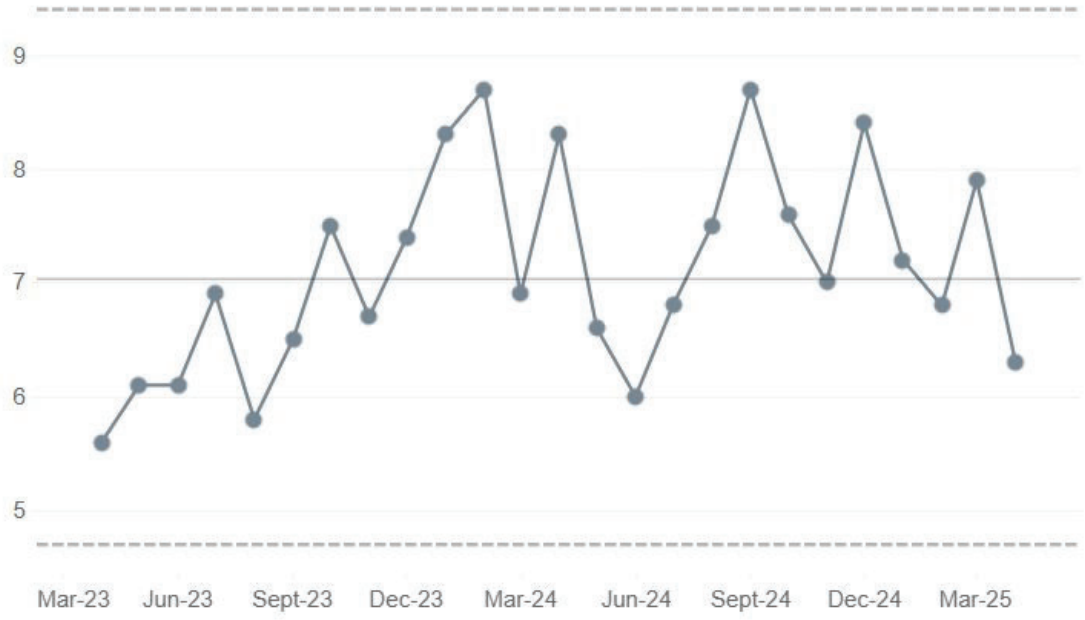
This year we continued to focus on supporting our training program for nursing and therapy staff and re-established the falls links education days to a whole day's training, incorporating all aspects of falls in more depth. Work began on incorporating how we look at all falls in line with PSIRF, to ensure that learning is gained from all falls.

Table: Falls Risk Assessment compliance for in-patients over 65 years of age

Metric	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of year average 2024/25
Compliance of falls risk assessment on admission for patients aged 65+	**74.7%**	**75.2%**	**77.1%**	**76.0%**	**75.8%**

The number of inpatient falls per 1000 bed days has remained stable as per the table below.

Table: The number of patients' falls per 1000 bed days



In addition, we have:

- Reviewed patients who repeatedly fall with prevention strategies developed by the Falls Specialist Team with the ward teams.

- Continued to provide falls prevention training, as a whole day's training. This year 199 colleagues have been trained in total. Unfortunately, several sessions were cancelled due to pressures within the hospital and team capacity.

- Provided "Falls Link Education" days (there was a total of 4 sessions this year). These days have been very well received. Each day looks at an aspect of falls and we hold collaborative conversations to listen to each other's ideas to make prevention improvement. The subjects we have covered this year have been 'Clinical Psychological', 'Vision and falls' and 'Learning disabilities and falls'.

- Made changes to the bed rails assessment on the electronic patient record (EPR) for more accurate documentation of the use of bed rails.

- Replaced the Falls Steering Group with the Falls Improvement Group under the Patient Safety Incident Response Framework for system learning.

- Provided education on our Preceptorship Programme (224 staff have received education) by the specialist team.

- Trialled slippers, instead of slipper socks, on the Stroke Unit. The Medical

Division are now able to order slippers for patients who have no means of obtaining them from home.

- Completed a Sliver Quality Improvement project with regard to the correct calculation of the Lying/standing blood pressure. The project did show a slight improvement on the 3 wards chosen; however, the most significant outcome of the project was that the training provided by the falls team (to only 1 of the 3 wards chosen) proved to be the most effective change idea that reduced falls.

- Piloted a project for PSIRF around the use of Hot Debriefs on 3 wards. This provided learning from all falls, not just falls with significant injury. This resulted in themes being identified and added to the Datix investigation form, to then be able to work on the themes to improve learning.

- Held a Falls Quality summit in November 2024 and identified a number of improvement projects which included to make improvements to Datix, locations for Hot Debriefs and to improve the electronic patient record.

Plans for improvement 2025-2026

We will:

- Develop and implement an audit tool for improving falls risk assessment and implementation of the use of bed rails.

- Implement the Silver Quality Improvement project on calculation of the lying/standing blood pressure monitoring.

- Continue with the quality improvement projects following on from the Falls Quality Summit.

- Continue with the introduction of Hot Debriefs for all falls.

- Develop the nursing and medical post falls electronic form. This is to replace the ‘blue sticker’ that was put in paper medical notes to ensure that immediate post falls assessments are consistent.

- Review the Falls Prevention and Management Policy for learning on risk assessment for longer-stay patients.

3. Quality Priority: Delay to Recognition and/or Escalation of Deterioration in Maternity

Background

This quality priority focused us to review our systems that enable us to detect **deterioration of maternal or fetal condition, during pregnancy and/or delivery, and to prevent delays.** We have focused our improvement efforts to target and enhance the overall quality of care for women and birthing people. It represents our decision to prioritise this work over others and this was driven by patient safety incident data.

The Patient Safety Incident Response Framework and the detection of patient deterioration are closely related, with the framework emphasising the importance of responding to incidents involving patient safety, including cases of deterioration. Patient Safety Incident Response Framework aims to learn from incidents and improve systems. Patient Safety Incident Response Framework is designed to promote learning from patient safety incidents and to improve systems and processes that can help prevent future incidents, including those related to patient deterioration. The framework emphasises the need for timely intervention and escalation when the maternal or fetal condition deteriorates, highlighting the importance of recognizing and responding to changes in a patient's condition.

Care Quality Commission – Section 31 Enforcement Notice

The Care Quality Commission inspected the Maternity Service at the Gloucestershire Royal Hospital site in March 2024. After the inspection, in May 2024, they applied 8 conditions on our registration that related to this priority and we have written about 2 of these priorities – **Modified Obstetric Early Warning Scores** and fetal monitoring **peer reviews**.

Monitoring maternal condition

Modified Obstetric Early Warning Scores

The Modified Obstetric Early Warning Score is a scoring system used in maternity settings to identify and track the clinical deterioration of pregnant women and postpartum mothers. It helps healthcare professionals quickly assess a woman's condition, determine the appropriate level of monitoring, and initiate timely interventions. Modified Obstetric Early Warning Score assigns points based on a woman's vital signs (heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, and mental status) and other relevant factors. The score determines the urgency of the situation and the level of care required, ranging from

routine monitoring to immediate transfer to critical care. Modified Obstetric Early Warning Score provides a standardised approach to assessing maternal well-being, ensuring consistent care and communication within the healthcare team. By focusing on early signs of deterioration, Modified Obstetric Early Warning Score can identify women at risk of developing critical illnesses, allowing for proactive management.

Benefits of MOEWS:

- **Improved Early Detection:** Modified Obstetric Early Warning Score helps identify women at risk of developing critical illnesses before they become severely ill.
- **Enhanced Communication:** It facilitates clear and efficient communication within the healthcare team.
- **Standardised Assessment:** It provides a consistent and standardized approach to assessing maternal well-being.
- **Increased Awareness:** It raises awareness among healthcare professionals about the signs and symptoms of maternal deterioration.

In essence, Modified Obstetric Early Warning Score is a tool that empowers healthcare professionals to proactively manage the care of pregnant and postpartum women, potentially saving lives and reducing maternal morbidity. Within the chart are coloured zones and so if vital signs were recorded within these zones (a “trigger), then an action should be prompted. An amber zone ‘trigger’ should alert the clinician to increase the frequency of monitoring and red zone ‘trigger’ should prompt a medical review by a doctor.

Quality Improvement

Our approach for the Care Quality Commission section 31 enforcement notice has been based on the empowerment of frontline teams. We identified 2 clinical leads (Matron and Consultant Obstetrician) and they commenced a quality improvement project to improve compliance of completing clinical observations and to ensure that they were escalated accordingly. The Team was initially tasked with completing a quality improvement plan on a page that they updated on a 2-weekly basis with the actions they had taken and the actions they were going to take in the next period.

The Modified Obstetric Early Warning Score Improvement Team identified a

SMART AIM
To increase compliance with acting on amber scores to 80% within 3 months (July), and 95% within 1 year (March 2025).

SMART aim:

What did the data demonstrate and what did we learn?

Amber triggers

Amber zone triggers indicate to the clinician to repeat the Modified Obstetric Early Warning Score observations. Since May 2024 we have improved our compliance with “act on amber” scores from 75% to 83% across all 3 clinical areas.

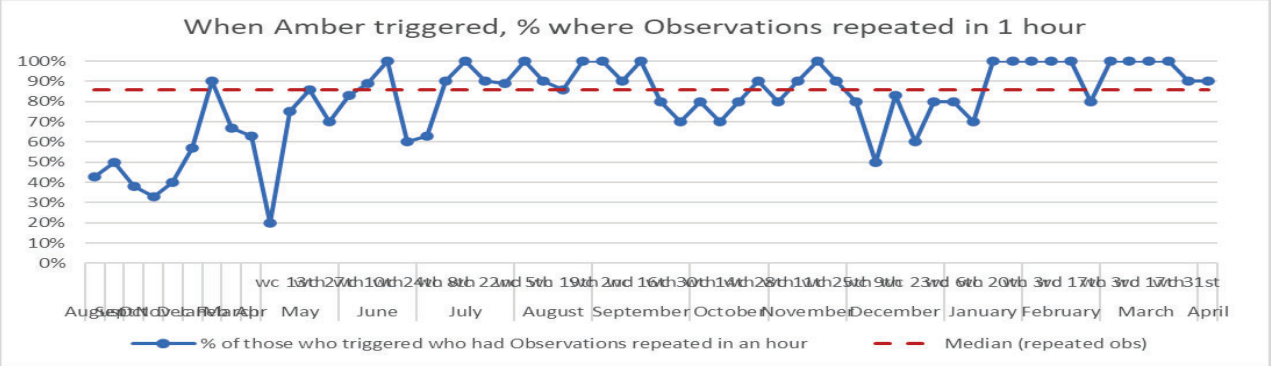
The area that continues to flag decreased compliance is the Birth Unit with only 70% women getting repeated observations when the amber score is triggered. Continued actions are being driven in this area to improve compliance which is the Birth Unit Lead is supporting individuals, teaching/training has been repeated within the service and also focused work to discuss with staff the barriers to retaking observations within 1 hour.

Table: “Act on Amber” compliance

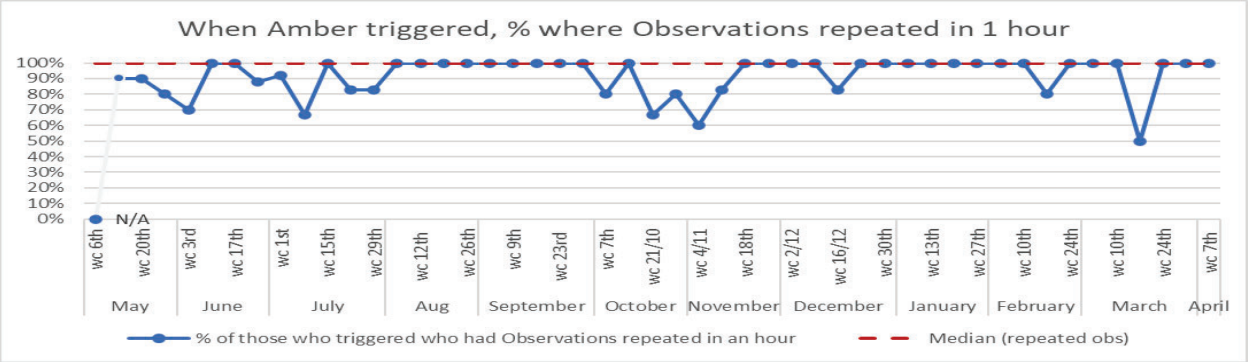
Area	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Maternity Ward	63%	83%	86%	94%	89%	80%	95%	71%	100%	95%	90%
Delivery Suite	87%	90%	83%	100%	100%	*60%	85%	97%	100%	95%	90%
Birth Unit GRH	75%	80%	100%	100%	100%	100%	70%	83%	83%	70%	70%

Charts: When amber triggered % where observations repeated in 1 hour – Maternity Ward

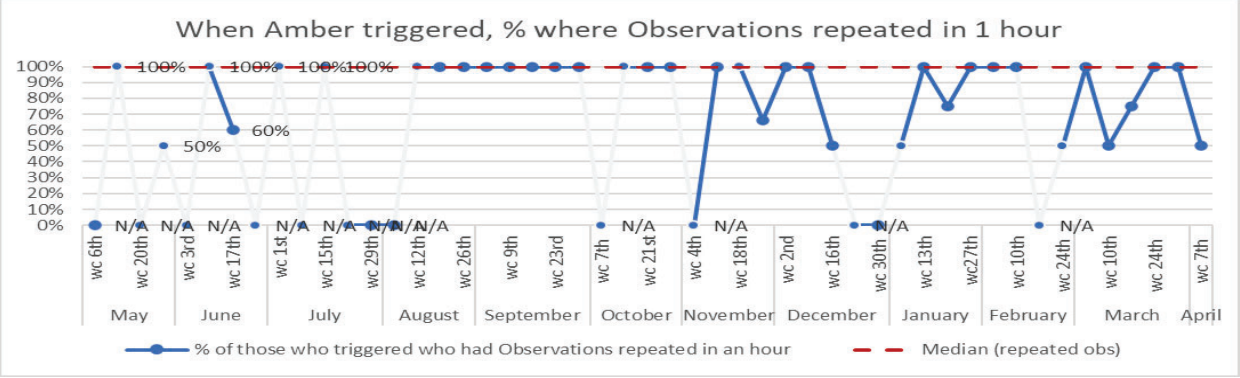
Graph: Maternity Ward



Graph: Delivery Suite



Graph: Birth Unit



Early Warning Scores, like the Modified Obstetric Early Warning Score, are tools used to identify and track patients at risk of clinical deterioration. In essence, the Patient Safety Incident Response Framework has provided us with the framework for how we review and responds to safety incidents whilst we have an improvement programme running as we have linked the two together by reviewing safety incidents whilst we improved our processes within a quality improvement programme.

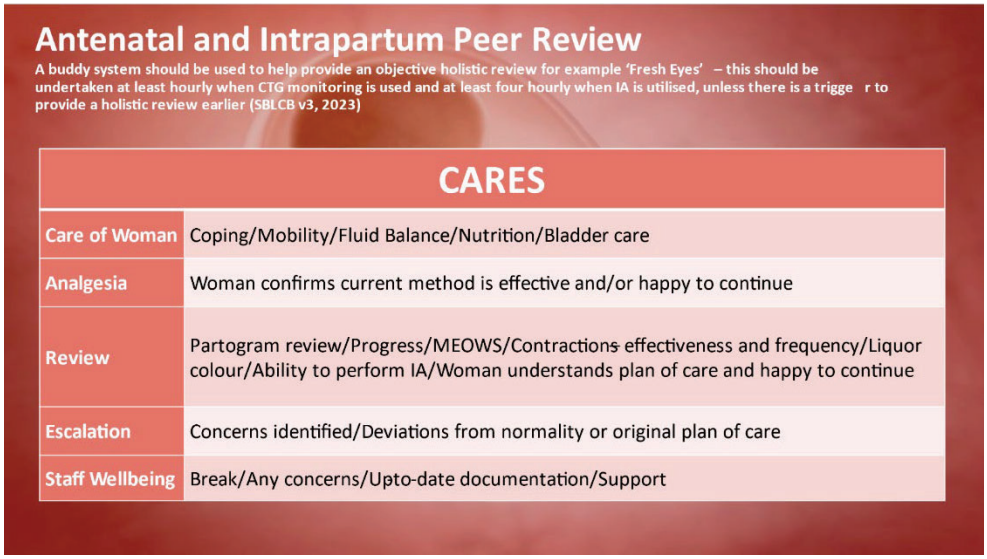
Plans for improvement 2025-2026

- There had been no national standard for the Maternity Early Warning Score but this has now been developed and will be rolled out in the Trust in December 2025. We have a plan for its implementation as this will change our coloured triggers to numerical triggers.
- We will continue monitoring compliance with “act on amber” until we see improvement within the Birth Unit and sustained compliance across all the other clinical areas.
- We will continue to introduce the Martha’s Rule project for patient and carer concern for clinical deterioration to be documented in the clinical notes and lead to clinical escalation.
- Once we have sustained our improvement target, we will invite Care Quality Commission to inspect against the conditions and this will likely to be at the end of the Summer 2025.

Monitoring fetal condition: Cardiotocograph peer reviews

In the UK, National Institute for Clinical Excellence guidelines recommend that a CTG (cardiotocograph - continuous fetal heart rate monitoring) trace should be assessed and documented at least every hour in labour, with more frequent assessments if there are concerns. A "fresh eyes" or peer review, where another midwife or doctor skilled at CTG interpretation reviews the trace, should also be completed every hour. The purpose is to identify any deterioration, or any concerns, about fetal condition. We have utilised a *CARES* model peer review, which is a more comprehensive review that includes a discussion of the woman's care, risk factors, and the progress of labour.

Picture: CARES for fetal monitoring peer review



Remember that:

- fetal heart rate monitoring is a tool to provide guidance on fetal condition, and not a standalone diagnostic tool
- the findings from fetal monitoring need to be looked at together with the developing clinical picture for both woman and baby.

Benefits of peer reviews: enhanced accuracy and interpretation

A second clinician reviewing the fetal heart rate trace can offer a fresh perspective and potentially identify subtle changes or patterns that might be missed by the initial observer, leading to more accurate interpretation of the trace.

Benefits

Improved Decision-Making: The "fresh eyes" peer review approach allows for a safety net check of the situation.

Reinforcement of Good Practice: The peer review process encourages consistent and accurate interpretation of fetal heart rate traces, reinforcing best practices in fetal monitoring and ensuring a high standard of care.

Improved Communication and Collaboration: The peer review process fosters communication and collaboration between healthcare professionals, leading to a more coordinated and effective approach to fetal monitoring and management.

Cost-Effectiveness: While it might seem like an extra step, peer review can be cost-effective in the long run by reducing the risk of complications and ensuring that interventions are appropriate and timely.

In essence, peer review is a tool that may help improve accuracy, reduce interpretation errors, and reinforces good practice by leveraging a fresh perspective. It also allows for a learning process if a coaching approach is taken at each review.

Quality Improvement

Our approach for the Care Quality Commission section 31 enforcement notice has been based on the empowerment of frontline teams. We identified 2 clinical leads (Matron and Consultant Obstetrician) and they commenced a quality improvement project to improve compliance of completing hourly peer reviews. The Fetal Monitoring Team were initially tasked with completing a quality improvement plan on a page that they updated on a 2-weekly basis with the actions they had taken and the actions they were going to take in the next period.

The Fetal Monitoring Improvement Team identified SMART aims:

SMART AIM
To confirm through audit within one month that staff are identifying and escalating fetal compromise effectively and addressing any issues found, sharing learning and providing assurance.

- To increase initial intrapartum risk assessment on admission to 95% by 31 March 2025
- To increase hourly risk assessment to 85% by 31 March 2025
- To increase our hourly peer review rate to 85% during intrapartum care by 31 March 2025
- To increase the accurate interpretation of CTGs to 85% (escalated appropriately for their interpretation) by 31 March 2025
- 100% of CTGs escalated appropriately by 31 March 2025

What did the data demonstrate?

We have carried out an audit once a month to check that we are complying with National Institute for Health and Care Excellence fetal monitoring standards.

Risk assessment on admission

Our data demonstrates that we are now completing a risk assessment on admission in labour which means that after appropriate risk assessment the appropriate method of fetal monitoring is being offered to women.

Hourly risk assessment

Our data demonstrates that we are carrying out hourly risk assessments of the woman and her baby.

Peer reviews

In March 2025, the Team trialled a 2-week Plan Do Study Act cycle of having dedicated peer reviewers on Delivery Suite. This Plan Do Study Act cycle was successful as 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 and so this will continue. We have met our target of 85% of women having hourly peer reviews.

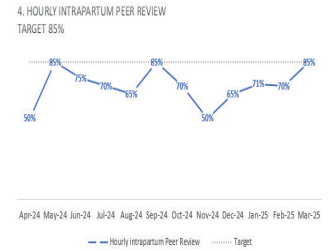
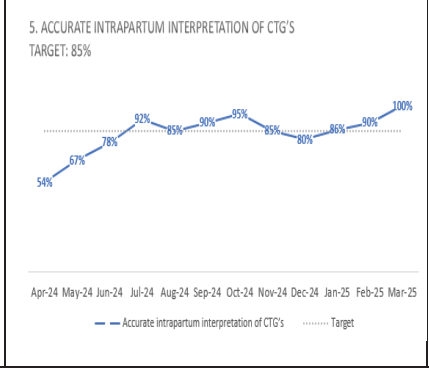
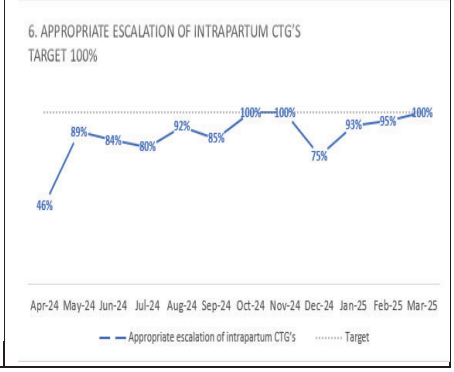
Accurate assessment and appropriate escalation

Our data demonstrates that we are carrying out accurate assessments and when appropriate care is being escalated to the obstetric team or senior midwife when appropriate.

Table: Fetal monitoring audit results

Issue	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	March 2025	Target end May 2025
Intrapartum risk assessment on admission	60%	95%	90%	95%	85%	90%	100%	100%	86%	86%	95%	Target 95%
Hourly risk assessment	80%	75%	42%	65%	85%	70%	50%	65%	67%	63%	90%	Target 85%
Hourly peer review	85%	75%	70%	65%	85%	70%	50%	82%	71%	70%	85%	Target 85%
Accurate assessment	67%	78%	92%	85%	90%	95%	60%	80%	86%	90%	100%	Target 85%
Escalation	89%	84%	80%	92%	85%	100%	100%	75%	93%	95%	100%	Target 100%
Total mean of hourly intrapartum peer reviews							77.5%	82%	95%	93%	98%	Target 85%

Graphs: Fetal monitoring compliance with standards (April-March 2024/2025)

Graph: Hourly peer reviews	Graph: Accurate assessment	Graph: Appropriate Escalation
		

Fetal monitoring safety incidents falls under the scope of Patient Safety Incident Response Framework as a specific type of incident that we can learn from. Any safety incidents that related to this improvement work stream have been shared with the team so they can identify the lessons learned and implement changes to improve

fetal monitoring practices such as better training. Our aim is always to deliver safer care for women and babies.

Next steps

- As the Patient Safety Incident Response Framework encourages a data driven approach to incident response we will review all the incident data and look for any themes/trends to inform our programme of work for the next year.
- We will continue to audit our practice against NICE recommendations and will decrease the frequency of the audits once we have sustained our performance and keep meeting the compliance targets.
- The new Maternity Incentive Scheme requirements are being scoped to ensure we have continued compliance to the national requirements for meeting the scheme requirements.

4. Quality Priority: Safer Staffing

Background

Safe staffing is crucial in the Patient Safety Response Framework because it directly impacts the ability to respond effectively to patient safety incidents, investigate them thoroughly, and learn from them to prevent future harm. Adequate staffing levels and the right skill mix ensure that staff can provide the necessary care and support to patients, which is essential for both patient safety and the successful implementation of Patient Safety Response Framework. In this section we have focused on the nursing workforce.

How safer staffing and PSIRF are linked:

- **Incident Prevention:**

  Adequate staffing allows for more effective patient care, reduces the risk of errors, and minimises the likelihood of incidents happening in the first place.

- **Incident Response:**

  PSIRF provides a framework for responding to incidents when they do occur. The framework includes compassionate engagement with affected individuals and families, system-based approaches to learning, and proportionate responses.

- **Learning from Incidents:**

  Both safer staffing and PSIRF are focused on learning to improve future care. PSIRF emphasises using system-based approaches to identify care or service delivery issues within safety incidents and implement changes to prevent recurrence, while safe staffing ensures there are enough staff with the necessary skills and knowledge to implement these changes effectively.

- **Quality of Care:**

  Adequate staffing ensures that there are sufficient staff to provide quality care, which is a key factor in preventing patient safety incidents and improving patient outcomes.

- **Patient Experience:**

  Safer staffing and the Patient Safety Response Framework both contribute to improving the overall patient experience by ensuring safe and compassionate care and by addressing incidents promptly and effectively.

In essence, the Patient Safety Response Framework provides the framework for responding to incidents when they occur, while safer staffing is crucial for preventing incidents from happening in the first place and for ensuring that there are enough qualified staff to provide safe and effective care, which aligns with the goals of the Patient Safety Response Framework.

How we have performed in 2024-2025

Safe staffing levels help prevent burnout and fatigue, which can negatively impact staff performance and patient care. All incidents, including those related to staffing shortages or staff skill gaps, were reported through our established incident reporting system. By implementing robust safe staffing practices and effectively managing safety incidents, we can improve patient safety, enhance staff well-being, and contribute to high-quality care.

We are very proud to be in a position of having very few nursing vacancies on our inpatient wards. Vacancies on adult inpatient wards at the end of February 2025 were 10.73 whole time equivalent posts, on the paediatric ward there were 16 whole time equivalent vacancies and 8.8 whole time equivalent in the Emergency Department. By way of comparison there were 434 whole time equivalent nursing vacancies in September 2022.

Our international recruitment campaign has been very successful and has brought many new colleagues to work with us from many countries including India and the Philippines. Our focus now moves from our attraction campaigns to our retention plan by increasing support for staff in post making this our key priority.

A Trust wide review of nursing workforce has been undertaken using the Safer Nursing Care Tool, which measures patient acuity and dependency and helps calculate the care hours required per patient day. From the table below five wards had planned for fewer care hours and three wards had planned for more care hours. This variation can be a reflection of the increasing complexity of the patient population, growth in services, changes in the workforce due to role development and reshaping the workforce to reflect the growth of the Nursing Associate role.

It is important we achieve optimum planned care hours to prevent harm for our patients, such as patient falls, pressure ulcers and healthcare acquired infections. Optimum care hours enhance both the patient and staff experience of care. Bespoke care hours calculations are in progress in the emergency department and critical care, which will accommodate improvements such as a streaming nurse role for the emergency department and Healthcare Support Worker roles in critical care.

Table: Data for actual and planned care hours and the variance by ward and department

ANNEX A NURSING STAFF FILL RATES Sep-24		Acutal CHPPD				Planned CHPPD			Variance		
		Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall	Registered nurses/ midwives	Care staff	Overall	Registered nurses/ midwives	Care staff	Overall
	HASU	407	11.4	3.2	14.7	11.1	3.1	14.2	0.4	0.1	0.5
	BIBURY/SNOWSHILL	486	6.6	2.0	8.6	6.5	2.4	8.8	0.1	-0.4	-0.2
	GUITING	868	4.9	3.6	8.5	4.8	3.1	7.9	0.0	0.5	0.5
	TIVOLI	445	5.8	4.0	9.8	6.1	4.4	10.4	-0.2	-0.4	-0.7
	KNIGHTSBRIDGE	504	5.4	2.8	8.3	5.4	3.0	8.3	0.1	-0.1	-0.1
	LILLEYBROOK	425	5.4	2.2	7.6	5.3	2.8	8.1	0.1	-0.6	-0.5
	RENDCOMB	568	6.1	2.0	8.1	6.1	2.1	8.2	0.0	-0.1	-0.1
	RYEWORTH	939	4.1	3.2	7.3	4.2	3.2	7.3	0.0	0.0	0.0
	WOODMANCOTE	915	4.5	3.4	8.0	4.6	3.3	7.9	0.0	0.1	0.1
	AMU	1562	5.5	2.5	8.0	5.1	2.7	7.8	0.4	-0.2	0.2
	FRAILTY UNIT	409	6.9	3.2	10.1	6.6	3.7	10.3	0.3	-0.5	-0.2
	CARDIOLOGY	726	12.5	2.5	15.0	11.6	2.7	14.3	1.0	-0.2	0.7
	DCC	414	29.7	1.7	31.5	36.2	1.8	38.0	-6.5	-0.1	-6.6
	SCBU	517	11.6	1.7	13.3	11.6	1.5	13.1	0.0	0.2	0.2
	CIPD	459	12.6	3.6	16.2	16.3	4.5	20.9	-3.7	-0.9	-4.6
	ZA	596	5.6	3.9	9.6	5.8	4.2	9.9	-0.1	-0.2	-0.4
	ZB	611	4.4	3.1	7.6	4.4	3.2	7.6	0.0	-0.1	0.0
	3A	881	3.4	3.4	6.8	3.1	3.4	6.5	0.3	0.0	0.3
	3B	851	4.1	3.0	7.1	4.2	3.2	7.4	-0.1	-0.2	-0.3
	4A	872	3.9	2.7	6.6	4.2	2.8	7.1	-0.3	-0.1	-0.4
GRH	4B	822	4.1	3.0	7.1	4.2	3.3	7.5	-0.1	-0.3	-0.3
	5A / SAU	869	4.1	2.9	6.9	4.0	3.0	7.0	0.1	-0.1	-0.1
	5B	541	6.9	3.5	10.3	7.2	3.6	10.8	-0.3	-0.1	-0.5
	6A	685	5.2	4.3	9.5	5.0	4.4	9.4	0.1	-0.1	0.0
	6B	1031	4.1	3.1	7.2	4.1	2.9	7.0	0.0	0.2	0.2
	7A	890	4.5	2.5	7.0	5.0	2.6	7.6	-0.5	-0.1	-0.6
	7B	655	4.7	2.1	6.8	4.8	2.3	7.1	-0.1	-0.2	-0.3
	8A	1649	5.0	2.9	7.9	5.0	3.1	8.1	0.0	-0.2	-0.2
	9A / AMU3	336	4.5	2.1	6.5	4.5	2.2	6.7	0.0	-0.2	-0.2
	9B	807	4.8	3.1	8.0	4.8	3.3	8.2	0.0	-0.2	-0.2
	GALLERY WING 1	710	4.2	2.9	7.1	3.7	3.2	6.8	0.6	-0.3	0.3
	GALLERY WING 2	712	3.8	3.1	6.9	3.8	3.2	7.0	0.0	-0.1	-0.1

Chart versus Actual CHpPD (Trust).

Plans for Improvement in 2025-2026

- We are working towards facilitating Band 6 Nurse in Charge cover for 24 hours a day consistently across all departments.
- We are assessing the Department of Critical Care to reflect the need to have Health Care Assistant cover on both sites, 24 hours a day.
- In the Department of Critical Care, we are going to set the training provision at 28% as per the Guidelines for the Provision of Intensive care Services.
- In the Emergency Department we are working to set the training provision requirements at 27% as per the Royal College of Emergency Medicine Nursing Workforce standards.
- Within the Specialities of Paediatrics and Neonates we are going to set the training provision at 25% as per the Royal College of Nursing and Neonatal Nursing Workforce tool respectively.
- Also, we will set nursing budgets to reflect actual staff pay point and any in year incremental drift.
- We will backfill maternity leave to at 100% for inpatient departments.
- On Guiting Ward, Ryeworth Ward, Ward 3a and Ward 3b the budgets are to be set to reflect the changes in patient acuity.

5. Quality Priority: Safety Culture

Background

The Patient Safety Incident Response Framework is designed to enhance staff culture by fostering a learning environment where mistakes are viewed as opportunities for improvement and where staff feel supported in reporting incidents. It emphasises a compassionate and "just culture" where staff are treated fairly and are not unfairly blamed for incidents, promoting open communication and a proactive approach to safety.

Here is how PSIRF impacts staff culture:

- **Promotes Open Communication:**

  The Patient Safety Incident Response Framework encourages staff to speak up about incidents, recognising that learning from mistakes is crucial for improving patient safety.
- **Fosters a Just Culture:**

  It emphasises fairness and transparency in how incidents are investigated and responded to, ensuring staff are not unfairly blamed for mistakes.
- **Empowers Staff:**

  The Patient Safety Incident Response Framework empowers staff to be involved in the learning and improvement process, recognising their valuable insights and contributions.
- **Supports Psychological Safety:**

  By promoting a supportive and non-punitive environment, the Patient Safety Incident Response Framework contributes to staff's psychological well-being and their willingness to report incidents.
- **Focus on Systemic Issues:**

  The Patient Safety Incident Response Framework encourages a systems-thinking approach, recognizing that many incidents are caused by systemic flaws rather than individual errors.
- **Compassionate Engagement:**
  The Patient Safety Incident Response Framework emphasises the importance of compassionate engagement with patients, families, and staff following an incident, fostering trust and building positive relationships.

In essence, the Patient Safety Incident Response Framework further shifts the focus from blaming individuals to learning from systems, creating a culture where staff feel valued, supported, and empowered to contribute to safer patient care. By fostering a positive safety culture, the Patient Safety Incident Response Framework ultimately improves patient safety and staff wellbeing.

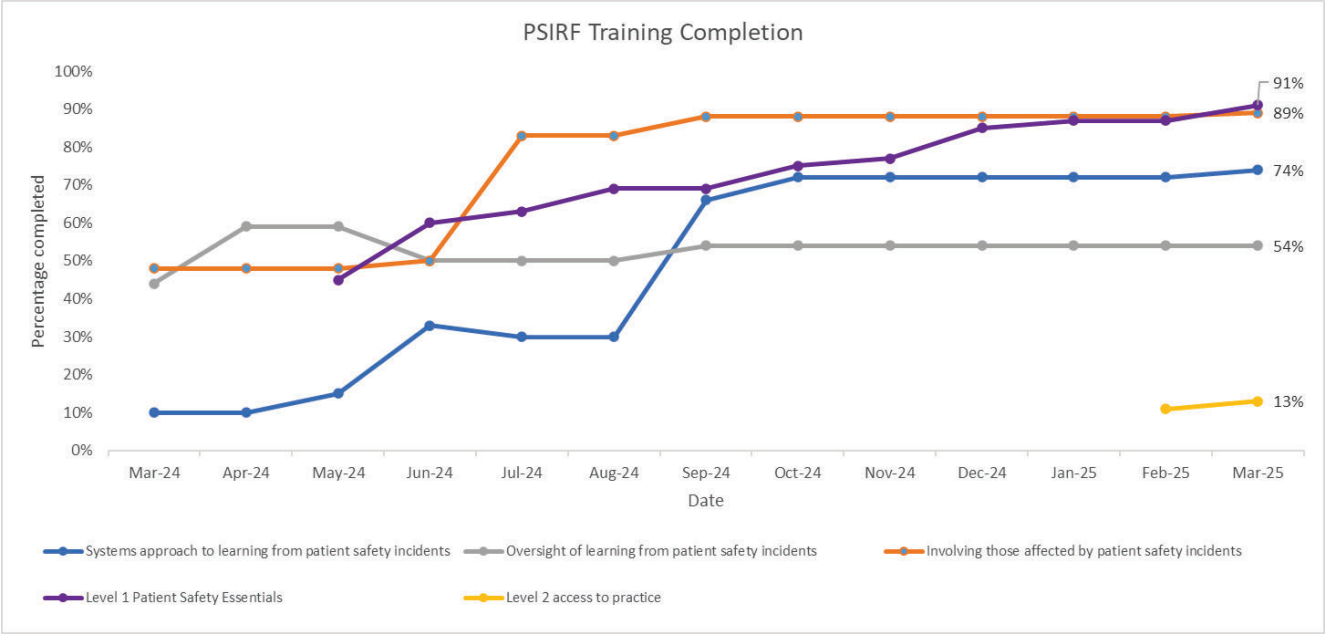
How have we performed and what we have learned in 2024/2025

Training is crucial for improving a culture that supports the Patient Safety Incident Response Framework by equipping staff with the knowledge and skills to effectively respond to incidents and learn from them.

The Patient Safety Incident Response Framework Training

The Patient Safety Incident Response Framework introduced new training requirements for those leading learning responses and those responsible for the oversight of the application of the framework. The chart below, shows current percentage completion across the three training courses introduced by PSIRF and the level 1 and 2 patient safety training, which is also a requirement, for those in Patient Safety Incident Response Framework roles.

Graph: Patient Safety Incident Response Framework training requirements, completion status.



Patient Safety Associate Programme

The Gloucestershire Safety and Quality Improvement Academy Faculty has been running the Patient Safety Associate Programme to develop a network of Patient Safety Associates across the Trust to support and promote patient safety. This programme was recently awarded a Staff Award (Nov 2024) for **Exceptional Contribution to Research, Teaching or Innovation**. The programme aims to build knowledge and skills to enable staff to be a resource in Patient Safety (human factors, safe systems, risk management, incident management and creating a just culture) within our teams and support patient safety

improvement. The programme runs over 6 months with one study day a month and self-directed learning. It is aimed at all clinical and non-clinical staff with an interest in patient safety, and/or leadership or teaching aspect to their roles.

Human Factors

The Human Factors Faculty offers a Human Factors Educational programme as part of the Gloucestershire Safety & Quality Improvement Academy (GSQIA). This is open to all staff to embed Human Factors awareness in our day to day working lives and the systems we work with the aim of improving the safety of our patients, the culture and environment we work in. The programme includes an **Introduction to Human Factors,** a half day workshop, which is open to all staff. This workshop explores how human factors impact on our working lives in healthcare from communication, team working and situational awareness to the systems we work in (for all clinical and non-clinical staff). An additional day and a half **Human Factors in Practice** training, builds on this baseline knowledge, introducing HF tools and approaches.

The Learning and Organisational Development Team have focussed on implementing specific programmes within a **Staff Experience Improvement Programme** which includes:

Restorative, Just and Learning Culture: Launch of a *Case Assessment Framework*, new policies introduced (*Mutual Respect, Disciplinary, Grievance, Sexual Behaviour*), and training/ Masterclasses for managers. This programme is strongly linked to PSIRF as they both emphasise the on learning, accountability and compassionate engagement after a patient safety incident.

Speaking Up Culture: Training for managers, champion network launched, new *Freedom to Speak Up* policy finalised. PSIRF emphasises open communication and learning from errors and freedom to speak up provides channels for staff to safely report concerns and issues without fear.

Anti-Discrimination: Relaunch of the Equality Diversity and Inclusion intranet page, establishment of a campaign task force, procurement of an external reporting platform. Anti-discriminatory practice significantly impacts the Patient Safety Incident Response Framework by ensuring that responses to patient safety incidents are fair, equitable and address potential disparities in safety risks. It promotes a culture of inclusion and respects the rights of all patients and staff, contributing to better patient outcomes and a more just healthcare environment.

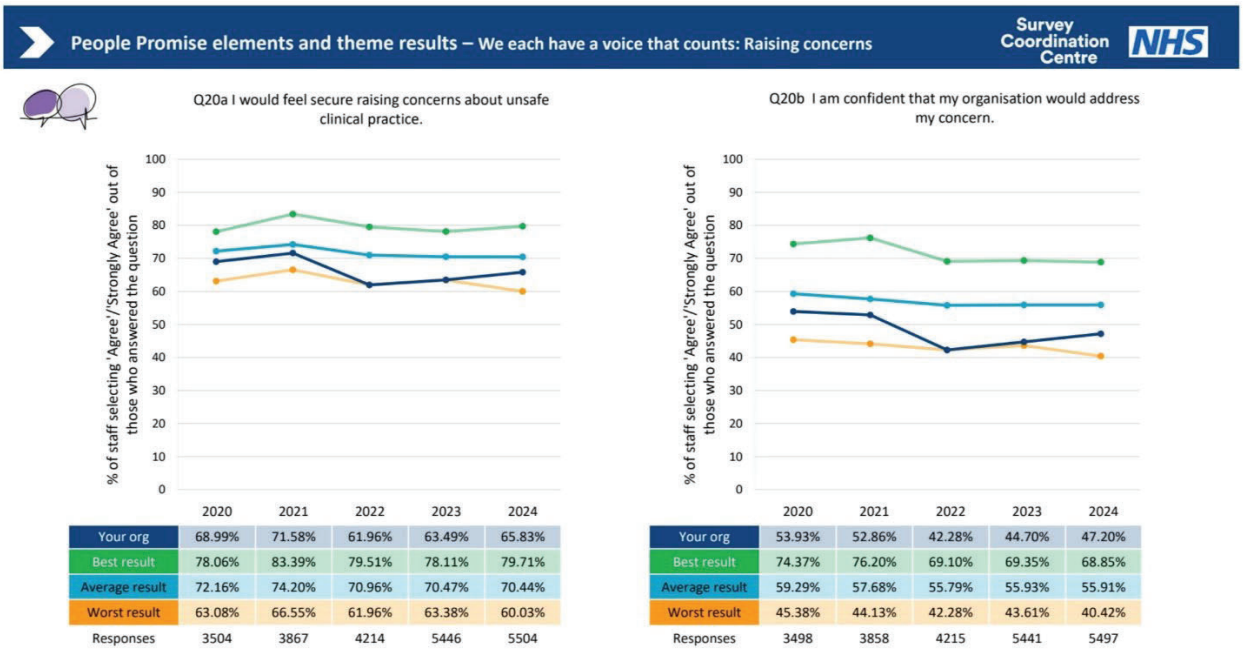
Our culture for raising concerns

The 2024 NHS Staff Survey, assesses employee experiences across seven People Promise elements. Each element is mapped to sub-scores and relevant questions. The results are scored on a 0-10 scale, where a higher score is more positive. The table below illustrates where our Trust scores (dark blue column) against the average Trust score (light blue column) and the best (green line) and worst (yellow line) Trusts.

For the purposes of this Account, we have highlighted 2 questions which demonstrates aspects of our safety culture. The results show that in 2024 we have moved from being in

the worst performing Trusts towards being an average scoring organisation. This is a sign that we are improving our reporting culture but we have a long way to go to be rated the same as the best organisations.

Table: Staff Survey scores for raising concerns and addressing concerns



Patient safety must be at the centre of our Trust's operating model, with our leadership team supported and held to account in creating a culture where staff feel safe to speak up.

Plans for Improvement in 2025-2026

The Safety Team and the People and Organisation Development Team will continue with delivering the training requirements and programmes which will in turn enable us to continue to build our safety culture within the Patient Safety Investigation Framework.

6. Quality Priority: Digital Systems Improvement

Radiology Results Acknowledgement and Alerting

Background

There are many benefits to digitising diagnostic results. We have made efficiency savings as we have stopped printing, distributing and filing paper results. We have removed delays in getting results into the patient records and there is now less chance of results getting lost or misfiled. However, when we had paper, a clinician used to “sign off” the result before it was filed. So, rather than doing a “sign off” before filing the result, we now need to “acknowledge” the result as soon as practicable after it is filed in the record. We call that “result acknowledgement” to signify it is done after the result is issued. That acknowledgement step in the digitised workflow is quite complex which is why we have set up an improvement workstream to tackle this. Acknowledging and acting upon test results is crucial for patient safety. Timely communication and verification that results have been acknowledged and acted upon, if necessary, helps prevent delays in care and ensures appropriate follow up, potentially minimising harm.

A prolonged delay in diagnosis can allow disease to spread and reduce treatment options and whenever there is harm, we report this as a safety incident under PSIRF and the most appropriate learning response is agreed at the Trust Patient Safety Review Panel.

How have we performed in 2024-2025:

Why is it important?

- **The Royal College of Radiologists guidelines state:**

  “It is the responsibility of the requesting Doctor and/or their clinical team to read and act upon the report findings and fail-safe alerts as quickly and efficiently as possible.”

- **Patient Safety:**

  Failure to follow up on test results can lead to delayed treatment, increased morbidity, and even mortality, particularly when abnormal results are not recognised promptly.

- **Improved Communication:**

  Result acknowledgements can improve the flow of information between clinicians and ensure that results are seen and acted upon.

- **Enhanced Accountability:**

  Systems that track acknowledgement and follow-up can help hold clinicians accountable for their actions.

- **Proactive Risk Management:**

  Acknowledging results helps identify potential issues early on and allows for timely intervention.

- **Reduced Inefficiencies:**
  Electronic result acknowledgement systems can streamline workflows and reduce time spent on manual processes.

Quality Summit

A quality summit was previously held in October 2023. A quality summit is a multi-disciplinary collaborative designed meeting to use collective knowledge and wisdom to explore a complex issue with the intention of bringing about measurable and sustainable improvement. Quality summits use a variety of systems based diagnostic approaches combined with quality improvement methodology. A number of issues were identified for improvement including, those listed below.

We were not always able to:

- Alert the correct consultant on our digital system.
- Run accurate reports stating which results have been acknowledged and which results have not.
- Have a safety net or second person identified for each consultant in the event that an alert has not been acknowledged within the set timeframe.
- Increase the frequency of alerts/reminders for critical and significant findings.
- Forward, within the digital system Communicator, an alert to the correct consultant / Specialty and Associate Specialty (SAS) doctor when the patient the alert refers to someone that is no longer in their care or has been transferred.
- Remove no concern or low-level concern result reminders as this made searching for serious concerns difficult.

Red Flags

A red flag group, led by the Deputy Medical Director and the Divisional Director for Quality and Nursing (DDQN) for the Diagnostics and Specialties Division, was convened to progress the issues for improvement. A detailed action plan is in place, for all the issues identified, and the implementation of solutions is coordinated and monitored by the group.

- We have made improvements to the Codes requiring acknowledgement, removing clinically unimportant addenda from requiring a response and moving to current Royal College of Radiologist guidance – Now 2 codes require a response:
    - Urgent Unexpected Result
    - Alert Code Cancer
- Changes to the radiology results alerting frequency and escalation was implemented on 07 January 2025.
    - The system will now continue to alert the report requester nine times, every two days, unless it is acknowledged (this frequency was chosen as this covers off 2 weeks leave and still alerts on first days back from leave to ensure visibility).
    - After this time, it will be escalated to a designated individual or shared mailbox, highlighting that it remains outstanding.
- Creation of a Business Intelligence dashboard that enables clinicians to monitor their outstanding reports, is the first stage of managing the risk associated with failing to action critical radiology findings.
    - Ongoing work to create reports/alerts to go out to clinical leads/department leads for review/safety checks.
- Work is continuing in relation to cleansing the results alerting distribution lists and escalation routes.
    - To support specialties in describing or instating appropriate governance practices around the monitoring of results a Standard Operating Procedure template is being produced to be shared with specialties.
    - This will help to ensure that the work in progress is maintained and managed locally by specialties.
- A harm review of the data being captured and reported by the Business Intelligence dashboard, related to a sample of retrospective unacknowledged reports is now also underway as this data will be used to understand the status of historic unacknowledged radiology reports and support a proposal for any further retrospective review of outstanding cases.

Unacknowledged radiology alerts recorded on the Business Information (BI) Dashboard as of 2 April 2025

Note since changes were implemented in December 2024 - January 2025 to types of alerts and frequency of repeat alerts, the percentage of unacknowledged alerts has reduced significantly from April – November 2024 - range 26-32.8% to 8.9-10.8% January /February 2025. These dashboards can now be easily reviewed and dealt with by individuals/teams as the dashboard is more accurate and easier to interrogate.

Plans for Improvement in 2025-2026

The Red Flag Group will continue to improve and reduce the risk of unacknowledged radiology results alerts and each Division must have a process in place for monitoring the compliance within each speciality.

The plan will include:

- Having a clear pathway in place for monitoring and reviewing radiology alerts that remain unacknowledged outside of the Trust agreed time frame for acknowledgment and that exceptions are acted on.
- Reporting of monthly status reports of unacknowledged radiology alerts through Divisional quality governance structures and onwards to the Quality Delivery Group.
- Taking action to review and address radiology alerts that remain unacknowledged outside of the Trust agreed time frame for acknowledgment to ensure that every effort is made to maintain patient safety.
- Building oversight systems that are held by the Clinical Lead/Specialty Triumvirate, with reporting via Service Line reviews to the Division senior leadership team.

7. Quality Priority: Clinical Vision of Flow (admission and discharge)

Background

In the NHS, “flow” generally refers to the movement of patients in a smooth and efficient manner. It is about optimising the patient’s journey from initial contact to discharge, ensuring timely care and reducing delays. Flow specifically refers to the way patients move through the different stages of care; such as emergency department to ward, from a doctor’s appointment to specialist consultation, or from hospital to home. Improving flow can lead to better patient outcomes, increased hospital capacity and improved satisfaction for staff and patients.

Clinical Vision of Flow Improvement Programme

The overarching goal of the Clinical Vision of Flow improvement programme is to make sure that every patient's journey is efficient, seamless, and centred on what’s right for them. We are committed to swiftly connecting our patients with the right clinical team and ensuring admission only when truly essential.

How have we performed in 2024-2025

Our Clinical Vision of Flow programme includes four clinically-led workstreams in the:

- Emergency Department,
- Assessment and short stay areas,
- General/ specialty areas, and
- Frailty Service.

Our ambitions will be to make the following improvements:

Workstream 1: Emergency Departments

- No ambulance handover more than 40 minutes in line with national standards.

Workstream 2: Short stay

- No patients in short-stay units for more than two nights. This includes the Acute Medical Units and the Surgical Assessment Unit.

- No patient in Same Day Emergency Care for more than eight hours.

Workstream 3: Specialty wards

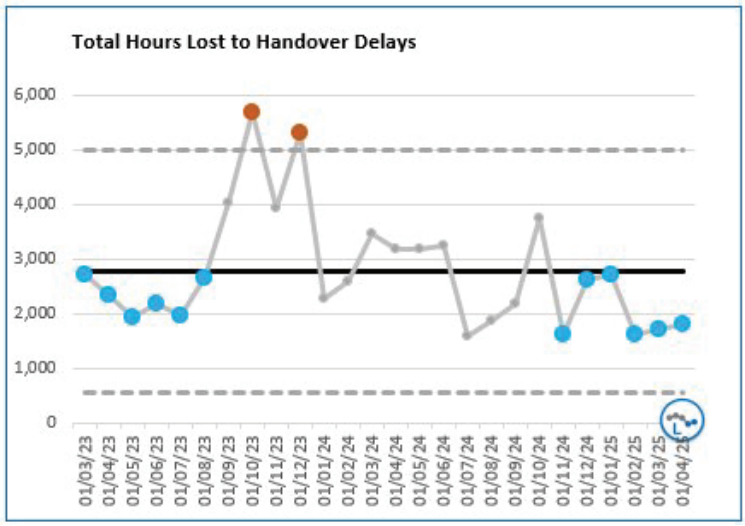
- No outliers e.g. no medical patients in surgical beds
- No boarded patients in corridors
- 80% of patients being discharged through the discharge lounge at Gloucestershire Royal Hospital.

Workstream 4: Frailty

- No escalation beds open within our Same Day Emergency Care services or frailty assessment areas

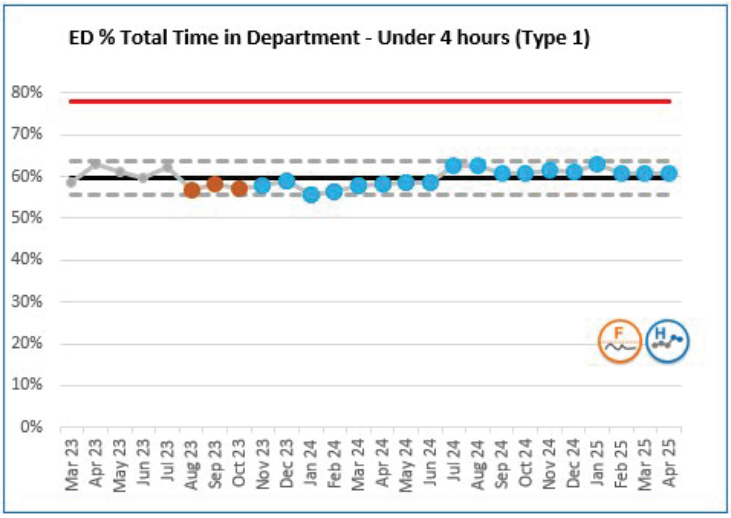
The below tables demonstrate our journey so far with the Emergency Department metrics/measures. The first shows the sustained reduction in the hours lost to ambulance handover delays, from 3200 per month in April 2024 to less than 2000 per month in March 2025.

Table: Total hours lost to handover delays



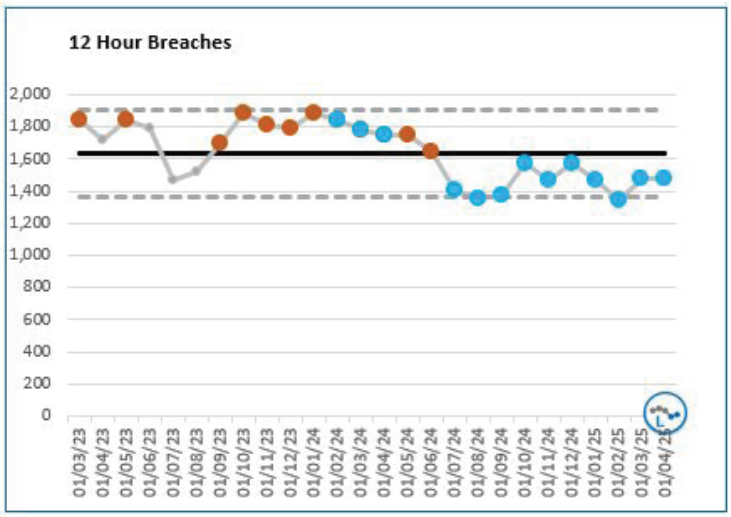
The next table demonstrates the sustained increase in the percentage of patients who are treated and discharged from the emergency department in under 4 hours.

Table: Percentage of Patients who were in the emergency department for under 4 hours



The next table demonstrates a sustained improved position in the reduction of 12-hour breaches.

Table: 12-hour breaches.



Emergency Department initiatives

We have:

- Introduced minor injury and illness walk-in patient streaming and rapid assessment, with refined protocols and action cards.
- Introduced a new and successful emergency department handover processes involving operation manager, site managers, and Community Assessment and Treatment Service attendance to facilitate escalations and referrals.

- Reviewed the long-established Pitstop process, for rapid assessment of patients with major illness and injury, including those who walk in. We have also reviewed the location of Pitstop to improve, safety and privacy and improve flow.

Assessment/short stay workstream initiatives

We have:

- Improved patient flow through rapid assessment processes and optimised short stay bed utilisation.
- Introduced a trial of multiple quality improvement projects, like the Advanced Care Practitioner-led Rapid Assessment and Patient Initiated Follow Up, which have been recognised for external presentation.
- Ongoing PDSA (Plan, Do, Study Act) cycles/trials that highlight continuous improvement, such as those for the Same Day Emergency Care initiatives and the new discharge models. These include nurse-led discharge, one-stop ward rounds and the rapid renal assessment and procedure unit.

Specialty workstream initiatives

We have:

- Illustrated how structured quality improvement projects across different wards have engaged multidisciplinary teams, incorporating training sessions, board rounds, and revamped discharge pathways.
- Improved emphasis on deconditioning initiatives to decrease patients' length of stay and enhance clinical outcomes.

Frailty workstream initiatives

We have:

- Provided optimal care through fewer patient moves and getting patients to the right place efficiently.
- Focused on the successful pilot of the Long-Term Services Supports for patients with chronic illness and the Frailty Assessment Unit, the launch of the Emergency Department Referral List on the Electronic Patient Records, and the accompanying updates (like the refreshed Frailty Dashboard).

These initiatives have resulted in significant operational benefits (e.g., saving bed days) and that future plans include a Direct Admission Bay and Frailty Same Day Emergency Care.

Plans for improvement for 2025-2026

- Each workstream has established clear milestones and actions. For instance, rolling out the new minors streaming process, finalising the Pitstop rapid review assessment protocol, scheduling and refining Emergency Department huddles, and expanding discharge models.
- Ongoing staff engagement and training efforts are required to sustain these improvements, ensuring everyone is up to date with the new pathways and protocols.
- Sustained improvement will be measured across all the programme metrics.

8. Quality Priority: Communication (Martha's Rule)

Background

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha, aged 13, would probably have survived had she been moved to intensive care earlier.

In response to this, and other cases related to the management of deterioration, the then Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule' – a patient safety initiative as part of a wider NHS strategy to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

Martha's Rule is an NHS England patient safety initiative designed to enhance the ability of patients and their families to escalate/communicate their concerns regarding clinical deterioration.

The 3 components of Martha's Rule are as follows:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

In May 2024 NHS England announced the implementation of Martha's Rule across 143 pilot sites across the country, with plans to expand to all providers, including community and mental health, in the coming years, as appropriate and subject to government funding. This is part of a wider programme of work to improve the management of deterioration, incorporating work to improve prevention, identification, escalation and response to acute deterioration. **Our Trust is one of the pilot Trusts.**

How have we performed 2024-2025

The Martha's Rule Implementation Group was established to oversee the delivery of this initiative.

The Martha's Rule Implementation Group is responsible for:

- Monitoring implementation progress and reporting to NHS England.
- Ensuring adherence to NHS clinical guidelines.
- Reporting progress, risks and issues to the Quality Delivery Group.

The project follows a phased delivery plan, covering different timeframes from October 2024 to April 2026.

Table: Implementation plan for Martha's Rule

Phase	Timeline	Status
Awareness and engagement	Oct - Jan 2024	Completed
Training and education	Jan - Mar 2025	In Progress
Pilot implementation	Feb - Apr 2025	Ongoing
Evaluation and refinement	Mar - Apr 2025	Planned
Full rollout and embedding	Apr 2025 Onwards	Planned

So far we have:

- Delivered teaching sessions and are conducting training in pilot areas to support staff in implementation of the 3 components of Martha's Rule.
- Assessed staff awareness and confidence and then will evaluate staff understanding, confidence, and use of patient wellness questions within the adult national early warning score.
- Enhanced patient awareness by distributing leaflets to increase patients' and families' awareness about the process.
- Mapped processes so that all Divisions can be fully compliant in staff having 24 hours a day escalation process.
- Enabled, in acute adult in-patient areas, for patient and carers to be able to escalate to the Acute Care Response Team since April 2024.
- Enabled the processes to be delivered in Paediatrics since July 2024 and the patient wellness question is embedded in the Paediatric Early Warning Score nationally.
- Prepared to pilot the maternity patient escalation process in April 2025.
- Planned for the Maternity Early Warning Score updates on BadgerNet, which are in December 2025, to include the patient wellness question.
- Noted that Neonates are out of scope for Martha's Rule as they have fully integrated parental feedback systems in place.

Table: Our progress so far with the 3 Martha's Rule components

Component	Paediatrics	Adults	Maternity
Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.	Nov 2023 national paediatric early warning score charts launched (we have been part of pilots since 2018)	Implementation of fields on adult national early warning score charts	To launch with new maternity early warning score charts Dec 2025
All staff will be able, at any time, to ask for a review if they are concerned that a patient is deteriorating, and they are not being responded to.	Complete July 2024	Since launch of Acute Care Response Team in 2017	Pilot process to be launched April 2025
This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.	Complete July 2024	April 2024	Pilot process to be launched April 2025

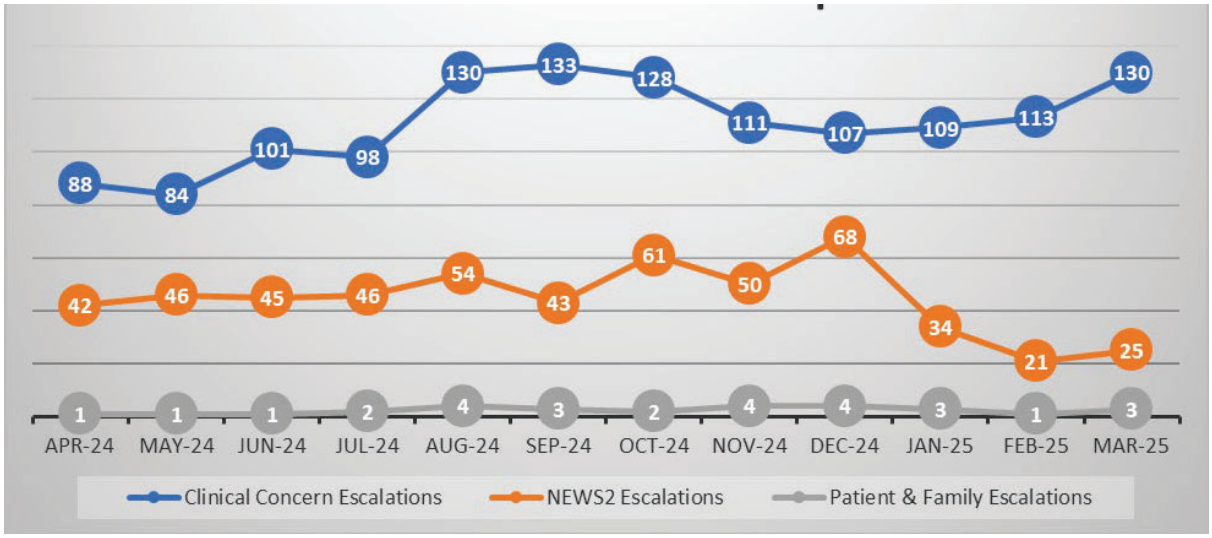
A deeper dive into adults, NEWS2 and Martha's Rule

Early warning scores are systems used in hospitals to identify patients at risk of deterioration, including sepsis, and to prompt timely intervention. In the adult areas we use a system called National Early Warning Score 2. Below are 2 charts that demonstrates Martha's Rule in action at our 2 main hospital sites Gloucestershire Royal Hospital and Cheltenham General Hospital.

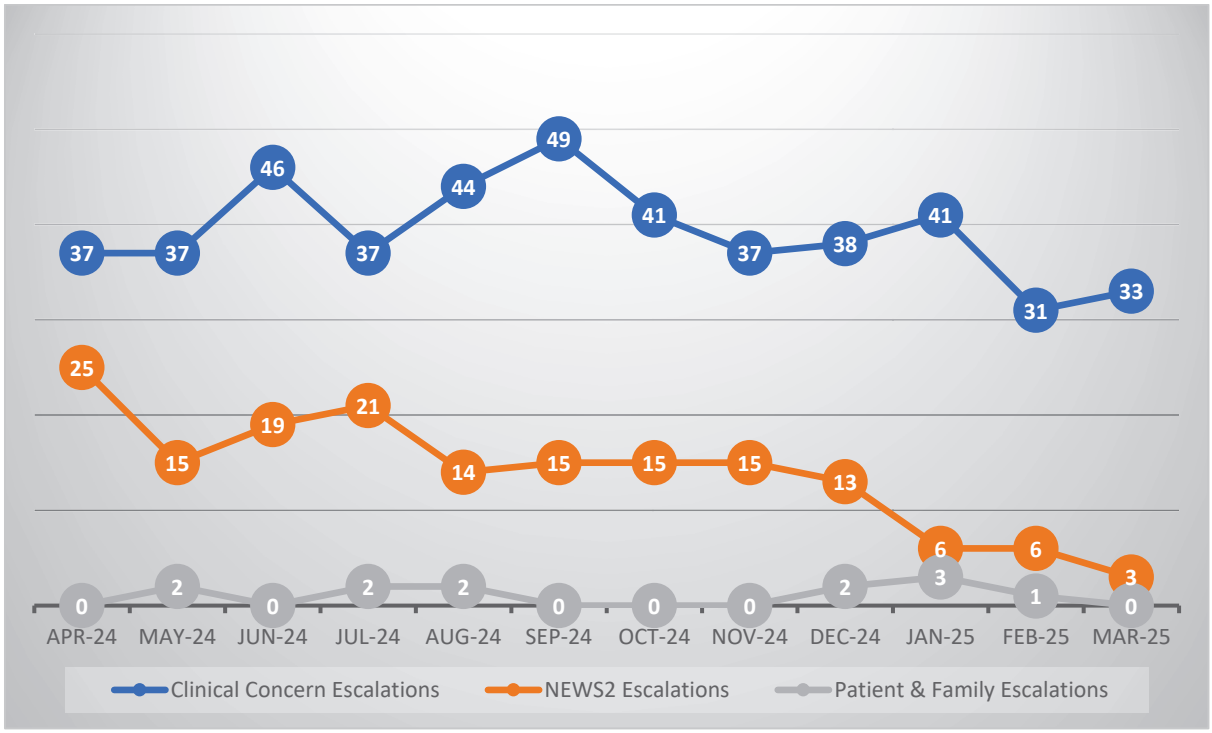
Clinical deterioration is detected by clinical staff every day, using their own skills and knowledge as well as our early warning scores. Each month we have approximately 110 staff escalations of concern from the Gloucester hospital and 40 staff escalations of concern from the Cheltenham hospital to the Acute Care Response Team due staff recognising the need for urgent clinical review and action. The Acute Care Response Team review the patient and make a plan of care for the next steps. Also, early warning scores may alert the clinician to calling the Acute Care Response Team and over the year the scores triggered staff to call the team about 45 times a month at Gloucester and 14 times a month at Cheltenham. Lastly, we have captured data for our patient/family/carer escalations and we have approximately 2/3 calls from Gloucester hospital and 1 call from Cheltenham directly from patients a month to the

Acute Care Response Team as part of the “Martha’s Rule” programme we have been running.

Graph: Escalations of care due to concerns of clinical deterioration by early warning scores, staff concerns and patients/families/carers at Gloucestershire Royal Hospital



Graph: Escalations of care due to concerns of clinical deterioration by early warning scores, staff concerns and patients/families/carers at Cheltenham General Hospital



Learning to date:
Patients and carers are experts in their own clinical condition and often notice signs of deterioration before clinical observations change.

Examples of escalations:

- A family member identified “soft signs” of type 2 respiratory failure prior to any change in NEWS2 score or clinical indication. The process was activated and the patient was reviewed and then admitted to a Critical Care bed.
- A family member identified new confusion in a frail patient with dementia, the patient did not recognise their son, a full review was carried out and with reassurance there was no need for a change in treatment plan.
- A parent challenged the discharge of their son in the emergency department as they had identified morbidity that had not yet established itself in clinical observations and the child was assessed and not discharged.

Plans for Improvement for 2025-2026

The following actions will be carried out to ensure continued progress and sustainability.
We will:

1. Expand training and awareness initiatives and integrate Martha’s Rule training into mandatory staff induction.
2. Enhance data reporting and develop a Business Intelligence (BI) dashboard to track compliance with escalations and outcomes.
3. Refine escalation pathways to address barriers identified through the pilot phase evaluations.
4. Formalise governance integration and embed Martha’s Rule oversight into existing patient safety structures.
5. Continue ongoing patient engagement and use patient stories to improve our communication materials.
6. Continue to feed our learning into the communication safety priority.
7. Collaborate with the Emergency Departments to establish if Martha’s Rule can be implemented safely there.

Part 2.2 Statements of Assurance from the Board

Health Services

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist healthcare for a population of more than 650,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal Hospitals, so that we can make the best use of the expertise and specialist equipment needed. Our Trust employs around 8000 staff. Our success depends on the commitment and dedication of our colleagues. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible.

Our patients are cared for by more than 2,512 registered nurses and midwives, 736 Healthcare Assistants and 1042 medical staff. 249 Healthcare Scientists and 474 Allied Health Professionals. In addition, our estates are looked after by 910 NHS Gloucestershire Managed Services staff, Further details, including our organisational chart can be found on our website.

https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/

Health Inequalities

Health inequalities are preventable, unfair and unjust differences in health across the population and between groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact health and wellbeing. These are sometimes referred to as the wider determinants of health. For example, people living in areas of high deprivation, with low educational attainment and in poor quality work would be at even greater risk of experiencing health inequalities.

Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. NHS trusts play a crucial role in addressing health inequalities by focusing on providing equitable access to services and ensuring patients receive a consistent level of care. People living in more deprived areas are more likely to experience poor health, shorter life expectancy and less good access to health and care services due in part to poor housing, lower incomes, and lower health literacy (knowing how to understand and navigate the health and care system). Despite being a relatively affluent county, within Gloucestershire there are pockets of significant social deprivation with 12 neighbourhood areas that are within the 10% most deprived nationally.

Our population is ageing but those from more deprived neighbourhoods are spending increasingly more time in ill health and people are developing multiple long-term conditions at younger ages than before. Whilst there is a stark difference in life expectancy between the most and least disadvantaged men and women. In Gloucestershire, male life expectancy at birth is 79.8 years and female life expectancy at birth is 83.6 years. In 2018-2020, males born in the most deprived deciles of Gloucestershire could expect to live 7 years and 7 months less than those born in the most affluent areas. Females born in the most deprived areas could expect to live 7 years and 10 months less than those born in the most affluent areas.

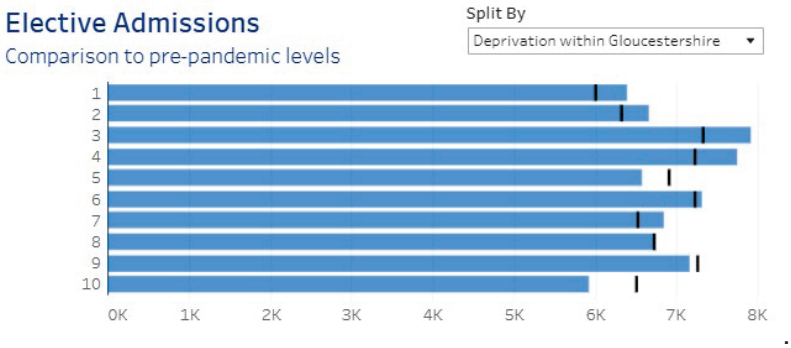
Gloucestershire is characterised by a comparatively small population of ethnic minorities (excluding white minorities). The 2021 Census showed the population of ethnic minorities (excluding white minorities) accounted for 44,765 people or 6.9% of the population; this was much lower than the England percentage of 19.0%. The population of Gloucestershire is, however, becoming increasingly diverse. The population of ethnic minorities (excluding white minorities) increased by 63.8% between 2011 and 2021, from 4.6% to 6.9% of the population. The number of people classed as ‘other white’, which includes migrants from Europe, increased by 55.1%, from 3.1% of the population in 2011 to 4.5% of the population in 2021.

NHS organisations have a legal duty to collect, analyse and publish information on health inequalities every year. NHS England’s Statement on Information on Health Inequalities sets out how organisations should exercise this duty and what information should be published. This includes a list of indicators which organisations should report against. The indicators are aligned to key health inequalities priorities for the NHS, which includes the five priority areas for addressing healthcare inequalities and the Core20PLUS5 approach to reducing inequalities for adults and children and young people.

Elective Recovery

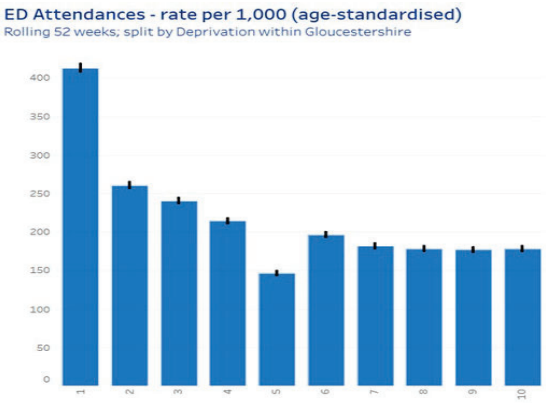
- Elective activity for children’s services is in-line with pre-pandemic levels
- Adult activity is below pre-pandemic levels by 7.4%
- No differences noted by gender or ethnicity

- However, we are carrying out more activity for patients living in the most deprived parts of the county, where we are delivering in excess of pre-pandemic levels.

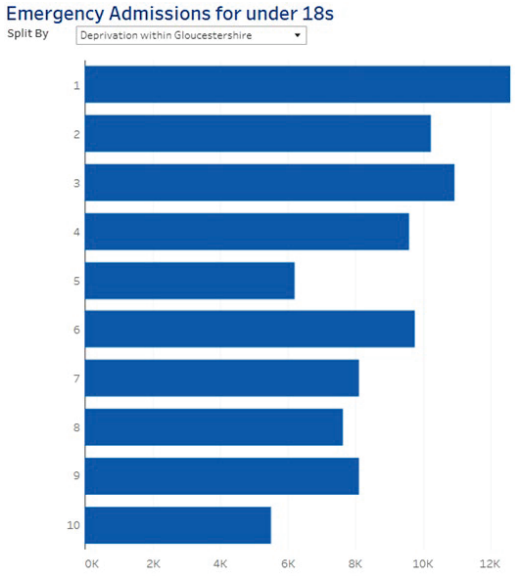


Urgent & Emergency Care

- There are consistent inequalities identified in urgent care. The 10% most deprived patients are significantly more likely to attend the Emergency Department.
    - IMD 1 (10% most deprived): 414 attendances per 1,000 population
    - IMD 10 (10% least deprived): 178 attendances per 1,000 population



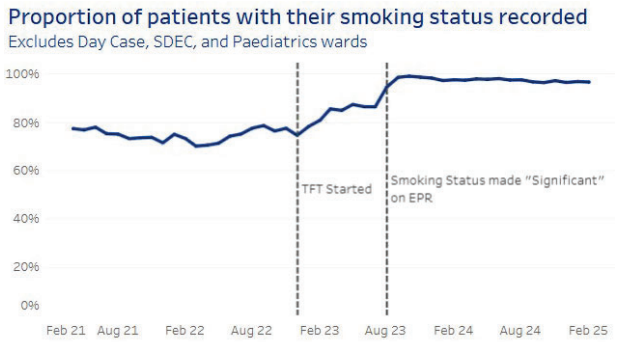
- Similar pattern of attendances by deprivation for children, although the difference between the most and least deprived is less stark.



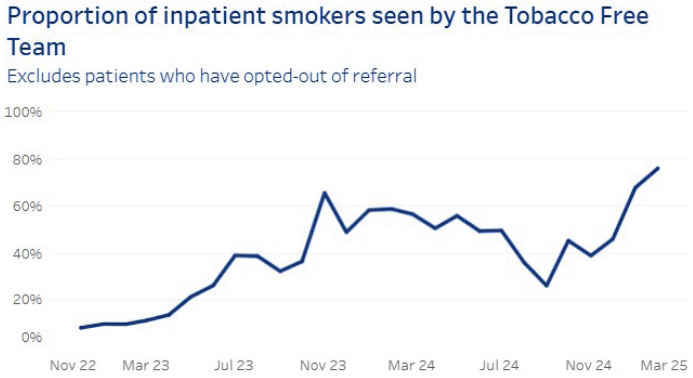
- No differences noted by gender or ethnicity

Smoking Cessation

- 97% of inpatients have their smoking status recorded on admission, compared to 74% prior to the introduction of the Tobacco Free Team

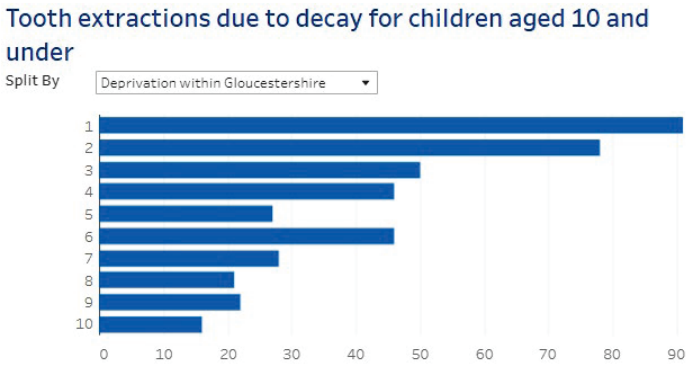


- Last month we saw a record number of patients. As of Feb 2025, 75% of inpatient smokers were offered support from the Tobacco Free Team

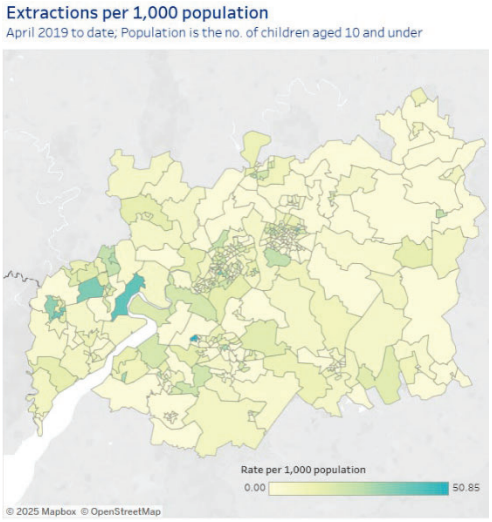


Children's Oral Health

- There is a stark difference in the rate of tooth extractions (due to tooth decay) being carried out between the most and least deprived parts of the county



- No differences noted by gender or ethnicity
- This is a more significant issue in certain parts of the county, in particular the Forest of Dean. Coleford, Cinderford & Newnham have the highest rates of tooth extractions in the county (around 40 extractions for every 1,000 children aged 10 and under)
- There are also pockets of inequalities in other areas:
    - Matson & Robinswood (Gloucester)
    - Oakley (Cheltenham)
    - Parts of Stonehouse (Stroud)



Health Inequalities Group

Over the past year, a Health Inequalities Working Group has been established, with the Executive Director for Improvement and Delivery taking strategic leadership to advance the Trust's commitment to addressing health inequalities. A comprehensive strategic approach and workplan are currently being developed, with collaboration from both internal and external stakeholders to drive meaningful progress in this critical area.

Information on Participation in Clinical Audit

From 1 April 2024 to 31 March 2025, 61 national clinical audits and 6 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides. During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2024/25 are as follows:

Audit Title	Eligible	Participated	Status
BAUS Data & Audit Programme: a) BAUS Penile Fracture Audit	Y	Y	Completed
BAUS Data & Audit Programme: b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Y	Completed
BAUS Data & Audit Programme c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Y	Completed
Breast and Cosmetic Implant Registry	Y	Y	Ongoing
Case Mix Programme (CMP)	Y	Y	Ongoing
Child Health Clinical Outcome Review Programme (NCEPOD)	Y	Y	Ongoing
Cleft Registry and Audit NEtwork (CRANE) Database *	N	Y	Ongoing
Emergency Medicine QIPs:b) Care of Older People	Y	N	N/A
Emergency Medicine QIPs:c) Time Critical Medications	Y	Y	N/A
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP): b) National Audit of Inpatient Falls (NAIF)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP): c) National Hip Fracture Database (NHFD)	Y	Y	Ongoing
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Y	Y	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK)	Y	Y	Ongoing
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): a) National Diabetes Core Audit. Includes: Care Processes and Treatment Targets, Complications & Mortality, Type 1 Diabetes, Learning Disability and Mental Health, Structured Education, Prisons and Secure Mental Health Settings	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): e) National Pregnancy in Diabetes Audit (NPID)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): g) Gestational Diabetes Audit	Y	Y	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	Ongoing
National Audit of Dementia (NAD)	Y	Y	Ongoing
National Bariatric Surgery Registry	Y	Y	Ongoing
National Audit of Metastatic Breast Cancer (NAoMe)	Y	Y	Ongoing
National Audit of Primary Breast Cancer (NAoPri)	Y	Y	Ongoing
National Bowel Cancer Audit (NBOCA)	Y	Y	Ongoing

Audit Title	Eligible	Participated	Status
National Kidney Cancer Audit (NKCA)	Y	Y	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing
National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	Y	Ongoing
National Ovarian Cancer Audit (NOCA)	Y	Y	Ongoing
National Pancreatic Cancer Audit (NPaCA)	Y	Y	Ongoing
National Prostate Cancer Audit (NPCA)	Y	Y	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (CRM)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y	Ongoing
National Child Mortality Database (NCMD)	Y	Y	Ongoing
National Comparative Audit of Blood Transfusion: a) National Comparative Audit of NICE Quality Standard QS138	Y	Y	Ongoing
b) National Comparative Audit of Bedside Transfusion Practice	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	Ongoing
National Joint Registry	Y	Y	Ongoing
National Major Trauma Registry [Note: Previously TARN)	Y	Y	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing
National Neonatal Audit Programme (NNAP)	Y	Y	Ongoing
National Obesity Audit (NOA)	Y	Y	Ongoing
National Ophthalmology Database (NOD): a) Age-related Macular Degeneration Audit	Y	Y	Ongoing
National Ophthalmology Database (NOD): b) Cataract Audit	Y	Y	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	Ongoing
National Perinatal Mortality Review Tool	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP) a) COPD Secondary Care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP) c) Adult Asthma Secondary Care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP) d) Children and Young People's Asthma Secondary Care	Y	Y	Ongoing
National Vascular Registry (NVR)	Y	Y	Ongoing
Perioperative Quality Improvement Programme	Y	Y	Ongoing
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Hemovigilance Scheme	Y	Y	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA) **	Y	N	PTP
UK Cystic Fibrosis Registry	Y	Y	Ongoing
UK Renal Registry Chronic Kidney Disease Audit	Y	Y	Ongoing
UK Renal Registry National Acute Kidney Injury Audit	Y	Y	Ongoing

Ongoing – relates to continuous data collection
NYR – data collection has not yet started
PTP – plan to participate in the next round

* This work is carried out in a clinic in Bristol.
** Unable to participate in 2024/25 due to centralisation of the acute take from Cheltenham to Gloucester hospital.

The reports of the above national clinical audits were reviewed (or will be reviewed once available) by the provider in 2024/25.

Audit Title	**Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?**
British Association of Urological Surgeons (BAUS) Data & Audit Programme: a) BAUS Penile Fracture Audit	This audit will collect data on all patients undergoing surgical repair for penile fracture between 1 April 2022 and 31 March 2024. Data submission will take place from 1 March to 31 March 2025 inclusive. Data submitted and awaiting results.
BAUS Data & Audit Programme: b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Launched in early 2024. The audit collected data on all patients undergoing Radical Nephroureterectomy for suspected Upper Tract Urothelial Cancer between 1 July 2022 and 31 July 2023, and subsequent follow-up data including the number of patients who had post-Radical Nephroureterectomy bladder Mitomycin-C and the number of patients receiving adjuvant chemotherapy for T2 or higher disease. Data submission took place between 1 April and 21 May 2024. Results presented and discussed at the team QI meeting in November 24.
BAUS Data & Audit Programme c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Audit will take place during 2024/25. Data for this audit will be collected on all patients undergoing transurethral resection of bladder tumour (TURBT) for a new diagnosis of bladder cancer, for whom TURBT was performed between 1 April and 31 May 2024 inclusive. Data submission will take place from 1 November to 13 December 2024 inclusive. Data submitted Dec 24 and we are waiting results.
Breast and Cosmetic Implant Registry	The Breast and Cosmetic Implant Registry (BCIR) was opened on 10/10/2016. It captures the details of all breast implant procedures completed in England, Scotland and Northern Ireland by both the NHS and private providers. Individual surgeons' access National Database for data entry, and have access to individualised feedback on request.
Case Mix Programme (CMP)	The Case Mix Programme (CMP), launched in 1994, is the national clinical audit of patient outcomes from adult critical care. Data are available to review via a public facing webpage, and the most recent comparative unit public report (2023/24) showed the Trust was in line with expected results
Cleft Registry and Audit NEtwork (CRANE) Database CRANE Database 2024 Annual Report	CRANE is a national registry and clinical audit. It evaluates and reports on the delivery of cleft services to children born with a cleft lip and/or palate in England, Wales, Northern Ireland and Scotland. Registry information is presented for children born in 2021-2023 and audit outcomes at 5 years of age are presented for children born in 2015-2017. Report posted: 12 December 2024 The Trust does not run a cleft service, any required details are sent to the Bristol cleft team for submission
Emergency Medicine Quality Improvement Projects (QIPs): Care of Older People	The Trust is not participating in this QIP at present due to departmental priorities. Other Care of the Elderly QIPS are ongoing including improving documentation of Clinical Frailty Scores.
Emergency Medicine QIPs: Time Critical Medications	In the Emergency Department (ED), a time-critical scheduled medication is essentially a medicine that the patient is already on, all doses of which will need to be prescribed and administered in the ED throughout their stay. Data will be collected nationally for people living with Parkinson's who

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	take oral levodopa medication and for patients living with Diabetes Mellitus on insulin.
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 has published a new report based on the first year of care for children and young people after a first paediatric assessment between 1 December 2021 and 30 November 2022 in England and Wales. This report contains a number of key findings relating to the involvement of appropriate professionals, mental health, appropriate assessment and care planning. The Trust continues to participate in the audit.
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	The Trust has recognised Falls as a Patient Safety priority through the Patient Safety Incident Response Framework (PSIRF) process, and as such has set up an annual Falls Quality Summit process to bring together all relevant audit data and other metrics to support improvement initiatives. Currently improvement work is being undertaken looking at the electronic documentation, suitable areas available to complete 'hot debriefs' following falls and the recording of information of these hot debriefs in order to pull together any learning associated with the incident occurring, whether harm was present or not. The Trust continues to participate in the audit.
Falls and Fragility Fracture Audit Programme (FFFAP): b) National Audit of Inpatient Falls (NAIF)	NAIF audits the delivery and quality of care for patients over 65 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales. As of January 2025, this will remain at people aged 65 and over, but include all fractures and Intracranial Head Injuries. The 2024 National Audit of Inpatient Falls (NAIF) report states that falls prevention activity should not focus solely on older people's wards, finding that nearly half of all inpatient femoral fractures (IFFs) occur on general medical wards (almost twice the proportion of IFFs that happen in older people's wards). To address the potential for harm caused by hospital-acquired deconditioning, this report presents a new approach to risk factor assessment that focuses on promoting activity to ensure each patient is fit to move as safely as possible. The Trust Falls Prevention team provide ongoing and regular training for all members of the multidisciplinary health care team with the aim of keeping staff competent and confident to carry out assessments. This includes management of post-fall checks and prevention of deconditioning. Initiatives are underway to improve the process and documentation of 4AT assessments, by the Admiral Nurse.
Falls and Fragility Fracture Audit Programme (FFFAP): c) National Hip Fracture Database (NHFD)	The National Hip Fracture Database (NHFD) was established to measure quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform. The Trust uploads data from all hip fracture cases admitted to GRH. These data are analysed locally and discussed at monthly governance meetings.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	NHFD provides 3 monthly update reports allowing us to benchmark our Trust against other hospitals, these reports are also discussed at governance meetings
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	The Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) programme, aims to improve healthcare for people with a learning disability and autistic people. LeDeR aims to: • Improve care for people with a learning disability and autistic people. • Reduce health inequalities for people with a learning disability and autistic people. • Prevent people with a learning disability and autistic people from early deaths. LeDeR summarises the lives and deaths of people with a learning disability and autistic people who died in England in annual reports. The Trust continues to participate and reviews national recommendations to identify quality improvements.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK)	MBRRACE-UK conducts national surveillance and investigation of the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK. By investigating these deaths, MBRRACE-UK hopes to prevent similar deaths or serious complications in the future, to support the delivery of safe, equitable, high-quality and patient-centred maternal, newborn and infant health services. *This year themed reports have been published on;* • Enquiries into Maternal Deaths from thrombosis and thromboembolism, malignancy and ectopic pregnancy 2020-2022, and morbidity findings for recent migrants with language difficulties. • The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death The Trust reviews MBRRACE UK recommendations to identify any action plans including quality improvement work. Report findings are shared on the MDT PROMPT study day to ensure National learning is shared amongst the team. Improvements in Health inequalities is a key focus in the Trust's maternal death action plan.
National Adult Diabetes Audit (NDA): a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	The NDA helps improve the quality of diabetes care by enabling participating NHS services and organisations to: • assess local practice against National Institute for Health and Care Excellence (NICE) guidelines • compare their care and outcomes with similar services and organisations • identify gaps or shortfalls that are priorities for improvement • identify and share best practice • provide comprehensive national pictures of diabetes care and outcomes in England and Wales Through participation in the audit, local services are able to benchmark their performance, identify where they are

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	performing well, and improve the quality of treatment and care they provide. The Trust has continued to participate in the NDA. Reports and Trust data are reviewed at Diabetes Team Operational Meetings and the Gloucestershire Diabetes Clinical Program Group.
National Adult Diabetes Audit (NDA): d) National Diabetes Inpatient Safety Audit (NDISA)	NDISA records the details of any adult who has one of four avoidable complications which can occur in inpatients with diabetes; Severe inpatient hypoglycaemia, Diabetic **Ketoacidosis** (DKA), Hyperglycaemic Hyperosmolar State (HHS) and Diabetic foot ulcer. Linking with other health datasets allows the identification of high-risk demographics which enables the development of proactive processes to reduce the occurrence. The Trust continues to submit to NDSIA Harms on harms that are reported, errors are discussed by the Diabetes Team.
National Adult Diabetes Audit (NDA): e) National Pregnancy in Diabetes Audit (NPID)	NPID is part of the NDA and measures the quality of pre-gestational diabetes care against NICE guidelines and the outcomes of pre-gestational diabetic pregnancy. The audit will answer the following three key questions: • were women with diabetes adequately prepared for pregnancy? • were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother? • did any adverse outcomes occur? The Trust continues to participate with ongoing data collection. Data is published nationally and reviewed at the annual Diabetes in Pregnancy conference.
National Adult Diabetes Audit (NDA): g) National Gestational Diabetes Mellitus (GDM) Audit	The National GDM Audit is a 3-year programme, part of the NDA. The focus on the first and second year was to raise awareness of the audit and to engage with maternity services to encourage improved completion of the data items required in the MSDS. Data that is routinely collected for maternity services nationally via the Maternity Services Data Set (MSDS) and linkage with other existing NHS datasets, is being utilised. In 2025 a dashboard will be available for services to see their performance in the key metrics relating to GDM. In the future there will be a national report.
National Audit of Care at the End of Life (NACEL)	The National Audit of Care at the End of Life (NACEL) has published its latest report. Based on 7,620 case note reviews, 3,600 quality survey responses and 11,143 completed staff reported measures in England and Wales, this report sets out the findings of the fourth round of NACEL, which took place in 2022. The NACEL action plan has been updated based on the 22/23 audit results and following presentation at the Hospital

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	Mortality Group, Grand Round & the End of Life (EOL) Delivery Group
National Audit of Dementia (NAD)	The National Audit of Dementia (NAD) audit relates to the quality of care received by people with dementia in general hospitals. A report on *Care in General Hospitals 2023-2024*, underscores the need for a continued strong focus on governance, monitoring and oversight of dementia care. Trust QIs in progress include; • Working with expert by experience groups on transformation work on Guiting Ward. Two activity coordinators have been recruited to help with cognitive stimulation, we are in the process of recruiting enhanced care support workers too • Improved Datix reporting of falls, pressure ulcers, violence and aggression, complaints and the ability to highlight dementia, delirium or another vulnerability • A 'bespoke training package for staff • Ongoing work on ensuring Trust hospitals are Dementia Friendly environments, including current transformation work on Guiting Ward.
National Bariatric Surgery Registry	The National Bariatric Surgery Registry is the result of a collaboration between ALSGBI (Association of Laparoscopic Surgeons of Great Britain and Ireland), AUGIS (Association of Upper Gastrointestinal Surgery), BOMSS (British Obesity & Metabolic Surgery Society) and Dendrite Clinical Systems. The key objective of the registry is to accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include reportage on weight loss, co-morbidity and improvement of quality of life.
National Audit of Metastatic Breast Cancer (NAoMe)	The NAoMe aims to report on all patients diagnosed with metastatic breast cancer in NHS hospitals in England and Wales. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NAoMe webpage for review. The current focus of the audit is on improving the completeness of key data items
National Audit of Primary Breast Cancer (NAoPri)	The purpose of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people diagnosed with primary breast cancer in England and Wales, and to support services to improve the quality of care for these people. As above, data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NAoPri webpage for review. Indicators suggest that GHT is performing better than the nation average for patients receiving breast cancer surgery within 12 months of diagnosis and patients who were recorded as having contact with a Clinical Nurse Specialist (CNS)

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National Bowel Cancer Audit (NBOCA)	Tim Cook and Jonathan Cutting listed as leads. Participation is confirmed, however the quality of the data uploaded from the Trust is in question. The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed for the first time with bowel cancer in NHS hospitals in England and Wales, to be able to improve the quality of the care that people receive. NBOCA has been a mandatory national audit since 2010.
National Kidney Cancer Audit (NKCA)	The purpose of the National Kidney Cancer Audit (NKCA) is to evaluate the patterns of care and outcomes for people diagnosed with kidney cancer in England and Wales and to support services to improve the quality of care for these patients. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NKCA webpage on a quarterly basis. All indicators have been found to be within control limits when compared with national data
National Lung Cancer Audit (NLCA)	The NLCA supports NHS lung cancer services in England and Wales to improve the quality of care for people diagnosed with lung cancer by providing information on patterns of care and patient outcomes. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NLCA webpage on a quarterly basis. All indicators have been found to be better than the national average, or within control limits
National Non-Hodgkin Lymphoma Audit (NNHLA)	The purpose of the National non-Hodgkin lymphoma Audit (NNHLA) is to evaluate the patterns of care and outcomes for people diagnosed with non-Hodgkin lymphoma (NHL) in England and Wales, and to support services to improve the quality of their care. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NNHLA webpage. Although not all indicators can be viewed for GHT due to low case volumes, where available each indicator is above the national average, or within the 95% confidence level.
National Ovarian Cancer Audit (NOCA)	More than 7,000 women in the UK are diagnosed with ovarian cancer every year, but we know that outcomes vary considerably across the country. This new audit, drawing on the work of a feasibility pilot audit which began in 2019, will produce granular information on diagnosis, treatment and surgery, to allow us to assess how we can improve care in England and Wales, and create better results.
National Pancreatic Cancer Audit (NPaCA)	The audit will be a really important tool, helping us to accelerate national efforts to improve the care and treatment of patients diagnosed with pancreatic cancer.

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	It will gather real world information from databases across England and Wales, allowing better comparisons to be made, and revealing where shortfalls need to be addressed. Pancreatic cancer is one the least survivable cancers, with virtually no improvement seen in survival rates in the UK over 40 years from the 1970s. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NPaCA webpage and available for regular review, though care should be taken in regards to the low case numbers.
National Prostate Cancer Audit (NPCA)	The National Prostate Cancer Audit (NPCA), which is part of the National Cancer Audit Collaborating Centre (NATCAN), has published a report on care received by men diagnosed with prostate cancer in England and Wales from 1 January 2019 to 31 December 2023. Published: 09 Jan 2025 and discussed at the team monthly QI meeting March 25
National Cardiac Arrest Audit (NCAA)	We subscribe to The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. The aims of the audit are to: improve patient outcomes; decrease incidence of avoidable cardiac arrests; decrease incidence of inappropriate resuscitation as well as to promote adoption and compliance with evidence-based practice. All NCAA reports are reviewed as a department as well as quarterly at the Deteriorating Patient & Resuscitation Committee. The reports are also available on the Deteriorating Patient & Resuscitation Committee shared drive so that they can be accessed and be reviewed by appropriate clinicians with access. We also publish the Audit data within the department newsletter issued across the Trust as well as being accessible on the Intranet, staff notice boards, and shared with department heads for dissemination. The Trust continues to share the results at Induction sessions and Mandatory updates. Any inappropriate CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned.
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	NHFA collects data on patients with an unscheduled admission to hospital in England and Wales who are discharged with a primary diagnosis of heart failure. The audit aims to drive up the quality of the diagnosis, treatment and management of heart failure, to improve mortality and morbidity outcomes for heart failure patients. The specialist input for the annual report April '23- March '24 is 61.5% The recent initiatives include: Establishment of a nurse-led inpatient heart failure service in GRH (February '24)

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	Establishment of a 'virtual ward' to manage ambulatory heart failure patients within a virtual environment at home rather than in hospital. The new service enabled an increase in hours available for auditing. Current data shows the specialist input since the nurse lead service started is now 88.6% thus achieving BPT.
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (NACRM)	NACRM collects information about all implanted cardiac devices and all patients receiving interventional procedures for the management of cardiac rhythm disorders in the UK. The audit aims to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures. Trust reports are reviewed at the Arrythmia Group meeting and with the clinical lead and pacing operators, where Trust data and scope for quality improvements are reviewed alongside national recommendations from the audit.
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	MINAP contains information about the care provided to patients who are admitted to hospital with acute coronary syndromes. Quality of care is assessed against a set of quality improvement metrics derived from national and/ or international standards and guidelines. We are attaining the new data entry submission targets. This annual report covers April 23- March '24 Includes data from CGH before the department move to GRH in Feb '24 We met the target of over 70% of STEMI patients DTB. We align with the National level of 51% of eligible NSTEMI patients undergo angiography with 72 hours We met the target of 90% of patients receiving an in-patient echo and achieved the target for secondary prevention medication.
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	NCAP collects data on all activity carried out in NHS hospitals and a selection of private hospitals throughout the UK. This provides an overview of the delivery of PCI services in the UK including activity and trends, and reporting on several specific quality improvement metrics, derived from national and/or international standards and guidelines. The Trust currently meets recommendations, specifically in the use of adjunctive imaging in LMS intervention and use of newer antiplatelet agents in the STEMI setting. Day case PCI for elective work is the default as was recognised by the GIRFT report in March 2023 and rates for the unit (87.4%) continue to be well above the national average of 71%, improving access to PCI for local population without impacting IP patient care/bed use. NICE recommended antiplatelet drug use in STEMI cases is higher at 76.8% than national average of 40%. 30-day mortality at 1.71% is lower than national average for matched activity/volume over the last reporting period.
National Child Mortality Database (NCMD)	NCMD aims to understand patterns and trends in child deaths where an event before, or around, the time of birth had a significant impact on life, and the risk of dying in

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	childhood. Over the past 12 months this has included thematic reports on; - Learning from deaths of children with a learning disability and autistic children - Child deaths due to asthma or anaphylaxis The Trust continues to participate in the NCDM and reviews local data at Perinatal and Paediatric Clinical Governance meetings. Action plans are in progress for both of this year's reports. The Trust works closely with the ICB in these respects.
National Comparative Audit of Blood Transfusion: a) National Comparative Audit of NICE Quality Standard QS138	Report published at the end of March – review completed and ongoing dissemination to the team Key objectives • Provide the opportunity to evaluate local evidence of progress towards compliance with the four quality statements in the NICE Quality Standard for Blood Transfusion since the 2021 audit • Provide data to hospital teams to allow their understanding of what steps they can take to implement PBM and to measure their effectiveness in improving patient car • Allow the transfusion community, including the National Blood Transfusion Committee, to benchmark the progress of PBM and its effect on improving patient outcomes
b) 2024 National Comparative Audit of Bedside Transfusion Practice (re-audit)	Key objectives • The key aim of this re-audit is to determine whether the current British Society of Haematology guideline 'Administration of Blood Components' (2017) is being followed and to determine if there has been any improvement in compliance compared to previous audit cycles. It also looks to assess whether any specially developed documentation or technologies used to support bedside transfusion practice have a beneficial effect. The audit seeks to understand the reasons for any areas for non-compliance, to help identify the barriers and facilitators of good practice. Action Plan • Blood transfusion Champions to meet, discuss & plan to improve practice. • SL to meet with Senior managers & discuss Action Plans. • Re-audit in next 12 months. • Waiting for the outcome of audit on National Guidance on improving practice.
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients over the age of 16 in rheumatology departments across England and Wales. Data collected and assessed includes waiting times, time to treatment, clinical response to treatment, and patient-

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	reported outcomes. Performance is measured against NICE quality standards (QS). Last year The Trust was a negative outlier for QS2 and QS3. Improvements in data collection and data accuracy are in progress, with a system for a new staff member entering the information on the NEIAA website for any newly diagnosed EIA. This will be reviewed with the upcoming NEIAA data report due in the Spring.
National Emergency Laparotomy Audit (NELA)	The latest NELA report was published in October 24. Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results.
National Joint Registry National Major Trauma Registry [Note: Previously TARN)	A new portal has been developed following the national outage of the previous version. The data backlog is currently being entered both retrospectively and prospectively.
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large-scale project established to provide data and information to those working in and using maternity services. It helps us understand the maternity journey by bringing together information about. In 2024 a report was published on 'Evaluating hospital and crisis care for perinatal mental health'. The Trust continues to participate in the NMPA and reviews reports alongside local data to highlight areas of potential service improvement.
National Neonatal Audit Programme (NNAP)	NNAP assesses whether babies admitted to neonatal units receive consistently high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes. The audit reports key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels and other important care processes. Trust data is submitted nationally and reviewed quarterly, alongside recommendations from the report to identify any scope for local quality improvement work. Current actions are in progress to improve data recording of intraventricular haemorrhage (IVH) and an audit project underway which has led to the introduction of continuous temperature monitoring from delivery to admission into the neonatal unit (NICU).
National Obesity Audit (NOA)	This audit looks primarily at obesity outcomes, treatment and access to weight management services and uses hospital episode statistics data alongside GP information to create a picture of obesity across the country. Dashboards are updated on a quarterly basis for review.
National Ophthalmology Database (NOD): a) Age-related Macular Degeneration Audit	The most recent AMD report was published in 2023
National Ophthalmology Database (NOD): b) Cataract Audit	The NOD webpage provides information on posterior capsular rupture (PCR) which is the most common complication during cataract surgery. Data is from the FY 22/23 and outcomes for GHT are within expected limits.

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National Paediatric Diabetes Audit (NPDA)	The NPDA collects information on the care and diabetes outcomes of all children and young people receiving care from paediatric diabetes teams in England, Wales and Jersey. The sole aim is to provide information that leads to an improved quality of care for those children and young people living with diabetes. Reports and recommendations are reviewed by the Trust Paediatric Diabetes Team Since 2021/22 data was submitted, there has been changes to the process; NPDA platform now enables live data capture, this means data is now input at the time of practice by clinicians. Twinkle has been approved and will be implemented next year, which will improve data validity. At the end of each quarter, checks are done to ensure that patients have had their health checks completed on time and any patient who hasn't had their checks will be followed up. It is expected that this will be reflected in next year's audit results.
National Perinatal Mortality Review Tool (PMRT)	PMRT aims to support objective, robust and standardised local reviews of care when babies die. This is to provide answers for bereaved parents and their families about whether the care that they and their baby received was appropriately safe and personalised or whether different care may have changed the outcome. The second aim is to ensure local and national learning results from review findings to improve care, reduce safety-related adverse events, and prevent future baby deaths. The PMRT is designed to support the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths. For about 90% of parents, the PMRT review process is likely to be the only hospital review of their baby's death that will take place The Trust participates in PMRT data reporting and inputs all stillbirths and early neonatal deaths. All parental feedback is gathered using locally adapted PMRT parental engagement materials and is shared and discussed monthly. National reports are disseminated at Maternity Clinical Governance meetings. Local PMRT summary reports are completed and shared with the Maternity Delivery Group/Trust Board. Actions are reviewed at monthly PMRT meetings.
National Respiratory Audit Programme (NRAP) a) COPD Secondary Care	NRAP's COPD secondary care workstream includes a continuous clinical audit of people admitted to hospital with flare-ups of COPD, and a snapshot audit of the organisation and resourcing of care. Data is measured against the key performance indicators recommended by NRAP to support good practice in the delivery of acute asthma and COPD secondary care. The Trust are continuing to undertake the NRAP organisational audit. A QI is underway in offering smart phone apps to COPD patients to help them self-manage their condition. The business intelligence spreadsheets tracking

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	admissions is continuing to support the identification of patients with COPD.
National Respiratory Audit Programme (NRAP) c) Adult Asthma Secondary Care	NRAP's adult asthma secondary care workstream includes a continuous clinical audit of people admitted to hospital with asthma attacks, and a snapshot audit of the organisation and resourcing of care. The audit is continuous and collects information on adults admitted to hospital in England and Wales with asthma attacks. Snapshot organisational audits collect information on how services are organised and what resources are available to them at a given point in time. The Trust continues to participate in this audit, combining data for both sites. The data is used to identify improvement priorities which can drive improvements to care.
National Respiratory Audit Programme (NRAP) d) Children and Young People's (CYP) Asthma Secondary Care	NRAP's children and young people's asthma secondary care workstream includes a continuous clinical audit of people admitted to hospital paediatric services in England and Wales with asthma attacks, and a snapshot audit of the organisation and resourcing of care. This audit aims to collect information on children and young people aged 1-18 years, admitted to hospital paediatric services with an asthma attack in England and Wales. Data is measured against key performance indicators recommended by NRAP to support good practice in the delivery of acute asthma care. The Trust has completed data for the organisational audit for this year. Outcomes from previous years' reports include staff working with CYP and families continuing to be appropriately trained to explain the risk of asthma exacerbations linked to smoking and indoor air quality and making referrals to smoking cessation specialist services. A formal transition service is in place for from child to adult asthma services. The Paediatric Respiratory service is reviewing options to meet recommendations on dedicated in-patient time for asthma.
National Vascular Registry (NVR)	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at specialty meetings
Perioperative Quality Improvement Programme	The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data to improve patient outcomes across the UK, reducing variation in processes of care and supporting implementation of best practice.
Sentinel Stroke National Audit Programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) measures how well stroke care is being delivered in in England, Wales and Northern Ireland. The clinical audit measures the processes of care provided to stroke patients in inpatient and community settings against evidence-based standards. The organisational audits measure the structure of stroke services in acute hospital settings and community settings.

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	The Trust SSNAP data is reviewed on a regular basis by ED, radiology, stroke nurses, consultants and the wider stroke team. Trust Improvements include: 1. Improved GRH pathway to reduce delays and missed thrombolysis/thrombectomy 2. Improved access to CT/CT angiograms and MRI scans to improve time to diagnosis, especially valuable for stroke mimics. 3. Reduction in vacancies in therapy for Physio, OT, SALT and psychology 4. Activity coordinator roles on Woodmancote ward to improve wellbeing and rehab of ward patients 5. Community Neuro Rehab team now embedded to increase community therapy offer and improve access to stroke Early Supported Discharge team 6. Work with ward nurses to improve training and management of continence and low mood/anxiety 7. Move of HASU into a dedicated ward (Hatherley) with therapy room and co-located ambulatory area for SDEC reviews (January 2025) 8. Ongoing work with the ICB/ICS reviewing the system pathway and resource 9. Business cases drafted for additional resource to provide 7-day therapy cover and ACPs
Serious Hazards of Transfusion (SHOT): UK National Hemovigilance Scheme	Since 1996 SHOT has been collecting and analysing anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are put into its annual report which is then circulated to all the relevant organisations including all of the reporting hospitals. Reports reviewed and actioned, but difficulties have been highlighted due to the infected blood inquiry report stating that NHS trusts should have a method of monitoring / evidencing the SHOT recommendations and if / how they are implemented. These recommendations are for the Transfusion Practitioner to review and implement, which is impossible given the very high-level nature and content of what SHOT are asking for. This has been fed back to SHOT, and a gap analysis is in progress for escalation at Quality Delivery Group due unfeasibility of the recommendations
Society for Acute Medicine Benchmarking Audit (SAMBA)	SAMBA is a national audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a benchmark for each Trust with the national average. The last audit took place on 20th June 2024. The Trust was unable to participate due to it occurring at around the time of

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	the centralisation the acute take from CGH to GRH, and being understaffed to do the audit. The aim is to ensure a full audit for 2025. Ongoing actions following last year's SAMBA include; - Further increase in AMU consultant body by 2.55 as of this month. - Amending job roles (Cinapsis consultant now doing 2 hours PTWR in ED) to reduce time to PTWR for patients admitted out of hours - Good data from medical assessment zone in AMU showing this stream is working to reduce patients in ED, expanded from 8 beds to 12 in past year.
UK Cystic Fibrosis (CF) Registry	The purpose of the UK CF Registry is to improve the health of people with cystic fibrosis. This includes; - helping people with CF and their families understand CF - giving clinical teams the evidence they need to improve the quality of care - monitoring the safety and effectiveness of new treatments for cystic fibrosis - providing data for research to find out the best ways to treat cystic fibrosis The annual CF Registry Conference in October is attended by the Trust. The annual report provides regional feedback and highlights opportunity for quality initiatives.
UK Renal Registry Chronic Kidney Disease Audit	The UK Renal Registry (UKRR) collates data from kidney centres and hospital laboratories to improve the care of patients with kidney disease in the UK. Data collection includes cases of acute kidney injury (AKI) in primary and secondary care in England and cases of advanced CKD in secondary care, not on KRT, in England and Wales. Data is also collected about children on dialysis or with a kidney transplant. The data is analysed against the UK Kidney Association's guidelines The Trust continues to submit data, with a quarterly annual validation and query resolution. Registry data is used for quality assurance and feeds in to other audit and quality improvement activity and is discussed in other meetings, such as GIRFT, regional Kidney Quality Improvement Partnership and the renal regional network.
UK Renal Registry National Acute Kidney Injury Audit	Acute kidney injury (AKI) is a sudden deterioration of kidney function, and is associated with about 100,000 deaths every year in hospital in the UK. The UK Renal Registry (UKRR) collects data on approximately 500,000 people with an AKI each year. The objectives of the audit are; - To demonstrate the impact of AKI on the English population, through analysis of the AKI rate and outcomes at the level of the Integrated Care Boards. - To show the different demographics and outcomes of various groups of people with AKI, but in particular, people who are entirely cared for in the community versus those

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	who are admitted to hospital with their AKI, or develop it during their stay. The Trust continues to participate and registry data is used for quality assurance and feeds in to other audit and quality improvement activity along with the UK Renal Registry annual report.

Local audits and Quality Improvement Projects

In the Trust 207 local clinical audits and Quality Improvement projects were registered in 2024/25 and these are reviewed and actioned locally. In addition, 41 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy during 2024/25.

Some examples of actions associated with audits and completed Quality Improvement projects are as follows:

Aim: To increase the number of discharge summaries sent from GHNHSFT to community pharmacies via PharmOutcomes to 500 by Oct 2024. Changes: Focus on Frailty sending DMS referrals for all patients on their ward due to COTE wards contributing to the largest proportion of discharges, sending DMS referrals via EPMA following launch, creating inclusion criteria for patients suitable for DMS referrals and sharing this with the pharmacy department, creating a SOP and sharing with department. Results: GHNHSFT have increased the average number of discharge summaries sent on Pharm Outcomes from 120/month in Sept 2022 to an average of 397/month, achieving the CQUIN target of >1.5%. Next steps: Statistics will be monitored, reminder emails to send DMS referrals if numbers begin to decline. Working with community pharmacies to improve their ability to complete the DMS referral in primary care.
Aim: to improve trainee self-development time uptake to 80% (of recommended guidance) by April 2024 Changes: Afternoon SDT allocated by a Care of the Elderly (CotE) ward-based trainee to other trainees whenever ward staffing larger than minimum, new consultants to ward informed and educated about trainee SDTs, afternoon SDT allocated by CotE rota coordinators with department-wide senior approval Results: increase in trainee SDT uptake from 0.4 hours/trainee/week to 2.3 hours/trainee/week by the end of the third PDSA cycle Next steps: re-evaluate trainee SDT uptake on a regularly basis to see if any further changes are necessary and disseminate our work to other departments across the country
Aim: to reduce use of single use cups by 50% in 3 months in ED Changes: staff education and raising awareness: green initiatives day, staff mug secret Santa, reusable cups introduced Results: disposable cup numbers reduced by average of 75%, monthly spending on cups reduced by 44% (incl. purchasing disposable as well as replacing lost reusable cups) Next steps: to remove all reusable cups from ED, consider viability of domestic housekeeper to reduce workload for nursing team
Aim: complete a frailty score assessment for 10% of Myelofibrosis patients who are over the age of 65 years, over a five-week period. Changes: staff training, extra appointments scheduled, Rockwood scoring tool added to Infoflex – score >4 requiring a further follow up appointment at 12 weeks. Results: 30% of MF patients with frailty score recorded consistently, exceeding target of 10%. Implementation of all patients attending clinic face to face to have weight recorded on monthly basis. Next steps: roll out frailty score assessment for Myelodysplastic and AML patients. Search for frailty scoring tool that can be used on patients <65 years

Aim: To reduce the monthly rate of postpartum haemorrhage>500mls from 41% to below the national average PPH rate of 25% of births and major obstetric haemorrhage >1500mls in Gloucestershire Royal Hospitals NHS Foundation Trust from 5% to 3% in 6 months

Changes: compliance with completion of antenatal risk assessment at booking at 36 weeks on Badgernet, compliance with admission/ intrapartum risk assessment, compliance with emergency management proforma,
evidence of early identification of risks and distribution of learning through Comms lead and multi-disciplinary team talk, Postpartum Haemorrhage / Major Obstetric Haemorrhage audit

Results: Major Obstetric Haemorrhage rates now below national target (5% to 2.9%) Postpartum Haemorrhage rate 33%.

Next steps: business case for blood product management submitted, weekly audit of Postpartum Haemorrhage, focus on reduction in PPH, and reduction of loss during instrumental deliveries, introduction of oxytocin infusion for 1000mls and ongoing bleeding regardless of cause, ongoing clearing of backlog with Microsoft forms.

Participation in Clinical Research

Research and Innovation are recognised as important pillars in enabling the NHS to provide quality care for its patients. Research active organisations are known to provide better care for patients and more stimulating environments for staff to work in. We need to ensure that R&I are integral to the day-to-day business of the Trust as they provide the organisation, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for.

In 2024/25 the Research and Innovation team has recruited to 80 open National Institute for Health and Social Care portfolio studies. This is a slight drop from 2023/24 where the team supported 100 open studies, but this is not a concerning drop, as activity is following national trends across the portfolio.

Of these studies, 15 (19%) are commercially sponsored trials, another slight drop from the 21% in 2023/24. However, this is not concerning considering the slight reduction in open, recruiting studies.

Despite this drop in the number of open portfolio studies, the Research and Innovation team has recruited 1,850 participants to these open studies which is a slight increase on the year-end total of 1,736 for 23/24. The total for 2024/25 may increase slightly over the next few weeks following this report as some central uploading of recruitment figures by sponsors can be delayed.

We are regularly approached to act as a site for commercially sponsored studies and continue to express an interest in all studies that the Research and Innovation team and Clinical Teams are able to support. Not all studies are suitable for the Trust's population and we are facing some issues opening studies with the current pressure on the Pharmacy Manufacturing unit, but we are monitoring these pressures and meeting regularly with Pharmacy to work on solutions. This activity has been achieved against a backdrop of a major reorganisation and staffing issues in the team, including a complete change in the senior management structure within Research and Innovation.

We also have exciting new developments in our medical technology partnerships and these innovations will be led by focussing on understanding and addressing the most critical challenges the NHS faces. In particular, tackling the issues the impact on patient experience, resource allocation and health outcomes. The Research and Innovation Team have successfully bid for and secured funding to evaluate an AI Tool designed to review prostate scans to reduce the need for invasive biopsies, as well as NHS England "Net-Zero" bids to evaluate projects designed to improve and reduce the carbon footprint in the areas of hand-surgery and midwifery. Although these projects are at an early stage, we anticipate being able to report outcomes for these studies in the next 12 months.

We continue to explore all opportunities to submit funding/grant bids for innovation and research and the team is currently waiting for the outcome of a first stage Decarbonisation project application worth several million pounds.

Care Quality Commission

The Trust continues to be registered with Care Quality Commission and the overall Trust rating remains at 'Requires Improvement'. Care Quality Commission last undertook a well-led inspection in 2022 (12-13 April and 14-16 June) and the overall rating for the Trust did not change in 2024/2025.

Enforcement notice - maternity

The Care Quality Commission inspected Maternity Services at the Gloucestershire Royal Hospital's site in March 2024. On 9 May 2024, the Trust was notified of Care Quality Commission's decision to serve an enforcement notice under section 31 of the Health and Social Care Act. The Care Quality Commission imposed conditions on our registration in respect of the maternity service and they took this action as they believed a person will or may be exposed to the risk of harm if they did not do so. Eight conditions were imposed, and the Trust have provided the Care Quality Commission with the required monthly update reports with the maternity service dashboard (data). Significant progress has been made with 2 out of the 8 conditions now fully met and 6 conditions nearing completion to be fully met. The findings of the Care Quality Commission inspection were of significant concern to the Trust board and the Executive Lead for Maternity Services. Support has been provided to the service and regular briefings on progress have been provided by the service leads at every public board session since the notice was received.

Inspection reports published

After significant delays, on the Care Quality Commission's behalf, the final maternity service inspection report from the March 2024 inspection was published in January 2025. The Maternity service retained an inadequate rating received in 2022. Also in January 2025, the Care Quality Commission published the Emergency Department report from an unannounced inspection in December 2023 and the service retained a "requires improvement" rating.

Inspection activity

There has been only one Care Quality Commission inspection in medicine and oncology services at the Cheltenham General site in July 2024 and the Trust are still awaiting the publication of the final report (it is likely that the service will be rated as "good" overall as this was the rating in the final draft of the report).

Information Governance Incidents

Information Commissioner's Office reportable IG incidents.

There have been three incidents reported to the Information Commissioner's Office since Apr 2024

ICO & Datix ref	Date reported to ICO	Incident	ICO action
37242 INC1939	24/05/2024	Personal identifiable data shared in error, in response to a FOI request. A request was processed through whatdotheyknow.com. The information was provided to whatdotheyknow.com by an attached spreadsheet. The information that was intended to be shared was included on a displayed worksheet tab. A hidden sheet included a pivot table and access to additional patient level data that had been used to create the high-level aggregated data in the displayed sheet. The FOI team where not aware of this hidden data and attached the spreadsheet in its entirety.	Information Commissioner's Office acknowledgement ref: IC-0235-2024 Follow-up questionnaire sent to Information Commissioner's Office in Aug 2024. Information Commissioner's Office confirmed no further action in Sep 2024.
38033 INC5491	16/07/2024	A member of staff took photo of email of referral on his phone in order to facilitate taking bloods listed in email. Blood tests include HIV and hepatitis screening. Patient identifiers thought to have been excluded, but name and local hospital identifier were captured. After work accidently posted on Facebook	Information Commissioner's Office acknowledgement ref: IC-320567-T5G2 No further contact since.
38618 INC8402	10/08/2024	Member of staff with extensive access to the electronic staff record system ESR found to have accessed a number of their managers and colleagues home addresses. Motive for	Information Commissioner's Office acknowledgement ref: IC-324998-D6S6 Follow-up questionnaire sent to Information Commissioner's Office in Aug 2024.

		access has been raised as a safeguarding concern as the staff in question is currently the subject of a disciplinary investigation, members of staff whose address has been accessed include line management, and the appointed lead investigator and witnesses involved in the disciplinary investigation	No further contact since.

Non-Information Commissioner's Office reportable Information Governance incidents.

The following have been submitted as Data Security & Protection (Information Governance) incidents to Datix since Apr 2024.

Classification	**Number**
Confidentiality	146
Integrity	31
Availability	7

Learning from Deaths in the NHS

Background

Learning from deaths, especially in healthcare, is crucial for improving patient care, preventing future avoidable deaths and supporting bereaved families.

- All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners.
- Any deaths that demonstrate identified triggers have a structured judgment reviews (SJR) which is a detailed examination of the circumstances surrounding the death, aiming to identify any issues in care and areas for improvement.
- All mortality reviews are reported through Specialty Mortality and Morbidity meetings and all specialties receive individual monthly data on SJR performance
- There are national requirements for reviews for identified groups of patients. Learning Disability Reviews, Child Death Reviews, Perinatal Deaths, and associated learning reports and national audits are conducted.

How have we performed during 2024-2025

- Hospital mortality rate for elective admissions is 0.5%, with the national average at 0.6%.
- Hospital mortality rate for non-elective admissions is 3.1%, with the national average at 3.4%.
- The current SHMI (Summary Hospital-level Mortality Indicator) is 1.15, with 2855 observed deaths and 2485 expected deaths.
- All serious incidents have action plans based on identified learning.

Family Feedback

- Positive feedback is consistently high regarding the care provided.
- Negative feedback trends relate to communication of next steps.

Plans for Improvement in 2025-2026

- Continuous improvement processes will monitor the mortality data and feedback from families and staff.
- National Campaigns such as ‘Dying Matters Week’ will be utilised for a Trust wide focus on what matters to patients and their families.

- Leads from the End-of-Life Improvement Group will attend the Trust wide Morbidity and Mortality meetings in order to implement areas for improvement in real time.
- Data quality work will be undertaken with the clinical coding for patients' co-morbidities to ensure an accurate for hospital mortality rates.

Statement from NHS doctors in Training Rota Gaps

Context and Background

Rota gaps remain a significant challenge for both doctors in training and the wider NHS workforce, with direct impacts on trainee wellbeing, morale, and patient safety. These gaps often result in longer hours, increased workload intensity, and additional responsibilities for those in post, while also risking the quality of care delivered to patients. Within our Trust, the prevalence and duration of rota gaps continue to vary by specialty, with medicine and acute care areas experiencing the largest and most persistent shortages.

The national context reflects a similar picture: recent surveys and reports highlight that rota gaps of 15–20% are now common in key specialties, with many gaps lasting three to six months or longer. The General Medical Council and Health Education England have both increased their focus on rota gap monitoring, with new questions in the National Training Survey to better capture the impact of rota design and workload on education, training, and patient care.

Monitoring, Delivery, and Assurance

The Guardian of Safe Working continues to provide quarterly reports to the Trust Board, highlighting the scale and impact of rota gaps and exception reporting across all specialties. These reports, combined with annual Quality Panel feedback from NHSE appointed trainees, offer valuable insights into the lived experience of doctors in training and the effectiveness of mitigation strategies.

The National Training Survey, now enhanced with specific questions on rota design and workload, provides a comprehensive nationwide overview, capturing feedback from both NHSE-appointed trainees and locally employed doctors. This data is critical for benchmarking our performance and identifying areas for improvement.

Rota Gap Mitigation Strategies for 2025/26

Building on last year's efforts, the Trust has expanded and refined its mitigation strategies to address rota gaps more sustainably:

- **Advanced Practice Roles:** Continued expansion of advanced clinical practice roles, including Advanced Care Practitioners, Physician Associates, and Advanced Nurse Practitioners, particularly in high-gap specialties, to support service delivery and reduce reliance on doctors in training.
- **International Medical Graduates:** Ongoing targeted recruitment of International Medical Graduates, with a focus on long-standing hard-to-fill gaps, supported by structured onboarding and mentorship.
- **Locally Employed Doctors:** Further integration of Locally Employed Doctors into the workforce, with pathways for permanent backfill in rotas with chronic vacancies.
- **Flexible Workforce Models:** Enhanced use of collaborative staff banks and digital workforce platforms to improve shift coverage and reduce agency reliance.

- **Workforce Planning:** Closer collaboration with NHSE Education & Training to ensure trainee numbers are matched to service demand, and to advocate for increased flexibility in training pathways.

Challenges for 2025/26

Despite these efforts, several challenges persist:

- **Rising Less Than Full Time Working:** The proportion of Rising Less Than Full Time trainees continues to increase, reducing available whole-time equivalents and complicating rota planning.
- **High Maternity and Parental Leave Rates:** Ongoing high rates of maternity leave and other statutory absences further reduce workforce availability.
- **Trainee Amendments:** Growing numbers of trainees requiring amended duties or being removed from on-call rotas for health or personal reasons.
- **Data and Communication Issues:** Continued misallocation of doctors under incorrect cost codes, especially in medicine, and communication breakdowns between rota leads, medical staffing, and finance.
- **Community Placement Pressures:** Challenges in arranging community placements and GP supervision due to part-time working, practice mergers, and retirements.

Next Steps for 2025/26

- **Permanent Backfill:** Assess and build business cases for permanent International Medical Graduates / Locally Employed Doctors backfill in rotas with persistent gaps.
- **Integrated Workforce Planning:** Strengthen coordination between medical staffing, finance, rota leads, and Post-Graduate Medical Education to proactively address gaps and ensure accurate workforce data.
- **Role Expansion:** Continue expanding Advanced Clinical Practitioners, Physicians Associates, and Advanced Nursing Practitioner roles to move towards a self-sustaining workforce, particularly in critical departments.
- **Trainee Allocation:** Work with NHSE to ensure ongoing adjustment of trainee numbers and allocation to balance workload and service needs.
- **Digital Solutions:** Leverage digital rostering and workforce management platforms to improve transparency, compliance, and proactive gap identification.

Summary

In summary, the Trust is taking a comprehensive, multi-pronged approach to address training rota gaps, combining workforce innovation, targeted recruitment, and digital solutions. However, the increasing trend towards Less Than Full Time Trainees working and persistent workforce shortages highlight the need for urgent, coordinated, and sustainable workforce planning. Addressing these challenges is essential to maintain a safe, supportive training environment and ensure the delivery of high-quality patient care in 2025/2026 and beyond.

Veteran Aware Hospital

Background

Gloucestershire Hospitals NHSFT was re-accredited as a Veteran Aware hospital in August 2022, recognising the work and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community.

Performance 2024/25

This year saw the beginning of a new model of Veteran Aware support for our patients. The Patient Advice and Liaison Service had two staff train specifically as Armed Forces Champions, through the Sussex NHS Armed Forces Network. They join a network of staff in the Trust who are Armed Forces Champions in the Human Resources department, Ward Clerk Lead, Improvements Lead, Head of Quality and Regulation Team. The Service Champions support the Armed Forces community by raising awareness of both the moral and contractual obligations under the Armed Forces Act 2021, the Armed Forces Covenant, the NHS Constitution and the Health and Social Care Act.

The Veteran Aware work has focussed on improving the quality of the patient experience by filtering the results from the Friend and Family test for Veterans and Armed Forces personnel. The results demonstrated a 2% average below the Trust average of 90%, but given the small numbers of Veterans and Armed Forces personnel, this was not statistically significant. New Veterans and Armed Forces ward posters were distributed to wards to encourage patients to advise us of their Veteran or Armed Forces status. New patient information leaflets have been produced to advise staff and patients of the NHS approved pathways for mental health, physical health, homelessness and the judicial system, as well as the main charities that provide emotional and practical support to Veterans, Armed Forces personnel and their families. Banner scrolls are on display in out-patient departments across the Trust to encourage patients to advise us of their Armed Forces status.

The patient administration system has been amended to capture all Veteran, Armed Forces serving personnel and their immediate partner/spouse and child/dependents, in order the Trust can understand the Armed Forces demographic and ensure no-one is disadvantaged in healthcare. There were 1563 veterans registered in the adult acute in-patient electronic records for the year 2024-2025. The capture rate of Armed Forces personnel in acute care remained steady at 86%, a 10% improvement on previous years. The average length of stay for Armed Forces patients at 7, 14 and 21 days was the same as for non-Armed Forces patients.

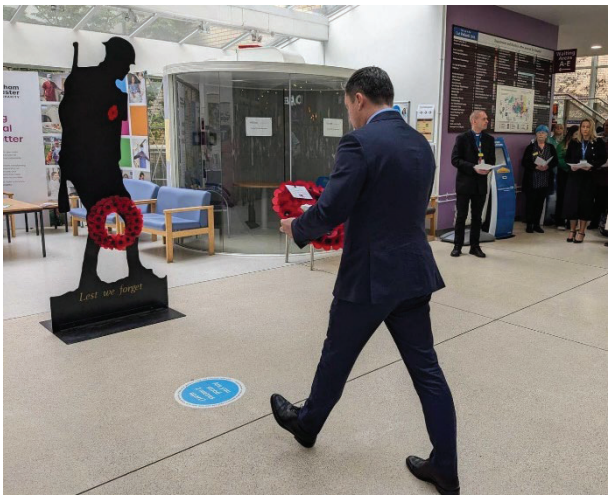
Trust induction training has been updated to advise that the Patient Advisory and Liaison Service team have been trained by the NHS Armed Forces Network, as Service Champions, and will be the first point of contact for a Veteran or Armed Forces patient need. NHS e-learning for Veteran Aware responsibilities has been requested on all staff training, to comply with the Armed Forces covenant.

The Trust has continued to support training and development of employees from the Defence Medical Services in placements in the emergency department and critical care clinical areas. The Trust also supports visits to Open Days from the 243 Multi Role Medical Regiment (previously Field Hospital) from Bristol and engages with them over the annual NHS-Military Challenge.

The Armed Forces Lead continues to represent the Trust on the Gloucester County Council Armed Forces Network forum, with other Health and Social Care organisations. The Trust celebrated Armed Forces week by our new Chief Executive signing the Armed Forces Covenant. Remembrance Day was commemorated by ornamental displays in the Atrium and a service of remembrance in both the Gloucester and Cheltenham hospitals.

Improvements achieved for 2024/2025

- The re-establishment of the Armed Forces Network enhances both staff and patient experience of Armed Forces and Veteran Aware work throughout the Trust
- The Step-Into-Health programme to actively encourage Armed Forces leavers into the NHS is in progress and the Armed Forces Lead organises informal visits and conversations for prospective Armed Forces applicants.
- Analysis of the Patient Administration System data to capture patients in paediatrics and maternity, where there are known health inequalities for Armed Forces serving personnel
- Publication of the Veteran Aware Policy
- Re-accreditation for the Employer Gold Employer Recognition Scheme id underway.



- 12 Armed Forces Consultant clinical placements are supported, as well as critical care nursing placements and emergency care placements for medics and combat medical technicians.

Plans for 2025/6

Significant outreach with Local Government, Integrate Care Board and Gloucestershire Health and Care Trust partners, already established through the Armed Forces Network.

Continued support of the Armed Forces Charity Sector, through invites to the Armed Forces Network.

Build up our own Armed Forces Champions forward liaison and engagement through the Armed Forces Network

Continued support through the LGBT Inclusion Network for our Armed Forces Staff and Patients who may have experienced disadvantage by Armed Forces inclusion policies prior to 2000, where Armed Forces law prevented inclusion of LGBT colleagues.

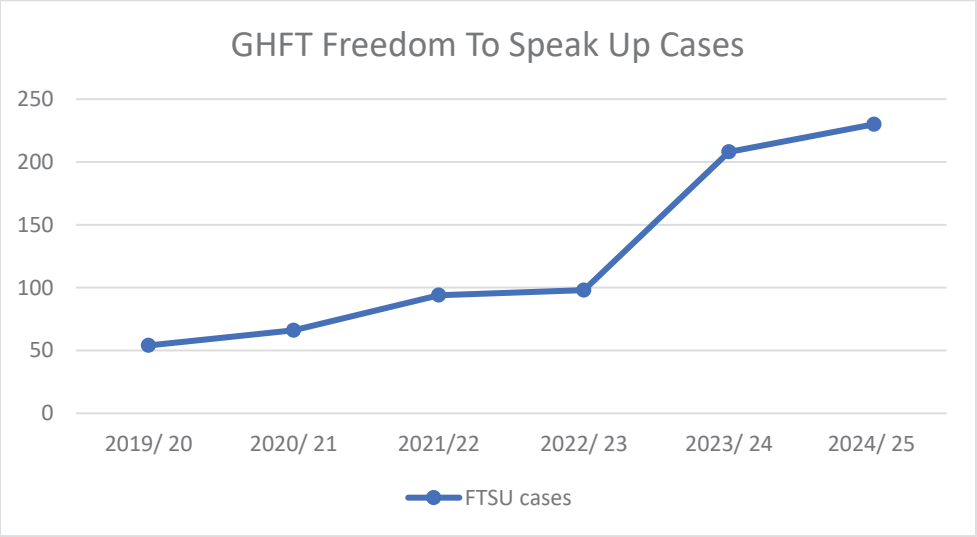
Freedom to Speak Up Service

Our Trust is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life and in all of its practices. The Trust recognises that those who work for our organisation are in the best position to recognise when something is going seriously wrong within it, and may want to voice concerns.

Trust Data

In 2023- 24, 208 staff accessed the Freedom to Speak Up service 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 the Freedom to Speak Up service this year are voicing barriers, indicating that the correct cases are now reaching the service.

Graph: Total number of cases per year

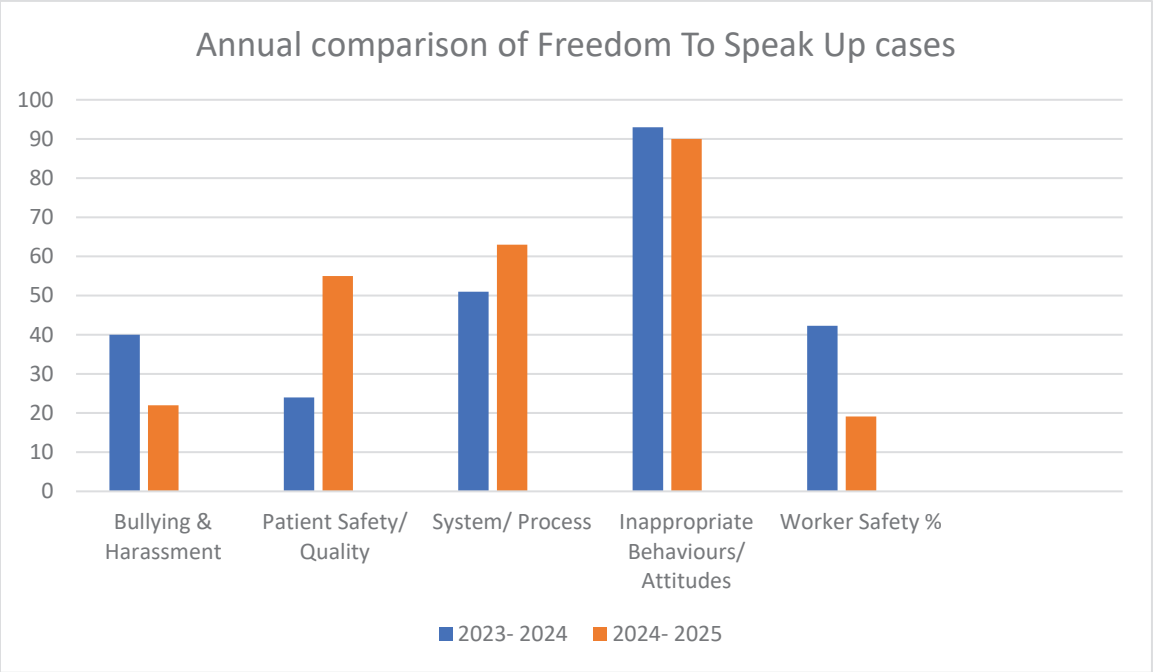


Staff have spoken up about a variety of concerns but inappropriate attitudes or behaviours remain the organisations highest reason for contacting the Freedom to Speak Up service. Themes have been captured in the service as voicing concerns about speaking up due to staff experience; poor experience connected to a process; poor behaviours witnessed or experienced in the organisation.

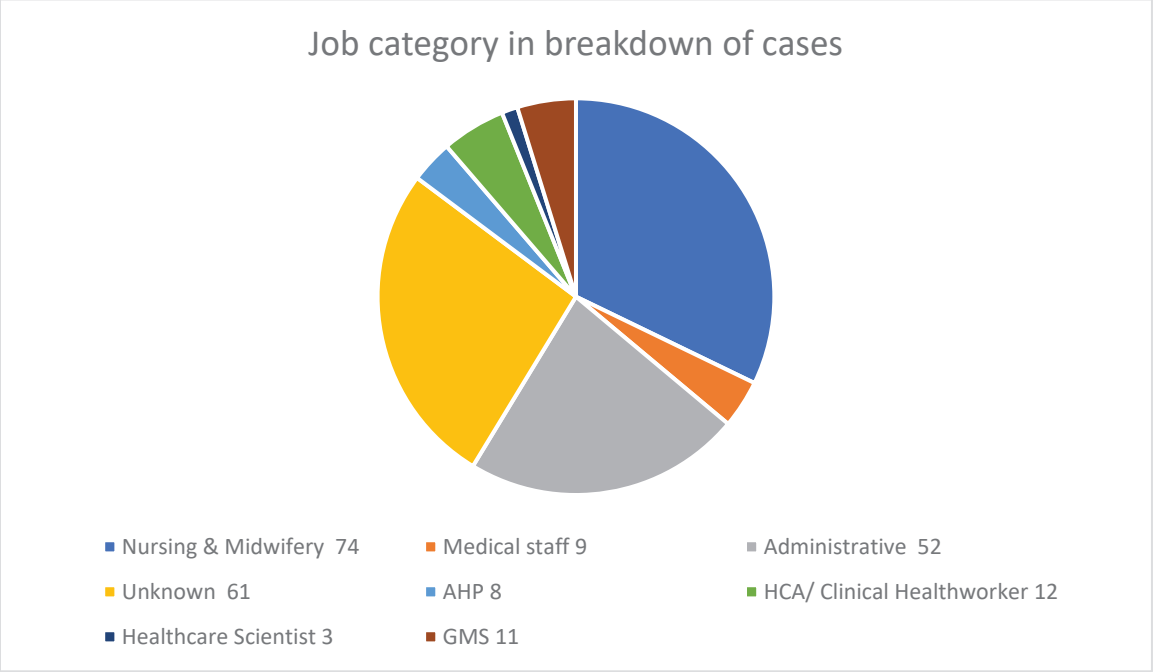
The Freedom to Speak Up service has implemented weekly managerial drop-in sessions to respond to the 151 out of 230 cases where staff reported their line manager as a barrier to

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.

Graph: Annual comparison of themes within Freedom to Speak Up Guardian cases



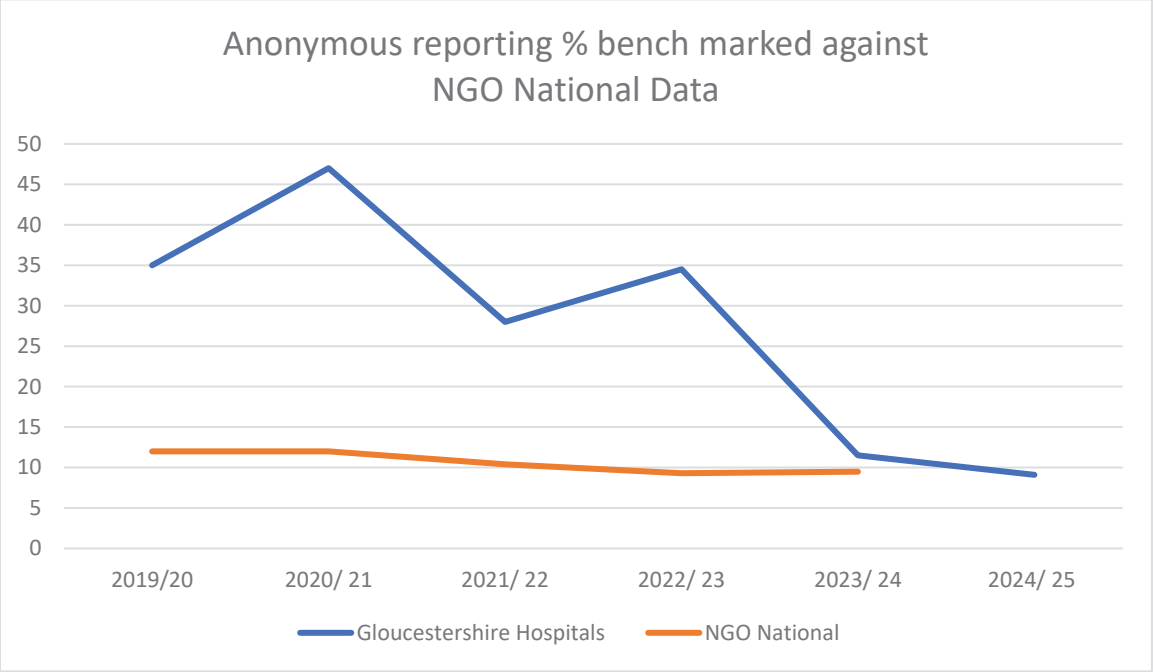
The types of cases that staff raise remain broad with staff accessing the service from all staff groups as can be seen in the graph below. It is reassuring that the reach of the service continues to be established in the organisation.



A stark change in the Freedom to Speak Up 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 the Freedom to Speak Up service 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%



The recruitment of the additional 0.4 whole time equivalent Band 7 the Freedom to Speak Up Guardian has improved the service function and supported important work such as building the Champion network and aligning the Freedom to Speak Up element of education into the Trust.

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 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 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 Freedom to Speak Up 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 Service is committed to seeing this multiplied across all levels of leadership. Looking ahead, the Freedom to Speak Up service will engage with all divisions every quarter to support this approach.

The 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.

Data Quality

Data quality: relevance of data quality and action to improve data quality

Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is: -

1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more difference records exist for the same patient)

Gloucestershire Hospitals NHS Foundation Trust will be taking the following actions to improve data quality

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine Data Quality reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence Hub
- We regularly send data submissions to the secondary users service and via these submissions we receive Data Quality reports back. Based on these reports we action all red and amber items highlighted in report to improve data quality.
- In data published for the period April 2024 to March 2025, the percentage of records which included a valid patient NHS number was:
    - 99.9% for admitted patient care (national average: 99.7%)
    - 100% for outpatient care (national average: 99.7%)
    - 99.4% for accident and emergency care (national average: 98.9%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 100% for admitted patient care (national average: 99.4%)
    - 100% for outpatient care (national average: 99.3%)
    - 100% for accident and emergency care (national average: 99.8%)

- A comprehensive suite of data quality reports covering the Trust's main patient administration system (TrakCare) and electronic patient records (Sunrise ePR) is available and acted upon. These are run on a daily, weekly and monthly basis.
- These reports and are now available through the Trust's BI Hub. These include areas such as but not limited to: -
    - Outpatients including attendances, outcomes, invalid procedures
    - Inpatients including missing data such as NHS numbers, theatre episodes
    - Critical care including missing data, invalid Healthcare Resource Groups
    - Emergency Department including missing NHS numbers, invalid GP practice codes
    - Waiting list including duplicate entries, same day admission

On a daily basis, any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is available on the Trust's Intranet Policy pages.

Audit trails are used to identify areas of DQ concern within the Trust, which means that these areas can be targeted to identify issues. These could be system or user related. Training is offered and process mapping undertaken to improve any data quality issues.

Most of the Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non- Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Data Quality is a part of the yearly mandatory training package for staff – a signed statement is needed that tells staff that DQ is everyone's responsible to ensure good quality and clinically safe data. The Data Quality team now present at the Doctors Induction.

Part 2.3 Reporting against core indications

Domain	Indicator	Years	Trust
Domain 1 – Preventing people from dying prematurely	Most recent value of the Summary Hospital Level Indicator SHMI for trust	2024/25	1.115
Domain 3 – Helping people to recover from episodes of ill health or following injury.	Percentage of Patients 0-15 Readmitted to hospital within 30 days of being discharged	2024/25	13.15%
Domain 4 – Ensuring people have a positive experience of care.	Staff who would recommend the trust to their family or friends	2024/25	49%
	Patients who rate the quality of their care as positive or extremely positive	2024/25	91.89%
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	Patients admitted to hospital who were risk assessed for venous thromboembolism	2024/25	77.34%
	Rate of C.difficile infection	2024/25	39.2
	Patient safety incidents and the percentage that resulted in severe harm or death	2024/25	43

Patient Reported Outcomes

Below is from the national website for period April 23 – March 24 (Most up to data finalised data).

	EQ-5D		EQ VAS		Oxford Score	
	Trust %	*England %*	*Trust %*	*England %*	*Trust %*	*England %*
Total Hip	87.50%	88.80%	77.20%	68.60%	98.60%	97.10%
Total Knee	85.50%	80.90%	68.70%	58.90%	96.60%	93.90%

Patient Experience

National Cancer Patient Experience Survey

This cancer patient experience survey is mandated for all hospital Trusts in England to provide data and make comparisons and improvement against Trusts, Integrated Care Boards and Cancer Alliances. The National Cancer Patient Experience Survey data is from 2023 and published in 2024. The data for 2024 will be published in July 2025. The survey includes all patients over the age of 16 affected by cancer who had an in-patient or day case stay. Our Trust had 273 responses out of a total of 440 patients, with the majority responding to a paper survey rather than on-line. No patients used the translation service to respond and the majority of patients falling outside of the most deprived groups. Patients who have purely outpatient treatment are not included in this survey. Our Trust is seeking to learn from their experience separately.

There were some pleasing results where the Trust scored much higher than the national average illustrated in the table below. There are also some areas where the Trust scored lower than national average, which provide areas for improvement.

Questions above expected range

	Case mix adjusted scores			National score
	2023 score	Lower expected range	Upper expected range	
Q3. Referral for diagnosis was explained in a way the patient could completely understand	**75%**	60%	73%	**67%**
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	**65%**	43%	62%	**52%**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	**47%**	21%	44%	**32%**
Q56. The whole care team worked well together	**94%**	86%	94%	**90%**

Questions below expected range

	Case mix adjusted scores			National score
	2023 score	Lower expected range	Upper expected range	
Q5. Patient received all the information needed about the diagnostic test in advance	**88%**	89%	96%	**92%**
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	**81%**	83%	95%	**89%**
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	**74%**	78%	92%	**85%**

There were some encouraging comments from patients too:

- *The entire staff I have encountered have been extremely supportive, helpful and caring. They all work hard to keep the wards working efficiently which means multi-tasking and still have the time to care for your needs and spend time with you.*

- *I have nothing but praise & admiration for everyone of the staff that I have encountered during my cancer journey! The support that I have had, has been outstanding all along the way, - from volunteers to consultants. I*

Improvements made in response to survey results in 2024/5

Staff have been trained not just to introduce themselves by name, which they usually do, but also their role and where they will support in the patient's recovery.

More cancer specific treatment summaries are being given to patients following their treatment to give them information about support services post treatment and information about possible recurrence and concerns that need medical intervention.

More Cancer Nurse Specialists are being trained to deliver Nurse Led Breaking Bad News clinics to reduce the time patients wait for their results.

Improvements planned for 2025/6

Cancer Clinical Nurse Specialists will analyse the survey data according to the site on the body the patient experienced their cancer, to identify specific improvements required. Leads for those cancer sites will action the identified improvements.

The cancer specific patient public voice group will join the improvement work to co-produce an action plan.

The Trust will design a bespoke survey for outpatient led cancer patient experience.

Local Indicators within the Trust's Integrated Performance Report

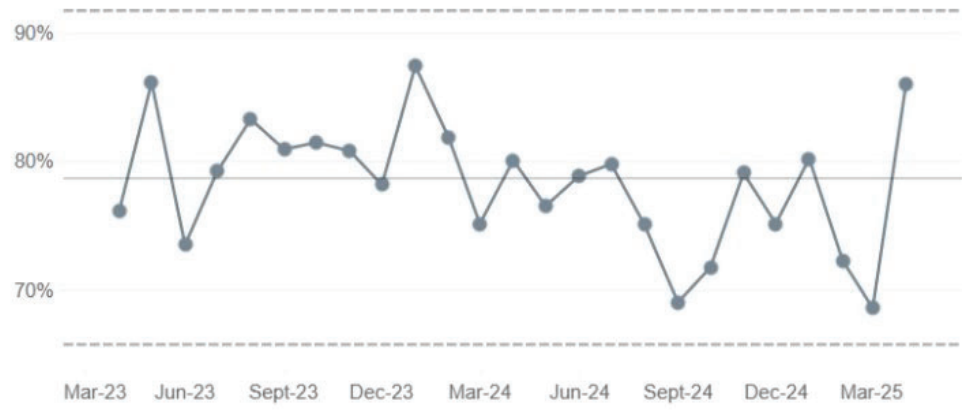
The Integrated Performance Report reports on operational performance, quality and safety metrics, use of resources and workforce monthly through quality and performance meetings to the Trust Board. The quality and safety metrics reported on monthly include the following:

Friends and Family Test

Friends and Family Test results below illustrates patients' response whether they would positively recommend the Trust to their friend and family.

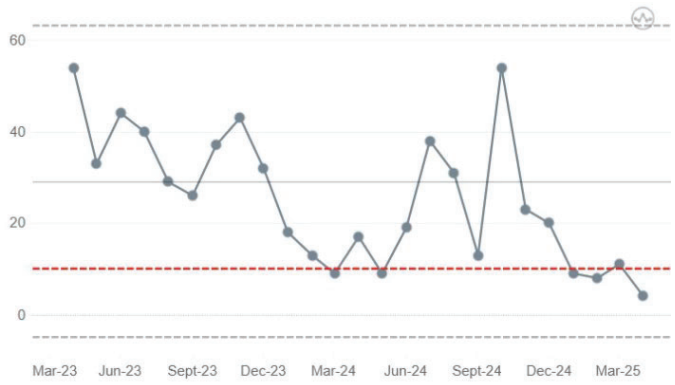
Patient Advice and Liaison Service

The performance of the Patient Advice and Liaison Service where the target is to complete all patient reports of concern and advise signposting within 5 days is illustrated below.



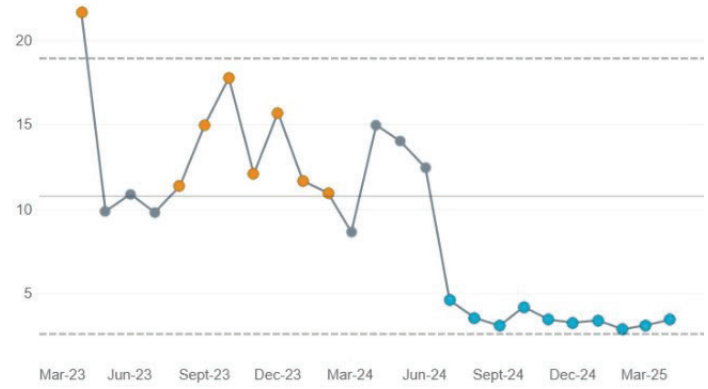
Mixed Sex Accommodation Breaches

Mixed Sex Breaches are reported below where patients of the opposite sex have to share bays or facilities. This occurs infrequently, but can happen in times of pressure on flow into and out of the hospital, and while patients are waiting for a ward bed from Critical Care.



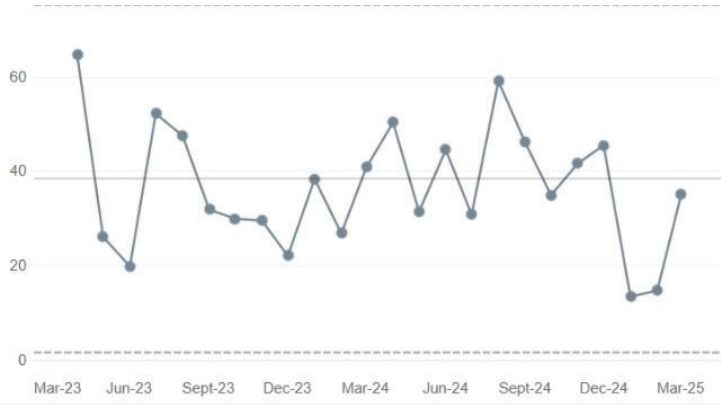
Boarding of patients in non-designated bed spaces

The daily average of boarded patients below reports where patients have had to wait or sleep in a corridor in the Acute Medical areas or the emergency department. This happens infrequently at times of increased pressure on flow into and out of the hospital.



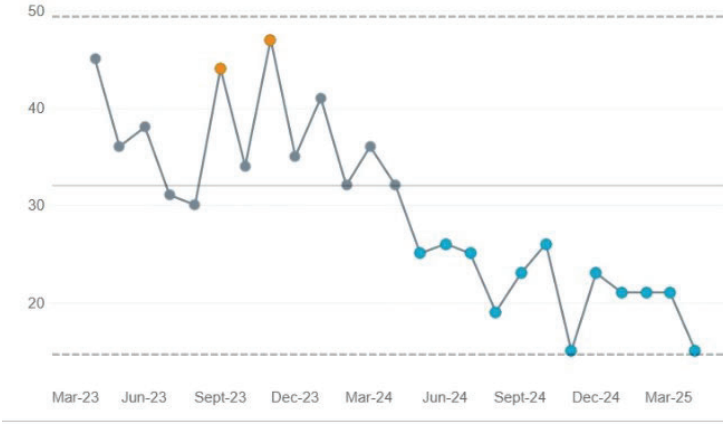
C. difficile infections

The infection rate of the infection C. difficile below is set by the NHS per 100,000 bed days. The Trust reports the rate monthly. The incidences are monitored closely and the Infection Improvement Group oversee targeted actions on preventing hospital acquired infection.



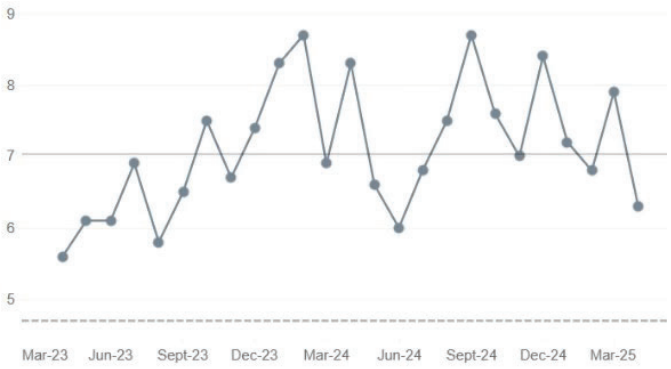
Pressure Ulcers

The incidences of Category 2 below and Category 3 pressure ulcers are reported monthly.



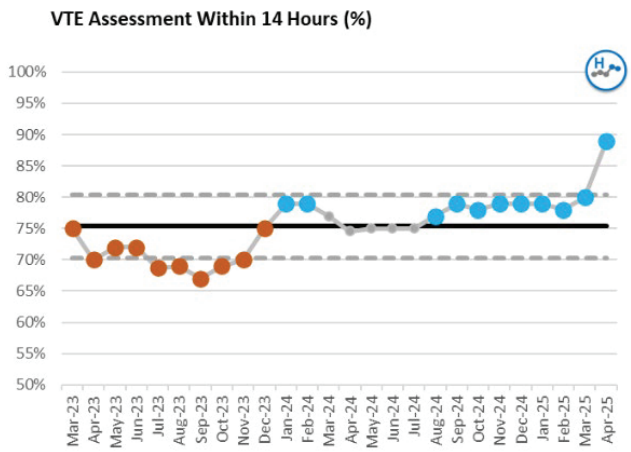
Falls

The incidents of the number of patient falls per 1000 bed days are reported. The Falls Prevention Improvement Group is leading quality improvements in recording falls to facilitate better analysis of the data, developing the electronic patient records and implementing post-fall hot debriefs for staff learning.



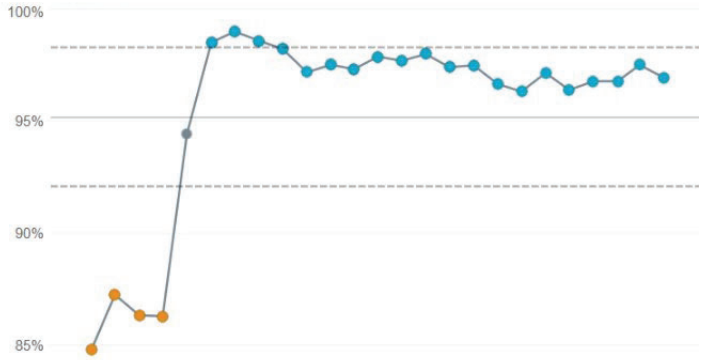
Venous Thromboembolism (VTE) risk assessment

The rates of Venous Thromboembolism risk assessment for preventing blood clots are reported below as a safety measure and performance is reviewed at the monthly Venous Thromboembolism committee. Improvements in data measurements and practice have seen Venous Thromboembolism assessment rates improve.



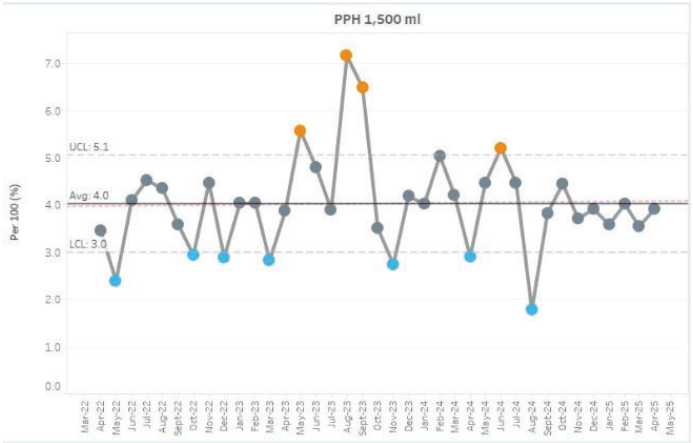
Smoking cessation

Smoking cessation compliance below asks all in-patients about their smoking history and offering nicotine replacement therapy is reported monthly as below.



Postpartum haemorrhage

Rates of maternity care postpartum (post birth) haemorrhages of over 1500mls are reported to monitor this obstetric emergency complication that occurs in between 1-10% of all deliveries.

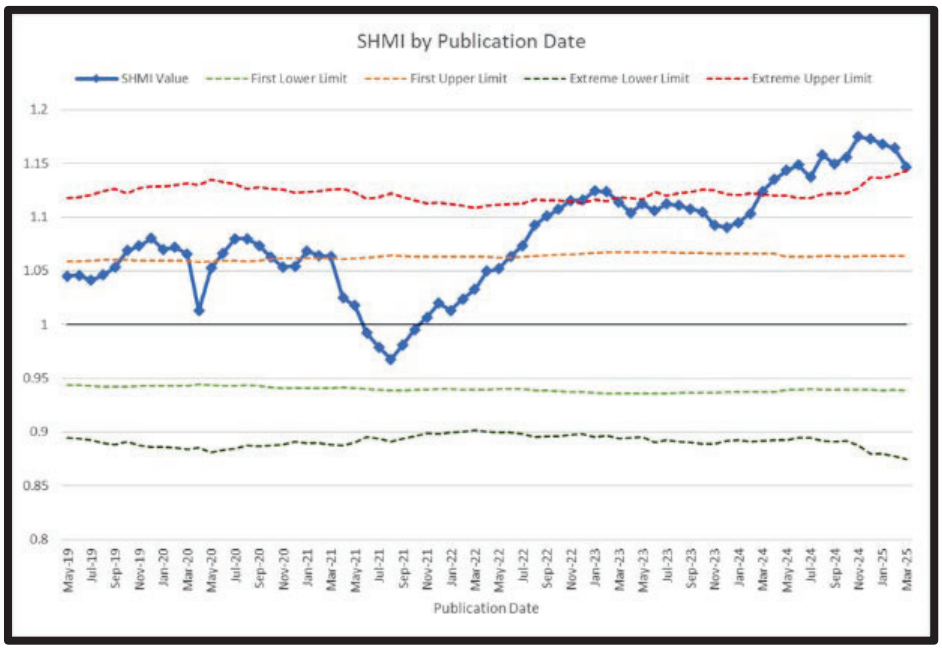


Summarised Hospital Mortality Index (SHMI)

The Summarised Hospital Mortality Index (SHMI) is a metric used to assess hospital mortality rates in England. SHMI is calculated using several patient characteristics, including the patient's primary diagnosis and their co-morbidities.

The table below demonstrates the increases in the SHMI, indicating higher than average expected deaths starting from 2021, which correlates with the time the electronic patient record system was introduced.

Table: Gloucester Hospitals SHMI data compared to the expected levels



Improvement Aim: A Quality Improvement project has facilitated better understanding and recording of Gloucestershire patient co-morbidities within the Trust and wider healthcare system.

Specific change ideas included:

- Strengthening clinician-coder collaboration.
- Implementing co-morbidity-specific Quality Improvement initiatives for patients with chronic illness such as kidney disease and diabetes.
- Developing educational programs for various specialties and staff.
- Optimising Electronic Patient Record systems to support accurate coding.
- Targeting remediation coding efforts based on age groups and diagnosis impact.

Measurements:

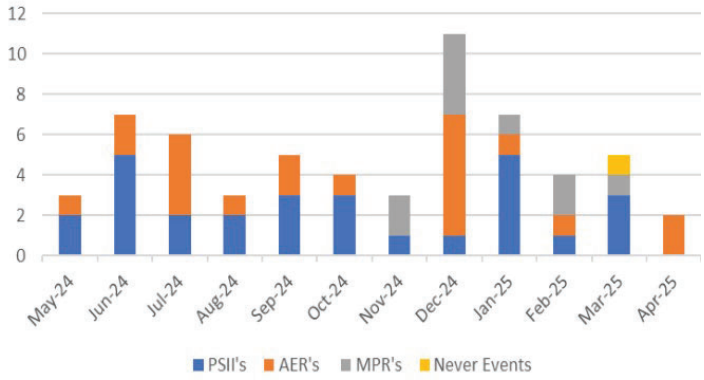
- **Outcome Measures:** Charlson score which identifies co-morbidities.
- **Process Measures:** Charlson score by age, specialty, and admission type.
- **Balancing Measures:** Trust SHMI and expected deaths rate.

Next Steps:

- Scale remediation coding efforts.
- Integrate coding into consultant job plans.
- Leverage financial benefits, with a more accurate Charlson score representing the general health of Gloucestershire patients, the Trust is likely to see its funding increase.
- Transition from retrospective re-coding to accurate coding from the outset.
- Strengthen collaboration with system partners across Gloucestershire.

PSIRF

The implementation of our Patient Safety Incident Response Framework (PSIRF) reports each of the 4 responses to patient safety incidents. Each response focuses on different aspects of investigation, learning, multi-professional consideration and system wide change.



Part THREE: Other Information

Annex 1: Statements from Healthwatch, Integrated Care Board and Overview and Scrutiny Committee

Statement from Healthwatch Gloucestershire 12.06.2025

Thank you for sharing the Quality Accounts for Gloucestershire Hospitals NHS Foundation Trust for 24/25.

Healthwatch Gloucestershire congratulate the Trust on their achievements last year including the opening of the Hyper-Acute Stroke Unit at Cheltenham General and the new Alstone Urology clinic. We also acknowledge the introduction of the Patient Portal and the potential for this to improve accessibility of information for many people.

We recognise the actions being taken in response to the CQC inspection into Maternity care and improvements made. We are pleased to see how the application of PSIRF has led to improvements in quality across the 8 local safety priorities through encouraging learning by involving patients and the empowerment of frontline teams to implement change.

We understand that shifts in organisational culture take time to embed but it is promising to see that this starting to show through staff feeling more secure about raising concerns in the staff survey. We note the recognition given to the Trust's dedicated staff and the invaluable services provided by volunteers by the CEO Kevin McNamara.

We are also pleased that the clinical vision of flow and ensuring the best possible outcomes for patients remains a priority as this aligns with one of our priorities this year, focussing on understanding people's experiences of being an inpatient at Gloucestershire Royal Hospital. We hope to explore communication between patients, carers and professionals and how people's care and support is made personal to ensure that a person can be discharged as early and safely as possible.

Healthwatch Gloucestershire values the strong connections we have with the Trust and look forward to working closely with the Trust this year to ensure that patient voices are at the heart of service delivery and improvement.

Statement from the Integrated Care Board 19.06.2025

NHS Gloucestershire ICB welcomes the opportunity to comment on Gloucestershire NHS Foundation Trust quality account. We recognise the continued efforts of the trust in delivering high-quality care during another challenging year, especially in the context of ongoing system pressures and the continued recovery from the COVID-19 pandemic.

We note the Quality account demonstrates a clear commitment to improving patient safety, clinical effectiveness, and patient experience.

We acknowledge the progress made against 2023/24 improvement priorities. It is pleasing to see that the Pressure Ulcer risk assessment rate for in-patients improved by 25% in 12 months. Although PSIRF is still a relatively new, it is good to see the shift in how the trust is managing patient safety incidents related to hospital acquired pressure ulcers and the potential learning to enable pressure ulcer prevention.

The trust has made enormous progress in nursing vacancies on inpatient wards and the positive impact of the international recruitment campaign with colleagues joining the workforce from so many countries. Rightly the focus is now on retention planning and its good to see a key priority is increasing support for staff in post.

The ICB encourages the trust to continue to address areas where they have faced challenges. We acknowledge the hard work from dedicated staff following the Care Quality Commission report on maternity services. The ICB has worked closely with the Trust and other stakeholders to ensure continued improvement to provide safe, high-quality maternity care.

The ICB notes the high compliance from Gloucestershire Hospitals NHS Foundation Trust of national clinical audits and national confidential enquiries. The Trust also participated in 207 local clinical audits, Quality Improvement projects and 41 ‘Silver’ quality improvement projects graduated through their Gloucestershire Safety and Quality Improvement Academy, demonstrating the dedication and commitment of staff to continuously improving the quality of healthcare provided.

The trust has successfully rolled out their PSIRF policy with a structured approach to respond to patient safety incidents, focusing on learning and improvement. The ICB will work with the Trust to continue this approach to further ensure embedding of learning It is pleasing to see that for the following year the trust has chosen to continue the focus on their Patient Safety Incident Response Plan.

The proposed priorities for 2025/26 align well with wider ICS objectives, the ICB will fully support the delivery and oversight in order to continually drive forward high quality, safe services.

The ICB values the strong partnership working and we look forward to working together to support further improvement across the local health and care system.

Marie Crofts,

Chief Nursing Officer, NHS Glos ICB

Statement from the Overview Scrutiny Committee To be received

Annex 2: Statement of Director's Responsibility for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, directors have taken steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2024/25 and supporting guidance.
- detailed requirements for quality reports 2023/2.
- requirements as set by the Gloucestershire Integrated Care Board.

The content of the quality report is consistent with internal and external sources of information including:

- board minutes and papers for the period April 2024 to March 2025 (link)
- papers relating to quality reported to the board over the period April 2024 to March 2025
- feedback from Gloucestershire Integrated Care System dated 19 June 2025
- feedback from Healthwatch Gloucestershire dated 12 June 2025
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2023/24 (Link to latest published report) (next report due July 2025)
- the 2024 National Patient Surveys published by CQC in 2024/2025 (Link)
- the 2024 national staff survey published Jan 2025 (Benchmark report Link)
- Current CQC inspection reports (RTE inspection Reports Link).

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.

The quality performance information reported in the quality report is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The quality report has been prepared in accordance with NHS England's reporting requirements and supporting guidance (which incorporates the quality accounts

regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Trust Chair

Deborah Evans

Chief Executive

Kevin McNamara

Report to the Board of Directors			
Date	10 July 2025		
Title	Safeguarding Annual Report 2025		
Author / Presenter **Sponsoring Director**	Matt Holdaway, Chief Nurse & Director of Quality Authored by the Safeguarding Named Professionals		
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 Safeguarding Annual Report was presented to the Quality & Performance Committee in June 2025.The Committee accepted the recommendation to note the report.

The Chief Nurse and Director of Quality delivered the report to Committee members, giving an overview of the Trust's safeguarding arrangements in accordance with the statutory obligations outlined in the Care Act.

The Annual Report provides a comprehensive overview of the safeguarding activities and initiatives undertaken during the 2024-2025 period. It aims to inform the Board of the progress made, challenges encountered, and the overall impact of the safeguarding measures implemented.

Key Issues to Note

1. **Progress and Achievements**: The report highlights significant progress in safeguarding practices, including the successful implementation of new policies and the positive outcomes of various safeguarding programmes and investment.
2. **Challenges and Obstacles**: Despite the progress, several challenges were encountered, such as resource constraints and ever-increasing workload.
3. **Stakeholder Engagement**: The report underscores the importance of collaboration with key stakeholders and the community in achieving safeguarding goals and demonstrates strong relationships across Gloucestershire's various authorities.
4. **Safeguarding Training:** This remains a challenge in relation Level 3 training compliance with the Trust now moving to the nationally available system for Children and later Adults.
5. **Child Protection Medical Assessment**: The report highlights concerns regarding the child protection medical examination process. The current challenges include professional difference of opinion and a breakdown in relationships in the system. There has been an external review of current practice and the recommendations in that report are being implemented.

Risks or Concerns

1. **Resource Allocation**: There is a need for increased use of resources to address the identified challenges and to sustain the progress made, particularly in relation to processing information sharing.
2. **Training and Development**: Ongoing training and professional development for staff are crucial to ensure the effectiveness of safeguarding measures, particularly in relation to level 3 training.

3. **Policy Review and Enhancement**: Regular review and enhancement of safeguarding policies are necessary to adapt to emerging issues and to maintain high standards of practice.
Financial Implications
None, this paper does not seek investment
Equality, Diversity, Inclusion and Workforce Implications
None
Sustainability (Environmental) Implications
None
Recommendation
The board are asked to: Receive this Annual Report for Assurance noting it has been previously received and reviewed by the Quality and Performance Committee.
Enclosures
Separate Appendix

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Safeguarding Annual Report 2025

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust recognises that safeguarding is a shared responsibility requiring joint efforts between agencies and professionals. This report provides assurance that the Trust meets its regulatory safeguarding responsibilities, with a focus on activity and performance across five pathways. It also reports on our learning disabilities and autism workstream, highlighting patients at higher safeguarding risk.

In the past year, the Gloucestershire Safeguarding Adults Board commissioned and concluded 1 Safeguarding Adult Review. The Gloucestershire Safeguarding Children Partnership commissioned 3 Rapid Reviews, 2 of which advanced to Local Children Safeguarding Practice Reviews. Safer Gloucestershire commissioned 5 Domestic Abuse Related Death Reviews (DARDRs) from 2024. No statutory reviews had specific recommendations for the Trust yet we continue to be fully involved.

The work of the Safeguarding Teams continues to increase in both volume and complexity. Whilst this presents a resource challenge to the organisation it is welcomed that we have a strong reporting culture. Achieving compliance with safeguarding training remains challenging, particularly at Level 3, with alternative strategies now being implemented.

The report has been collated by Jeanette Welsh, Named-nurse for Safeguarding Adults, Clare Freebrey, Named-nurse for Safeguarding Children, Dr Ravi Lehal, Named-doctor for Safeguarding Children and Sue Maxwell, Named-midwife for Safeguarding Children.

Glossary

ACEs - Adverse Childhood Experiences

CIC - Child in Care

CP medical – Child Protection medical

CP plan - Child Protection Plan

CP-IS - Child Protection Information system

CYP - Child and /or young person (includes infants)

DHR – Domestic Homicide Review

FGM-IS - Female Genital Mutilation Information service

GHC - Gloucestershire Health and Care Trust

GSAB – Gloucestershire Safeguarding Adults Board

GSCP - Gloucestershire Safeguarding Children Partnership

LCSPR – Local Child Safeguarding Practice Review

ND - Named Doctor

NN - Named Nurse

SAR – Safeguarding Adult Review

Introduction

Gloucestershire Hospitals NHS Foundation Trust (GHFT) is a busy multi-specialty District General level acute Trust. Safeguarding begins with the care of mothers and their unborn babies and continues throughout the entire lifespan and is threaded through every interaction our staff have with our patients.

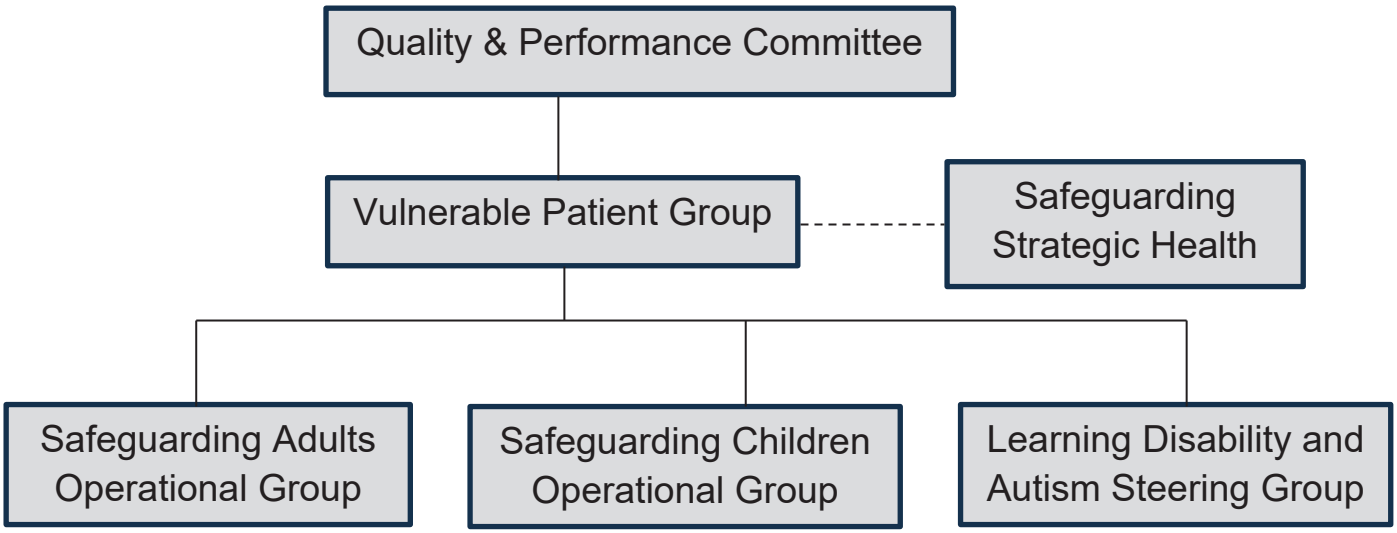
Safeguarding practice within the Trust is required to work in line with the statutory requirements of the Care Act (2014), the Children Act (2004), Working Together to Safeguard Children (2023), the Mental Capacity Act (2005), the Mental Capacity (Amendment) Act (2019), the Deprivation of Liberty Safeguards (DoLS) (2009) and Keeping Children Safe in Education (2023) *. We are also required to comply with Regulations 13 and 17 of the Health and Social Care Act (2008), relating to protecting service users from abuse/neglect and provision of good governance, respectively.

Over the year under report, we have made considerable progress in reducing Safeguarding risks, weaving Safeguarding related policies together with operational policies and Safeguarding training compliance percentages are much improved. Partly as a result of this work, all Safeguarding workstreams have been extremely busy as Trust staff have become more sensitive to earlier signs of neglect, abuse, self-neglect and exploitation.

Safeguarding governance

Governance arrangements

The safeguarding governance structure for 2024/25 is illustrated below



The Safeguarding Adults and Children Operational Groups are responsible for disseminating and monitoring information from Gloucestershire Safeguarding Adults Board (GSAB) and Gloucestershire Safeguarding Children Partnership (GSCP). In turn, as a partner agency the Trust provides challenge and scrutiny to both boards.

Operational governance throughout the year was provided by the Safeguarding Adults and Safeguarding Children Operational Groups and the Learning Disability and Autism Steering Group. Internal strategic safeguarding governance was provided by the Vulnerable Patient Group. External strategic governance is provided by the Safeguarding Strategic Health Group chaired by the Associate Director of Safeguarding at the ICB and encompassing all ages.

Safeguarding achievements over the year

- New Associate Director of Safeguarding, Louise Duce appointed
- Policies due by 31st March 2025 all reviewed and approved
- Risks have all been reduced over the year
- Vulnerable Women's Team have compassionately supported 40 baby removals
- Safeguarding Children legal documentation is now being uploaded to OnBase
- High risk Domestic Abuse alerts now being copied onto the records of all newborn babies, where mother had a similar alert in place prior to the baby's birth
- New process in place to ensure that Safeguarding information is shared by Maternity with Primary Care and Health Visiting
- Compassionate treatment of parents accused of abuse or neglect by Safeguarding Children team
- Close joint working by Lead for Safeguarding Adults, Named Midwife and Named Nurse of Safeguarding Children in a number of pregnancies to achieve the best possible start in life for the child and addressed the Safeguarding needs of the mother
- Mental Capacity Assessment and Best Interests meeting documentation digitised and now available in Sunrise following external audit findings
- Mental Health Act documentation now being uploaded to OnBase following external audit findings
- Safeguarding training compliance improved across all levels and both adults and children
- Funding to continue the High Intensity User service was agreed by the ICB
- Collaborating with Chief Psychological Therapies Officer to secure senior Psychologist support for HIU patients
- 3 new nursing posts appointed to within Children's Safeguarding

Safeguarding-related Policies

A considerable proportion of Safeguarding leadership time has been committed to policy revision during the year. The team have worked to reduce the number of policies so that they are all-age and whole Trust wherever possible. This makes finding the right policy easier for staff and revising all the policies sequentially has eliminated contradiction between policies. All policy links on the Vulnerability pages have been updated to reflect the updated policies. An overview of the policies managed by the Safeguarding Teams is available in the Appendices.

Risk Register

There were 18 Safeguarding related risks during the year, with improvement in some. Risks are now recorded on DatixCloud, detail of risks is available in the appendices.

Maternity Safeguarding report

The Trust focuses on safeguarding both the unborn and mothers, addressing risks that can lead to permanent needs and disabilities. In the year ending March 31st, 2025, the Trust's antenatal and perinatal services staff supported 5,345 births over 24 weeks gestation, a decrease of 244 births from the previous year.

The Vulnerable Women's Team is fully staffed with:

- WTE Band 8a Named Midwife
- 0.8 WTE Band 7 Specialist Midwife for young parents
- 0.9 WTE Band 7 Specialist Midwife for Alcohol and Substance Misuse
- 0.9 WTE Band 7 Specialist Midwife for Safeguarding
- 0.8 WTE Band 7 Job share for Perinatal Mental Health
- 0.6 WTE Band 3 Administrator

A vacancy of 0.15 WTE Band 7 in Safeguarding exists, with plans to increase team hours. Midwives participate in monthly on-call rota and an escalation rota. Despite staffing improvements, challenges remain for community midwives, affecting attendance at legal multi-disciplinary meetings.

Many safeguarding cases are complex due to individual vulnerabilities and professional involvement. The Trust has seen increased requests for meetings following changes in children's social care from the revised "Working Together" document 2023.

Uploading safeguarding documents onto Badgernet has posed a significant risk for safety and sharing information, but testing phase results may soon improve this. Other digital advancements include enhancing information sharing with primary care during pregnancy, supported by national safeguarding alert systems.

Safeguarding concerns raised by staff

Staff have raised safeguarding concerns via BadgerNet, Datix, email, by completing a Public Health Liaison Nurse referral form, by making a phone call to the Safeguarding team, by personal conversation with a member of Safeguarding staff or making an external referral to either Adult or Children's Social Care. The Vulnerable Women's Team have also supported a number of staff members throughout the year with personal situations they have disclosed including 2 referrals to the LADO which is highly sensitive.

Safeguarding Training in Maternity

Level 3 safeguarding children continuous to follow the maternity specific pathway developed last year which is different from the rest of the Trust. This is currently being reviewed as progress has not been as expected. The Trust compliance within maternity services is the subject of a regulatory warning notice from the CQC under section 29a of the Health and Social Care Act 2008

L3 Safeguarding Children compliance data maternity

Date	Fully compliant	4 of 5 components completed	3 of 5 components completed
March 2024	40%	71%	88%
Oct 2024	54%	81%	92%
Nov 2024	56%	83%	93%
Dec 2024	62%	86%	94%
Jan 2025	69%	86%	93%
Feb 2025	71%	89%	94%
March 2025-All staff Inc. Resident obstetric doctors from this date	58%	78%	82%
April 2025	68%	91%	95%
May 2025	58%	80%	85%

March 2025 Data for Children L3 SG training - split into staff groups

Staff group	Fully compliant	4 of 5 components completed	3 of 5 components completed
Midwives	66%	89%	93%
Consultants	0%	74%	92%
Resident doctors	0%	40%	80.5%
Locums	0%	100%	100%

Adult Safeguarding compliance March 2025

Maternity	Level 1	Level 2	Level 3
Total	98%	86%	78%

Adult safeguarding training follows the same training pathway as the rest of the Trust. This was updated during the year and staff are following the new pathway

Young parents - 0.8 WTE Specialist Midwifery time

Data showing last 3 years numbers of young pregnant people who were 17 years and 364 days or less pregnant at the time of conception. Risk identified for exploration as currently not compliant with NICE guidance. As demonstrated, there is a small reduction in numbers from last year's figures.

2022/23	57
2023/24	61
2024/2025	57

Breakdown of the 57 young parents seen this year into varying categories are as below:

Age at booking	13	14	15	16	17
Number	1	3	2	9	42
%	2%	5%	4%	16%	74%

Ethnicity	**Number**	**Percentage**
White British	44	77%
White Irish	1	2%
African	0	0%
Bangladeshi	0	0%
Caribbean	0	0%
Chinese	0	0%
Indian	0	0%
Pakistani	0	0%
Mixed background	5	9%
Other	7	12%
Not stated	0	0%
Not known	0	0%

Outcome	**Number**	**Percentage**
Normal Birth	26%	54%
CS	16	33%
Ventouse	3	6%
Forceps	3	6%

Employment/Education status	**Number**	**Percentage**
Employment	7	12%
Education & Employment	1	2%
Unemployed	30	53%

Education (school/academy)	3	5%
Education (college)	10	18%
Home schooled	3	5%
Training/apprenticeship	1	2%
Other	2	4%

As in previous audits the majority of our young people (53%) remain consistently not in education or employment, this is in line with previous audits although a slight increase. Highlighting the risk as in previous years audits the correlation between being NEET and becoming a young parent. All our school aged children were referred to hospital education for interprofessional working.

Family Planning in Young Parents

As you can see from the table below 82.5% of young people did not use contraception prior to becoming pregnant. These results have been acted on quickly due to the interprofessional working of the specialist midwives with the teenage pregnancy board partnership. This has resulted in a deep dive within the local schools to see whether there are any identifiable factors as to why contraception rates are low, such as a gap in education or the availability of products for our young people.

Contraceptive used pre-pregnancy	Yes	No
Number	10	47

The table below demonstrates a higher percentage of young parents who declined the use of contraception following birth and before they left the maternity service that last year. However, due to the percentage of not known responses due to no documentation, this may not be accurate.

PUPP contraception received	Yes	No	Not known	Declined
Number	16	10	12	11
Percentage	28%	21%	21%	20%

Data relating to the number of terminations of pregnancy before the young parent is referred into Maternity services is not available to us. Nationally it is known that the numbers in this age group are rising

Substance and alcohol Use – 0.9 WTE Specialist Midwife Hours

Below the tables identify the number of women receiving input from specialist midwives as for substances or alcohol misuse and their age range and ethnicity.

2022/23	148
2023/24	145
2024/25	171

Age at delivery	**< 20**	**20 - 25**	**26 - 30**	**31 - 35**	**36+**
Number	19	37	39	47	34
%	11%	21%	22%	27%	19%

Ethnicity	**Number**	**Percentage**
White British	160	90%
White Other	5	3%
Asian/Asian British	0	0%
Black/Black British	4	2%
Other	3	2%

This year, for this group of pregnant women we have introduced deprivation scores for additional detail in the County, using the Inform Gloucester tool. The Indices of Deprivation 2019 are national measures based on 39 indicators that highlight characteristics of deprivation like unemployment, low income, crime and poor access to education and health services. The 2019 indices offer an in-depth approach to pinpointing small pockets of deprivation. A score of 1 is the lowest deprivation score, 5 is the highest. Our data shows that 37% of women were in the lower areas of deprivation and only 15% in the higher.

Deprivation Scores:

1	37	21%
2	28	16%
3	54	30%
4	31	17%
5	27	15%

The table below shows a significant proportion of women experience domestic abuse either while pregnant or postnatally who also are dealing with substance and or alcohol abuse. This equates to almost a quarter in pregnancy.

Domestic abuse reported	Ante-natal	Post-natal	Referred to GDASS
Number	42	17	19
Percentage	24%	10%	

Some of these women receive domestic abuse support from GDASS and other sources such as The Nelson Trust. The Vulnerable Women's team encourage and support Midwives to complete a DASH form. We also receive MARAC reports which may be completed for the conferences but as these are from the Police they are not currently audited.

Adverse Childhood Experiences

The table below shows that a significant number of our mothers using Substances and or alcohol in pregnancy have at least 3 Adverse Childhood Experiences (ACEs) ACEs are specified as traumatic events occurring before the age of 18 years. People with 4 or more ACES recorded as a child have been shown to have a negative impact on their adult life, as you can see for our families in the table below this is approximately 62. High or frequent exposure to ACEs, can lead to toxic stress.

ACEs		
0	5	3%
1	19	11%
2	47	27%
3	43	25%
4	38	22%
5	24	14%
6	0	0%
7	0	0%
8	0	0%
9	0	0%
10	0	0%

Mental health remains an issue for many of the women who have problematic substance and alcohol misuse. Substance and alcohol use can obscure the threshold for acceptance by the

Perinatal Mental Health Team (PMHT). In the last year, 11 women were jointly under the care of the PMHT.

Referrals to the Perinatal Emotional Well-being Service within the Nelson Trust were offered from its commencement in May 2022. Referrals to this service are not exclusively made by Specialist Midwives so we may be unaware of some. From our available data, 18 women were under this service in addition to ourselves.

History MH + substance misuse	**Ante-natal**	**Post-natal**
Number	134	99
Percentage	75%	56%

Learning disabilities and neurodiversity

This is a new aspect we are auditing as there was recognition that a significant number of women may have additional needs. It is estimated 1 in 5 in the UK have a neurodivergence (Department for Education 2024). We have had 2 women in this period who have a diagnosis of fetal alcohol syndrome disorder themselves. This is an area we will explore in more depth in the coming year.

Learning disability?

Yes	23	13%
No	153	86%

Neurodiversity?

None / Not known	Yes (x1)	Yes (2+)
157	16	5
88%	9%	3%

Neurodiversity type

ADHD	14
Autism	6
Tourette's syndrome	0
Dyspraxia	1
Dyslexia	8

Substance Misuse

The substances used by women throughout their pregnancy journey provide insight into current trends in Gloucestershire. Gloucestershire now has patients using Buvidal (long-acting buprenorphine) injections on the trial but as yet none have been pregnant.

	Pre-booking	Booking	Birth
Alcohol	52	18	1
Cocaine	51	24	7
Cannabis	117	86	47
Nicotine	123	106	77
Heroin	8	6	2
Crack	13	7	3
Diazepam	5	5	3
Amphetamine	4	2	1
Buphrenorphine	2	1	1
Mcat (Meow Meow)	1	1	0
Methadone	3	4	4
Ketamine	2	0	0
MDMA	7	1	0
Espranor	2	2	1
Other	14	12	8

Alcohol use is assessed using the Audit C screening tool for all women at booking. If a score of 5 or more is obtained referral to the specialist midwife is made and we contact a woman to complete the remaining Audit C questions. This brief intervention could result in more contacts, signposting or additional referrals. We recommend that baseline blood tests are completed (LFT, Gamma GT and amylase) but we have not been auditing this currently, as it is just a recommendation.

Safeguarding is still a significant factor in the care of these families. Depending upon the substances used, the specialist midwife may provide brief interventions. Further referrals may be offered and completed if consent is given.

Woman/unborn referred to social care?	**Ante-natal**	**Post-natal**
Number	100	2
Percentage	56%	1%

Safeguarding outcome	**Child on Child Protection Plan**	**Child in Need**	**No ongoing concerns**	**Strategy meeting**
Number	42	23	22	34
Percentage	41%	23%	22%	33%

72% of the babies with parental substance/alcohol misuse were discharged to the family home. The outcomes for the others were as detailed in the table below;

Foster for Baby	14	70%
Mum and Baby Foster	2	10%
Mum and Baby Residential	4	20%

Women have a variety of local services available to them e.g. Home Start, Dads Matter, The Nelson Trust, and AA. Encouraging engagement with healthcare and appropriate services remains a significant proportion of the specialist role.

Hope boxes

If a mother and her baby are separated at birth maternity unit offers HOPE boxes (Hold on Pain Eases) for mothers being separated from their baby post birth. These have been developed by mothers themselves who have had their babies removed and include a letter to the new mother. Currently we have been funded to receive these by the LMNS following on from being a pilot for the service

Yes	12	7%
No	164	92%
Declined	2	1%

These are offered with memory making photography of baby and/or parent. A mother who declined had received a HOPE box previously so did not want this again.

Postnatal care

Postnatal inpatient length of stay is variable. This may be due to maternal or neonatal needs but the longer stays were most often safeguarding related, due to Court hearings and placement identification for the family unit or baby alone. Some of these postnatal stays required 24-hour supervision by an external agency. The length of stay has increased from the previous year's audit data.

Contraception

The PUP scheme (preventing unplanned pregnancies) has increased contraception choices for vulnerable women. It is important to encourage this option for those women who want this and discuss family spacing. Not all women have an agreed contraceptive plan by specialist midwives as we may have only delivered a brief intervention to them. We do make referrals with consent to the VANS team. The PAUSE service has been introduced to Gloucestershire this year with Specialist midwives supporting where possible. PAUSE nominations have been made where appropriate, with consent from the mother.

Contraception

	Yes	% Yes	Declined	% Declined
Agreed plan in notes?	73	41%		
Offered on discharge?	90	51%	0	0%
Received on discharge?	40	22%	10	6%

Additional Support for Vulnerable Families

Women have a variety of services available to them and we refer when necessary. Referrals to other agencies this year included VIA, Home Start, DadsMatter, The Nelson Trust, and AA. Encouraging engagement with health care and appropriate services remains a significant proportion of the specialist role. Women had up to 22 face-to-face antenatal contacts and over 50 additional contacts during the pregnancy/postnatal period. These are in addition to the universal midwifery offer of care.

- 13% of families were part of the Continuity of Carer teams
- 87% of families had universal community midwifery care in the County.

The Continuity team in Gloucester stopped intrapartum care in February and has now been paused. There is currently only one Continuity team in Cheltenham but there is currently a community transformation programme for Gloucestershire. We are unsure how this will develop and if this will impact our specialist roles. Referrals to the Specialist midwives continue to be accepted from any agency or patient self-referral. Those noted as ‘other’ include Hope House, VANS team, a consultant obstetrician and a delivery suite midwife or

safeguarding midwife. The later gestation referrals mean there is a shorter window of opportunity to engage the mother and promote engagement and lifestyle changes that may benefit the Unborn baby.

Referrals for specialist Midwife support

	No.	%
Community MW	140	80%
Drug agency	9	5%
GP	0	0%
Self	1	1%
Other	25	14%

Gestation at referral to Specialist midwife

4-12 weeks	101	57%
13-28 weeks	67	38%
29-40 weeks	8	5%
Postnatal	0	0%

Newborn Baby Care

The Unborn and newborn baby may be affected by parental substance misuse and/or alcohol use. The risks for babies can include intra-uterine death, growth restriction, placental abruption, fetal alcohol syndrome, and neonatal abstinence syndrome. Consultant-led care, increased monitoring of the pregnancy, and foetal surveillance reduce risks significantly.

9% of Babies had their urine screened for toxicology as recommended by specialist midwives. The length of stay for a newborn of 3 days is often due to monitoring of neonatal withdrawal observations. 5 babies were treated for withdrawal which takes place on the neonatal unit at GRH.

Female Genital Mutilation (FGM)

The numbers of women presenting at booking over the last year that have disclosed Female Genital Mutilation has increased significantly. We are unsure at present, why rates have increased so dramatically. Community intelligence suggest that it may be because families of Sudanese origin are moving up into Gloucestershire from the Bristol area. This has been discussed at the monthly vulnerability meetings as well as Maternity Clinical Governance. It has been discussed in Children Strategic Health meeting and the Designated Nurse for Safeguarding Children is aware. We are reviewing and updating our local policy.

Quarter (2023/2024)	Number of cases found
Q1	11
Q2	6
Q3	14
Q4	12

Safeguarding supervision

Safeguarding supervision has commenced but the business case for the mandated offer needs to be revisited.

BadgerNet

The national maternity IT system, BadgerNet, was launched in July 2023 and has had a mixed reception for our families with vulnerabilities. Where families move in and out of the county having access to their maternity notes can be very beneficial. However, there have been some challenges which have been identified, added to the divisional risk register and the actions are underway. There is currently an inability to upload documents onto BadgerNet to ensure the notes are contemporaneous for all health professionals. Safeguarding and mental health generates many reports from outside agencies which are critical to the family's care and decision making. As these are not able to be uploaded at present, staff have to continue to print reports out and add them to paper hospital files, which need to be retrieved. The Vulnerable Women's Team have developed a SOP we are part of a working group to develop a pathway are currently working on a SOP to enable this vital information to be uploaded onto the social pages of BadgerNet.

Perinatal Mental Health

Specialist Midwives continue to support weekly perinatal mental health clinics run collaboratively between Obstetrics and Mental Health team. We have had sickness in the team at the beginning of the year which was challenging and mitigated by increased flexibility of remaining staff. There continues to be a significant cross over between families who have numerous referrals into the Vulnerable Women's team.

Work to take forward for 2025/26

- Improvement in Safeguarding Training in compliance
- Improve knowledge about FGM across the service
- Re-audit Routine enquiry and Body mapping
- Ensure all new policies are launces across the service

Safeguarding Children report

The Safeguarding Children's Team activities include

- Safeguarding casework across all areas where children are seen
- Safeguarding casework where the parent is the patient where there are concerns for their children
- Local Children Safeguarding Practice Review and Rapid Reviews (completion of reports for GHFT involvement and membership in panel meetings)
- Child death reviews (where there has been a safeguarding concern)

For context, the number of children (under 18) attending unscheduled care areas (across ED and PAU) was 32,414, this year there was an increase from the previous year's total of 29,477 children.

From the September after their 16th birthday, children are cared for on adult wards. In the previous year just over 1200 16- and 17-year-olds were cared for on adult wards, an average of around 100 a month across 57 separate areas. Previously, most 16- and 17-year-olds were predominately seen across AMU, 5A and 5B. More children are now seen across 5B, SDEC and Snowshill with pockets of other children across multiple areas. This highlights the need for staff to complete their Level 3 training where required, regardless of whether they work in an area predominantly seeing adults.

Overview

- This year there were a total of 150 cot days for babies on the Neonatal Unit on a Child Protection Plan, this represents a significant reduction in days as the number in the previous year was more than double this.
- There were 14 Infants under 10 months with a significant injury whilst in the care of their parents, i.e. fractures or intracranial bleeds. This has increased from the previous year where there were 9 serious injuries identified. Some of these injuries were concluded to be accidental in nature in combination with the Local Authority and the police. However, some of them followed criminal and care proceedings as they were deemed potential Non-Accidental Injuries (NAI). 7 of these babies were progressed to Section 47 of the Children's Act. This increase has an impact on the ward due the emotional nature of this work as staff find these situations challenging. Children's

Social Care (CSC) will often suggest supervision of parents while the child is in hospital with a suspected NAI. There is often an assumption that the hospital staff will provide this supervision, which would not be appropriate or possible with limited resources. This is a common misconception by CSC and often causes some tension when this issue is explored. If CSC advise supervision, then they need to provide agency staff to manage this.

- There has been a 5% decrease in the number of adolescents presenting to the Emergency Department (ED) with an overdose, however, the number of adolescents attending ED with Deliberate Self Harm (DSH) has increased by 7%. Currently, the Mental Health Liaison Team (MHLT) offer a bio-psycho-social assessment to children admitted after self-injuring or attempting to end their life, or in a mental health crisis. Their remit does not include those children admitted with an eating disorder. The demand on the MHLT has increased, with an increase in the number of children requiring an assessment, this increase has been identified nationally. MHLT have employed two new members of staff. One band six MHN who is in an induction process at present and one Band 5 MHN in a development role, anticipated to be in a developmental process over the next 6-12 months. Due to the increased demand the MHLT have extended their cover to 08:00 to 16:00, seven days a week. When the additional staff are inducted, the team will start to offer a service to 16- and 17-year-olds and working hours will be extended to cover 09:00 to 21:00, in line with CAMHS Outreach service. The MHLT also provide consultation and education to GHFT staff.
- The number of children presenting to the Children's Ward with an eating disorder has doubled since the previous year. These children are often complex and require extended stays in hospital which can impact their mental heath. Where a decision is made for a Tier 4 bed, the wait for an inpatient bed can be quite extensive. All these children are discussed in the multi-agency and multi-professional SCRUM meeting (Severe Calorie Restriction and Malnutrition).
- Of the work undertaken by the Safeguarding team, neglect is the most common reason for communication or advice from the Safeguarding team. This is followed by poor Mental Health for children or their parents. Physical abuse and Domestic Abuse are the next significant categories for contacting the team.

Additional Safeguarding Children staff

In 2024, the business case for additional Safeguarding Children staff submitted by the Deputy Chief Nurse was partially approved by the ICB. This has meant that we have been able to fully recruit to three nurse posts with substantive contracts. We have augmented the team with an additional Band 7 Specialist Safeguarding Nurse, a band 7 Specialist Safeguarding Nurse for Children in Care (CIC) and a Band 6 Safeguarding Practitioner. This means that all strategy discussions are attended by one of the Safeguarding Children team when a paediatrician is not able to attend. Our vision is to expand the safeguarding service to focus on the multiple access points where children might attend across GHFT. 16- and 17-year-olds access the adult pathway in the trust and are often mistakenly treated as adults and subsequently there is the possibility of missed safeguarding, links have already developed with the adult wards where children most frequently attend. The team have identified expansion of core elements such as teaching and supervision within the Trust and have increased significantly the number of staff groups who now receive Safeguarding Supervision, predominately those with case holding responsibilities. These staff groups now being offered includes Paediatrics, enteral feeding team, bladder and bowel team, diabetes team, Neonatal unit, Neonatal outreach, respiratory team, Emergency Department, theatres and the paediatric neurodisability team. With an increase in workforce, we can now start to incorporate audit in our work to benchmark safeguarding and evidence any learning opportunities.

Public Health Liaison Forms

Trust staff completed nearly 3000 public health liaison forms in the last year, this is similar to previous years. This referral process has now been digitised by Gloucestershire Health and Care Trust (GHC) who receive the forms. This has improved the process as previously there were problems with legibility of handwriting on the forms. GHC have narrowed the scope of referrals compared to notifications to Public Health Nursing to reduce the number of unnecessary forms being completed. The process of completing these forms, predominately in the Emergency Department, is so well embedded in practice that it has been challenging to change behaviour in reducing referrals. Education and communications will continue to address this issue.

New daily meeting: Harm Outside the Home meeting (HOTH)

The multi-agency HOTH meeting occurs daily (Monday to Friday) with key agencies including GHFT Emergency Department representation, custody suite in the police, education safeguarding lead, Children's Social Care, youth justice and exploitation teams. The purpose of the meeting is to share information of those children who are or have been missing, those who are in police cells, concerning attendance in the Emergency Department (ED) or children who have had a child exploitation screening tool completed and their scores are high. An external tracker is populated with the child's details and they remain on the tracker until deemed safe. This meeting was piloted and is now well established as business as usual. This meeting allows for good multi-agency working and establishing themes across the partnership. The top ten most discussed children in HOTH are interestingly all Children in Care (CIC), with five of them being children placed in Gloucestershire by other Local Authorities. This is very relevant as our most recent recruitment holds a Child in Care portfolio.

Child Protection Medical Examinations

The GSCP Multi-Agency Child Protection Medical Assessment Procedure was published in 2024. There have been escalations of professional difference, which have resulted in a breakdown of relationships within the Gloucestershire system. This situation has necessitated the use of an escalation process with executive oversight and the use of an external resource to undertake a number of CPMA's in the last year. It is important to note that no harm has been detected associated with this situation.

An independent expert was asked to review the service with regard to the Child Protection Medical Assessment (CPMA), Professor Geoff Debelle has concluded his findings and written a report with his recommendations both for the acute trust, ICB and Gloucestershire safeguarding partnership. These recommendations have been accepted, some of them require scoping and investment, this work is underway. It is notable that the escalations and use of the external resource to undertake CPMA's has not been required recently.

The lack of data around CPMAs has been identified as gap in progressing these discussions, and identifying any additional resources required. At the request of the Gloucestershire Safeguarding Children Partnership Executive (GSCPE) the GSCP started collecting data

from all partner agencies regarding CPMAs, this includes GHC, GHFT and the Local Authority from the start of February 2025. Several data fields are being collected to identify reasons for CPMEs not being completed when the recommendation from the strategy discussion identified a need for a CPMA (Appendix 1). The expansion of the safeguarding team has allowed GHFT team to provide cover for all strategy meetings where discussions are held with regard for the need for a CPMA. On some occasions a paediatrician is not available due to clinical work. On these occasions, the recommendation is discussed with them for their decision if a CPMA is appropriate.

It has been established that the community paediatricians need to run their clinics at the same time as being on the rota for safeguarding, this means they have less time for strategy discussion, completing medicals and writing reports. The issue with strategy discussions has been resolved by the increase in the Safeguarding team. There are wider discussions about potentially moving towards a model whereby the paediatrician has protected time and would be available for safeguarding all day, this would need to be more fully scoped and resourced before implemented.

Youth workers on the Paediatric ward

In January 2024, a new pilot was launched involving youth worker working on the paediatric ward to improve young people experience of the hospital. This pilot has now been extended to March 2026 and has been very well received. Young Gloucester and the Paediatric ward were honoured to win the Partnership Award at the NHS Gloucestershire Hospital Staff Awards.

“The project supports young people under 18, who have been admitted to Gloucester Royal Hospital (GRH) or have presented at the hospital in a mental health crisis. The team offers a youth work intervention at the time of admission, supporting young people during their stay in hospital and for 6 weeks post discharge. The team has presence on the ward six days a week, Monday-Saturday, and offers community support across the County.

Our aims are:

- Reducing isolation whilst in hospital and providing support, and guidance to young people to help them manage their hospital stay.
- To develop positive coping mechanisms to use whilst in hospital and once they return

to community.

- Provide tools and mechanisms to provide distraction activities whilst in hospital.
- To advocate for young people and ensure their voice is heard in their treatment.
- Providing six weeks of caseworker support to help to support a young person to reintegrate back into the community and engage with positive activities.

The project is a creative and innovative blend of health and VCS colleagues, working together to improve the outcomes for our most young people in the county. The foundation of our model is youthwork, placing the young people at the centre of the work, and building their confidence, resilience and well-being so that they have the agency and skills to take their next steps" (Appendix 2 - Paediatric Youth Work: Inspiring young people, Young Gloucestershire.)

"What have we learnt so far and opportunities

- Youth work is an extremely effective model in supporting young people's well-being, both during admission and post discharge,
- Youth work is proving effective in reducing readmission for this cohort.
- Reduction in sedation and restraint has been significant.
- Surveys tell us week 3 after discharge is a critical time for wrap around support, as this is when young people's well-being scores drop slightly, and therefore the importance of timely intervention after discharge is key. YG are pleased to have been able to offer this within two weeks of discharge, in line with NICE guidelines.
- 100% of parents surveyed, raised that they would benefit from longer term parental support to help them manage the impact of the crisis on their lives. It would be beneficial to explore an offer for parents.
- Young people engage more readily in creative and visual well-being tools than written tools.
- In over 65% of cases young people admitted were known to other services pre-admission, reviews into this data offer substantial support toward a multi-agency triage to stop young people "falling through the cracks" and making sure they are "supported by the right people at the right time".
- Safeguarding data tells us the main area of concerns are related to the home environment and relationships.
- For continuity and staff security we are looking at funding and scope beyond 26.
- 16- and 17-year-olds within adult wards do not get the same level of support despite being

equally vulnerable. We would like to expand the service where possible to include working with this cohort."

Safeguarding Allegations against GHFT

See separate section for details of referrals to the LADO. There have been 10 referrals this year and the Named Nurse for Safeguarding Children attends the majority of these. In the previous year it was identified that 'Health' referrals are lower than would be anticipated given the large workforce. The LADO team have offered additional training around this area, they have already made contact with the Emergency Department to offer some training around this area.

Local Children Safeguarding Practice Review (LCSPR) and Rapid Reviews across Gloucestershire

The Named Nurse for Safeguarding Children has represented the Trust at all of these reviews and completed all the chronologies and independent management reviews. There have been five Rapid Reviews, of which none were progressed to LCSPR's. Two of the Rapid Reviews related to children who were well known to GHFT services, one was well known to the Paediatric Diabetes Team and the other child was well known to the Cystic Fibrosis Team.

Safeguarding Children Training

See Safeguarding Training section for details. All compliance across the three levels has slightly increased since the previous year reports. This all needs significant improvement, especially Level 3 training. There has been joint working with the paediatric matrons and the Divisional Director of Quality and Nursing, Women's and Children's division to improve the compliance in the Children's unit. The revised Intercollegiate Document is awaiting publication, this may impact on the amount of training required, dependant on details to follow.

Safeguarding Adults report

Safeguarding Adults covers all adults with actual or suspected Care and Support Needs (as defined by the Care Act (2014)); this includes those who are subject to various forms of exploitation. Our High Impact User service, Homeless Specialist Nurse and Substance Misuse Specialist Nurse work together with our patients who have the highest health inequalities – those who are care leavers, those who have significant substance misuse issues, those who are homeless, those who are sex working or any combination of these; and all of whom experience significant poverty and chaotic lives.

The Safeguarding Adults Team have interacted with the needs of over 1,000 patients every month.

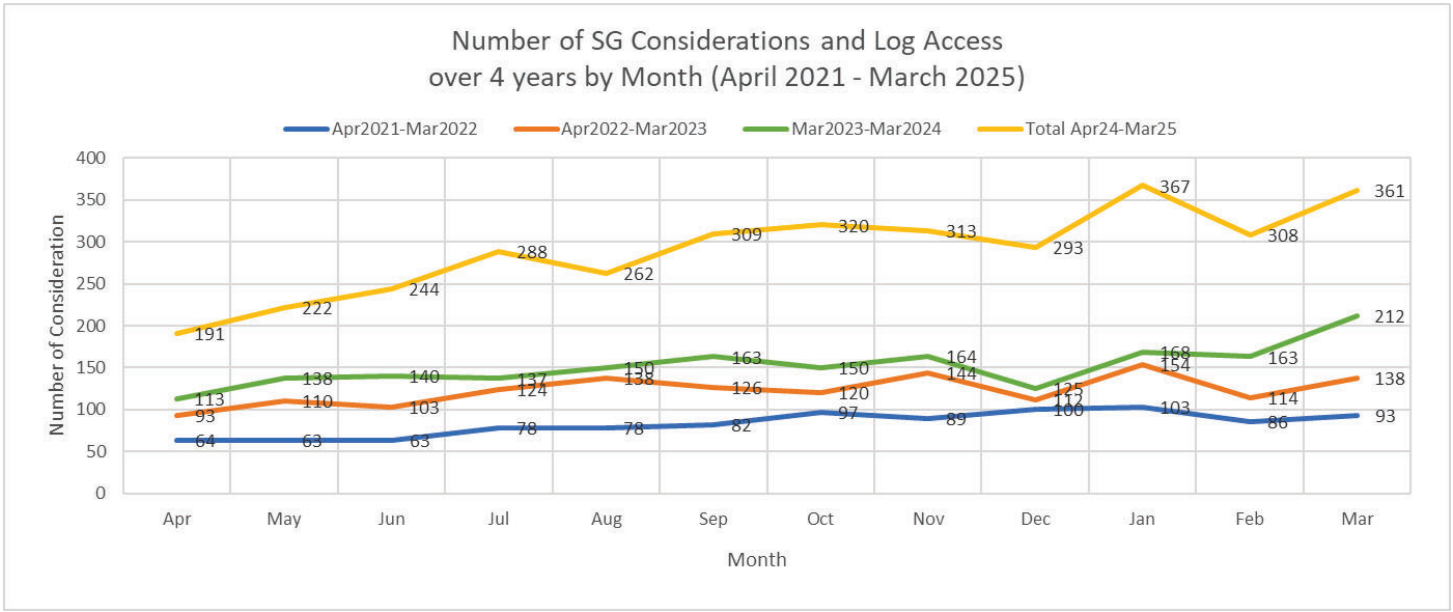
Adults with Care and Support Needs

The numbers of adult safeguarding referrals received by the team has increased further on the substantial increases of previous years. A comparison of the number of contacts to the Safeguarding Hub over of the last three years can be seen in the two graphs below. This is partially due to a change in the Safeguarding alert wording, which now advises contacting the Safeguarding Team during office hours for Safeguarding Log checks. Balancing this, several new Band 7+ staff have been taught to access and use the Safeguarding Log for queries in their own areas.

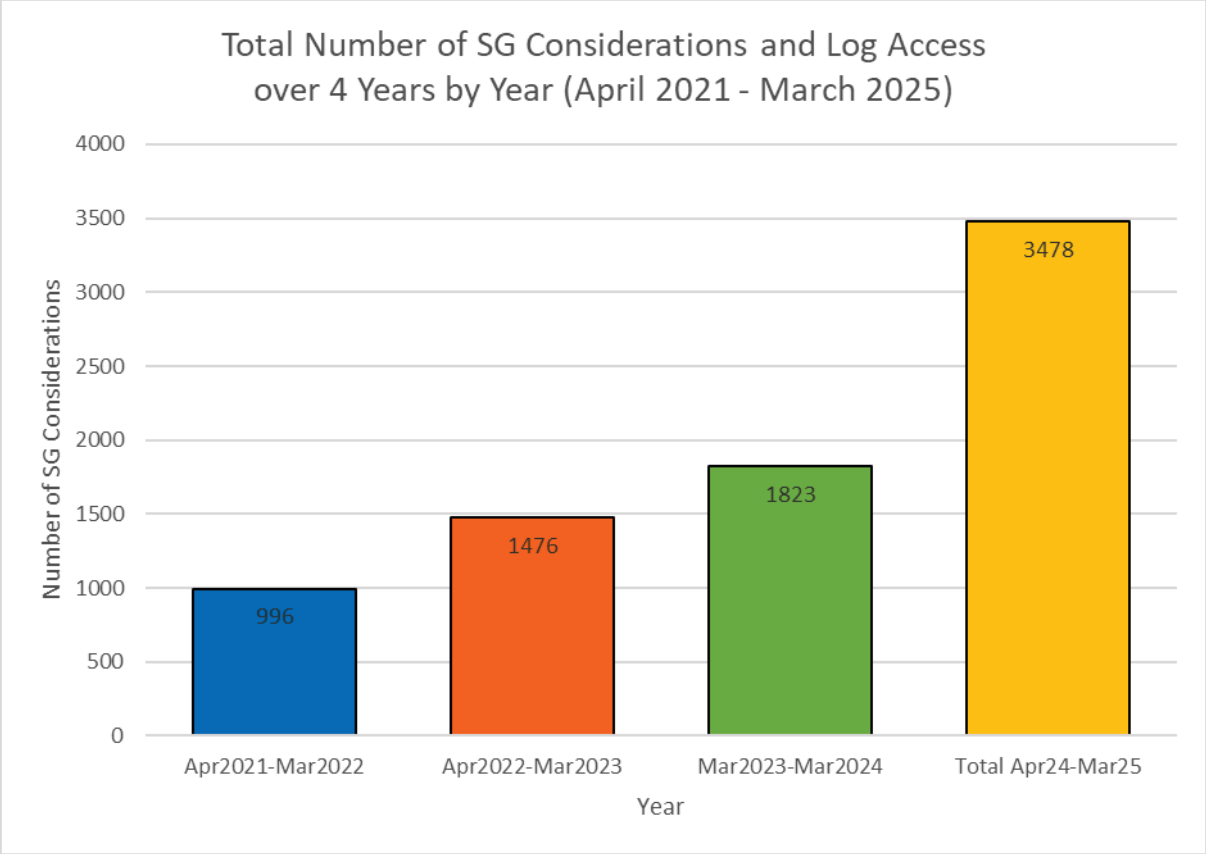
'Pathways other than safeguarding' remains the highest proportion of the referrals, of these patients those whose care and support needs are not being met remain the highest proportion of these referrals. Managing such referrals at this level reduces ongoing individual risk, often avoiding harm. Almost half a million people aged over 65 will experience some form of abuse or neglect (Age UK) and GSAB safeguarding audits have shown how much more prevalent domestic abuse is in this age group than Adult Social Care had previously acknowledged. Therefore, we have seen an increase number of shared pathways, for example, safeguarding adults plus domestic abuse.

There remains a continual high level of reporting of self-neglect, mainly amongst people living alone, often with capacity but not wishing to have support with their care needs. This latter

group are the cause of considerable professional, family and community anxiety as everyone can see that help is needed, but the person declines all offers. Under the terms of the Mental Capacity Act (2005) they have the absolute right to make such decisions, except where those adversely affect others and therefore often the only available action is a Fire Safety check by Gloucestershire Fire and Rescue Service (GFRS). An independent Safeguarding Adult Review chair has suggested that we give consideration to how we as healthcare professionals express our concerns to partner agencies and has suggested the use of the term 'medical self-neglect' where the patient does not appear to be classically self-neglecting, but is not following professional guidance in the management of their chronic disease. We have seen very difficult situations arise with diabetic patients and those on renal dialysis in particular. The language of 'this person is medically self-neglecting and this will have fatal consequences if 4 dialysis sessions are missed' makes more sense to non-healthcare staff than the ways we have been trying to convey concern to date.



Graph 1 - Number of Safeguarding considerations by month over a four-year period



Graph 2 Number of total considerations over a four-year period

Between one quarter and one third of monthly contacts consistently reach the threshold for referral for consideration of a s42 enquiry under the Care Act (2014), albeit the actual numbers of these are greater than previous years because of the ever increasing numbers of concerns brought to the attention of the Safeguarding Team. Approximately one third of our referrals are taken forward for a full s42 enquiry. Feedback from Gloucestershire Safeguarding Adults Unit (GSAU) is that although their workload has also significantly increased, our referrals are at a similar level to other agencies. However, in the light of CQC inspection of Adult Social Care and concerns being expressed that s42 enquiry levels seemed low compared to 'similar' counties the GASU leads will be coming to visit the GHFT Safeguarding Team twice a year to audit our work and confirm that our preliminary work is not missing or minimising cases which should be referred to GSAU.

It continues to be difficult to balance the needs and wishes of patients to make their own decisions and the level of risk aversion amongst clinical staff. Seeking the patient's voice and Making Safeguarding Personal remain a daily challenge.

Safeguarding Adults Reviews (SAR)

The first SAR commissioned this year was referred by GHFT. The subject was a 22 year old care leaver who was dependent on thrice weekly renal dialysis. She was 'resident' in GRH for several months whilst Gloucestershire and a neighbouring county seemed unable to decide which of them had the duty to accommodate and provide Adult Social Care. Her trajectory was hampered by a vagueness over whether or not she had a learning disability and her frequently changing her mind about where she wanted to live. Many staff in GRH and Cotswold Dialysis went out of their way to be flexible and adjust their normal boundaries, but her behaviour escalated to abuse and she was eventually subject to warning letters from our Behavioural Standards panel. She died of sepsis at the supported accommodation for young adults which Gloucestershire Adult Social Care had allocated her to, waiting for an ambulance to arrive after reporting to staff that she felt unwell. The final report is awaited, but an early recommendation is for healthcare staff to adopt the terminology of 'medical self-neglect', as discussed above.

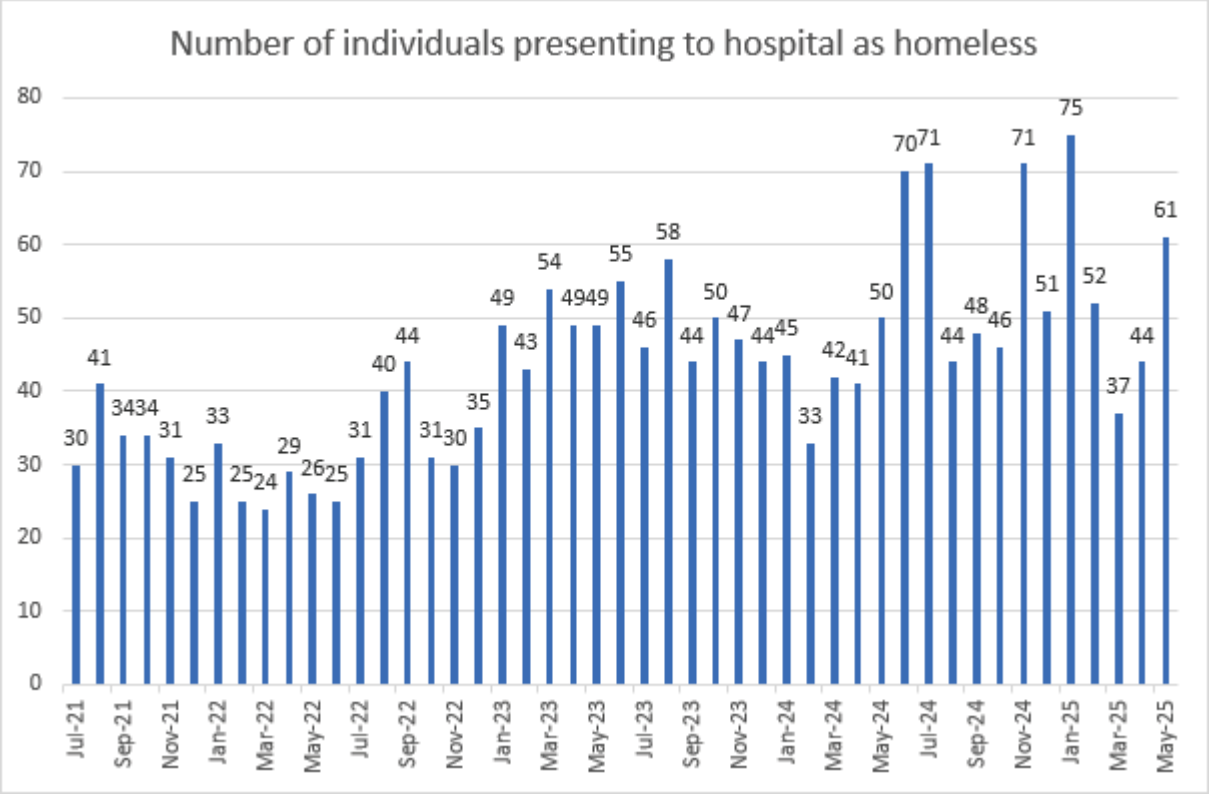
A Homeless Death Review was held for two men. Both were well-known within the homeless community and to services for the homeless. At year end the report into this review had not been presented for review, but there is no expectation of agency specific recommendations for GHFT.

There are additional SARs waiting to start:
- a man well-known to our Safeguarding Team as well as to criminal justice colleagues impaled himself on a large knife in Shire Hall in December 2024 and died in ED at GRH
- a rapid review of an elderly lady who community nurses and social workers had considerable difficulty with safeguarding is scheduled for the first quarter of 2025/2026

Homeless patients

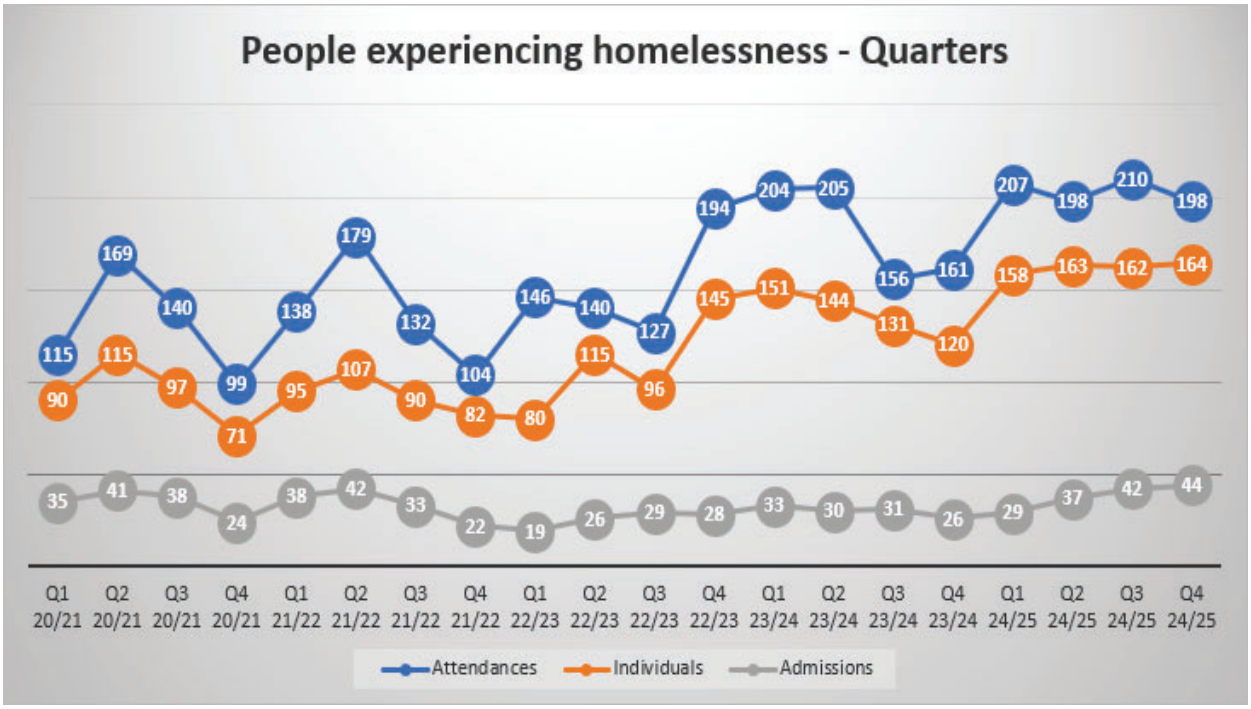
The Safeguarding approach to Homelessness, which GHFT has pioneered, has identified many people who are homeless with multiple vulnerabilities, such as victims of modern-day slavery, human trafficking, sex working for accommodation and victims of exploitation. The strong partnerships formed with other agencies often means a swift multi-agency response supporting the individual into accommodation and mitigating the risks of being on the streets or sofa-surfing. People experiencing homelessness continue to face extreme health inequalities.

The increase in 2024 of people presenting as homeless to GHFT has not subsided (graph 1). This is in line with a national rise in homelessness; with the current housing shortages and cost of living crisis, it is possible there will be further increases. This increase has been manageable due to support from other workstreams within the Safeguarding Team.

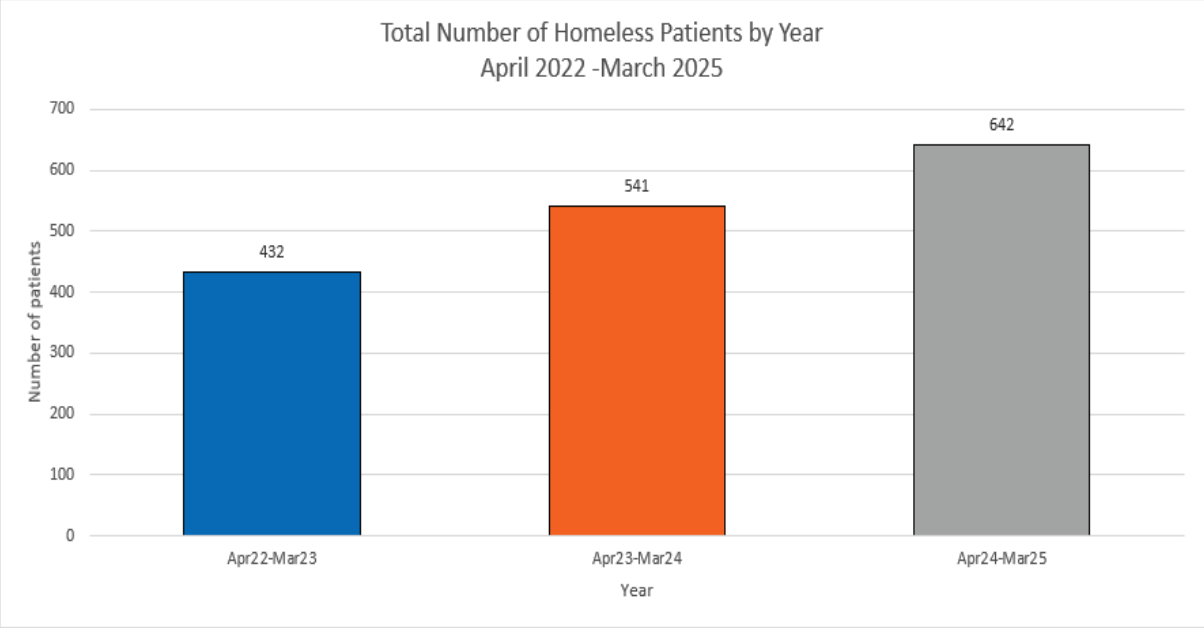


Graph 1

Recent changes in commissioned services and out of hours provision has meant we have not seen the reduction in Q4 attendances, as has been seen in previous years (graph 2). This has been escalated within ICB and housing partnership to address these concerns before winter 2025/26. This equates to a year-on-year increase (graph 3).



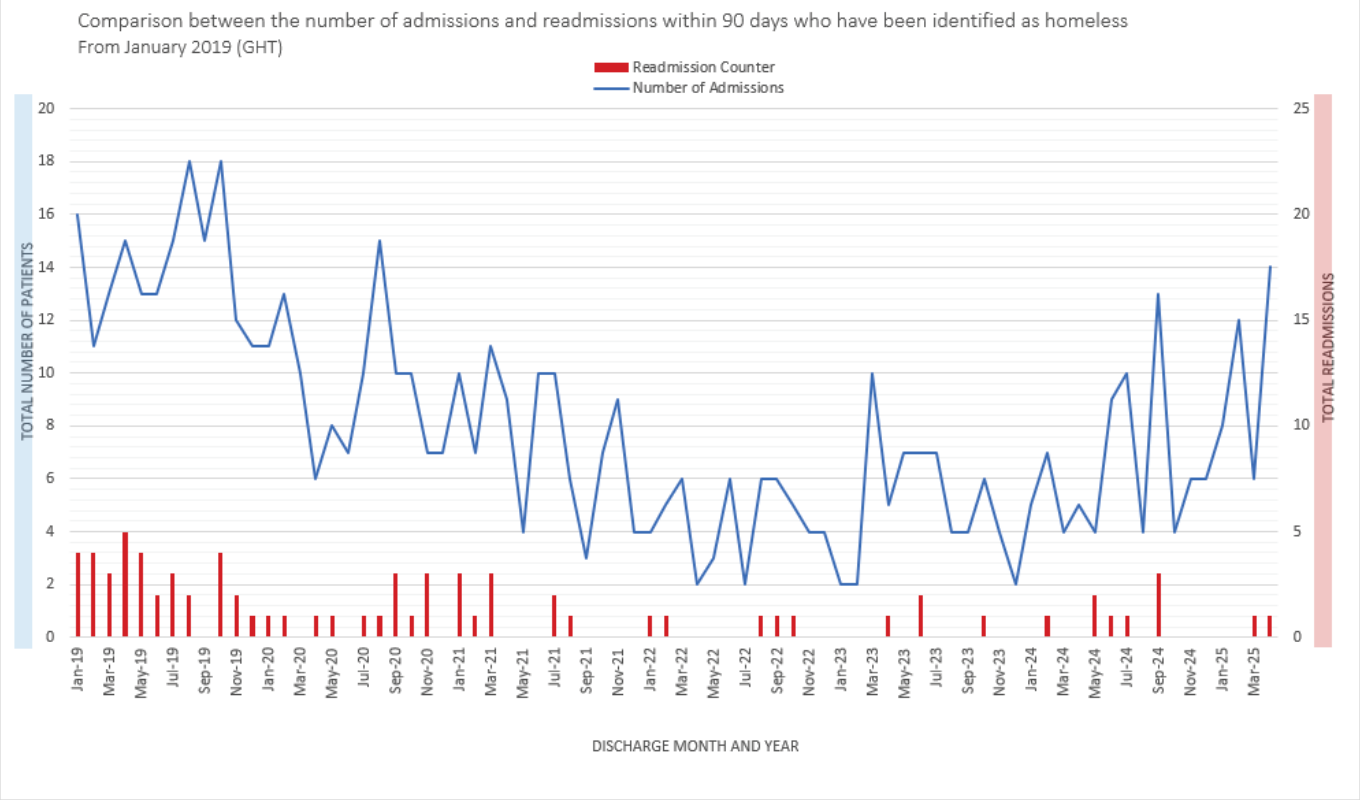
Graph 2



Graph 3

Despite this increase in the number of referrals, GHFT admission rates and readmission within 90 days figures stay comparatively low (graph 4); reaffirming that the GHFT approach of supporting people experiencing homelessness in the Emergency Department can prevent

admissions to the acute trust. As a result, frequent attendance to the Emergency Departments for people experiencing homelessness are well below the national average. Pathway UK recently suggested that, nationally 50% of discharges from hospital for homeless patients were back to the street. Recent audit undertaken by GHFT revealed 83% were discharged into accommodation, with the remaining 13% made up from those who self-discharged or declined support.



Graph 4

Due to the holistic approach towards homelessness taken by GHFT, we remain seen nationally as an example of best practice. The Homeless Specialist Nurse frequently guides and supports national projects and other acute trusts in implementing similar processes. Although the next year is likely to present some financial challenges and change in resources available, the approach will very much focus on ensuring every attendance to hospital is used as an opportunity to safeguard and engage any individual experiencing homelessness in a personalised way.

High Impact User (HIU) team

The team continue to innovatively grow the service with the funding provided by the integrated Care Board (ICB). This year has ended with secure recurrent funding for HIU clinician and administrative time moving into the block contract.

The HIU team funded by the ICB comprises:

- 2 PAs (8 hours / week) of medical time – during the year this has been provided by a pain consultant and an ED consultant. Due to maternity leave, this moved to a pain consultant and a psychiatrist by the end of the year
- 37.5 Hours of HIU coordinator time within Safeguarding. Since July 2024 this has been a made substantive and recurrent via additional Trust funding
- 8 hours of administrative support – an additional 22 hours a week is funded by GHFT Safeguarding Team to ensure that this workstream is adequately resourced

In addition:

- Emergency Department (ED) have funded 0.5PA of ED consultant time per week. As the consultant with HIU interest is leaving the from Trust July 2025 that SPA time is pending review within Unscheduled Care and may not be re-allocated
- 6 - 8 hours a month support from the Mental Health Liaison Team is funded by GHC on a bank basis
- 1.6WTE Specialist social prescribers were employed by the Community Wellbeing Service and funded by the ICB to work with HIU patients in Gloucester City and Cheltenham until the contract ended on 30th September 2024.

With the loss of social prescriber provision, the team are trying to use community organisations for support, to provide some support and bridge the gap in service. A multidisciplinary approach is always utilised to provide patient centred care and continue to work with community mental heath services/teams, hospital teams, primary care and many other organisations to utilise joint care planning. Nevertheless, there has been a noticeable increase in HIU patient contact with health services since removal of this resource, demonstrating that these roles were integral and essential in achieving the result to date, due to this patient cohort requiring intense directed community support. Their experience of health

and social inequalities is too great to expect them to be able to quickly manage with signposting and self-initiated options.

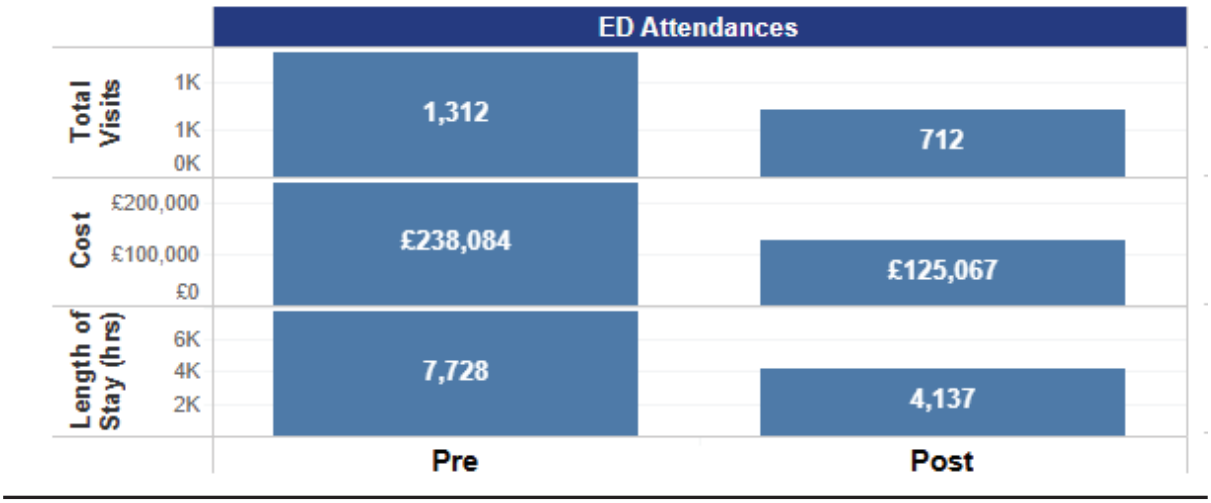
Business cases presented to the ICB for GHFT to employ specialist social prescribers were unsuccessful. This decision is now being reviewed by the ICB.

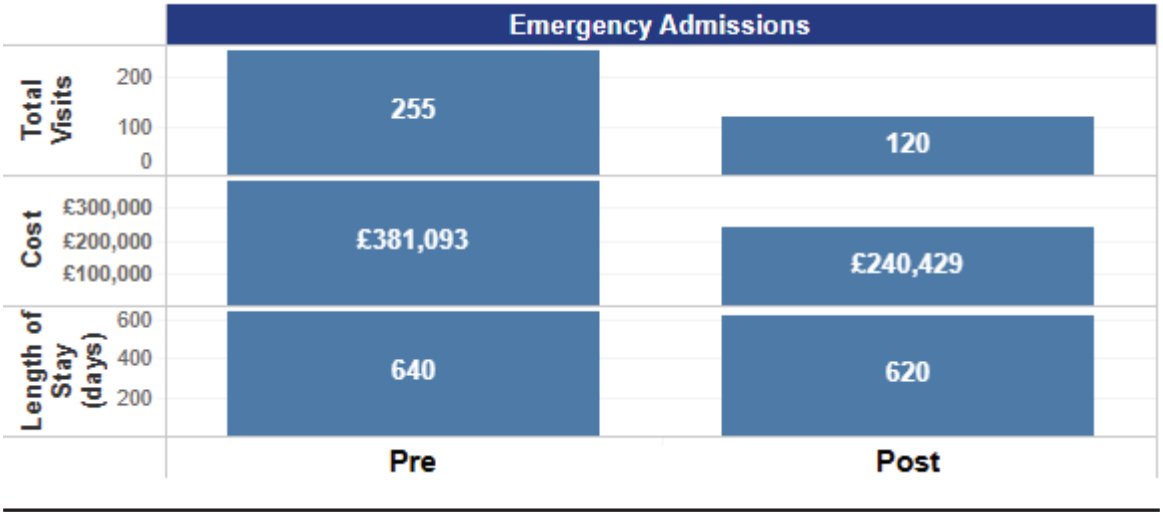
October 2024 saw the first joint clinics working with Primary care with inner-city Gloucester and Cheltenham primary care networks (PCN's). This has been welcomed by the networks and has proved invaluable in joint care planning, information sharing and drawing individuals back into gaining support from GP/Primary Care services and not urgent care.

The team still continue to review overall health contact data – ED attendances, acute admissions, elective admissions, MIIU, 111, GP, out of hours, mental health contacts and ambulance data. The aim is to see a reduction in length and number of hospital admissions, then the number of ED/MIIU/OOH attendances and increase each individual's range of coping strategies to manage distress and uncertainty, thus improving their quality of life and achieving non-cash-releasing savings within the healthcare system. This often alleviates pressures felt by other statutory partners. Many of the cohort live in areas of deprivation as noted below.

Data

Figures below demonstrate workload since the team started using EPR for 189 patients who have had intervention from the HIU team. These show an overall saving of £253,681 for hospital admissions and ED attendances when comparing the patient cohort three months prior to three months after HIU team intervention. 135 fewer hospital admissions and 600 fewer ED attendances, saving 3,581 hours of patient time which would have been spent in ED and, with this, a considerable improvement in both patient and staff experience.





Ethnicity, Gender and age summary (report run with a cohort of 175 individuals)

- 4.6% of patients are from a BAME background
- The cohort is predominately female (61%)

- Just under 3% of the cohort do not speak English as a first language
- The HIU caseload is a relatively young cohort. Approximately half the patients are under the age of 40
- Patients overwhelmingly live in urban areas and live in deprived area i.e. inner-city Gloucester and Cheltenham
- A third of the cohort live in the most deprived parts of the county, and a third of patients are among the top 20% most deprived in England

Ethnicity

Row Labels	Count of MRN	Count of MRN2
Any other Asian background	1	0.6%
Any other Black background	1	0.6%
Any other ethnic group	2	1.1%
Any other mixed background	4	2.3%
Any other White background	9	5.1%
Not Known	2	1.1%
White and Black Caribbean	3	1.7%
White British	152	86.9%
White Irish	1	0.6%
Grand Total	**175**	**100.0%**

Gender

Row Labels	Count of MRN	Count of MRN2
Female	107	61.1%
Male	68	38.9%
Grand Total	**175**	**100.0%**

Age Band

Row Labels	Count of MRN	Count of MRN2
<21	6	3.4%
21-30	42	24.0%
31-40	42	24.0%
41-50	33	18.9%
51-60	26	14.9%
61-70	17	9.7%
71-80	5	2.9%
81-90	2	1.1%
91-100	2	1.1%
Grand Total	**175**	**100.0%**

National Deprivation Decile

1 = most deprived, 10 = least deprived

Row Labels	Count of MRN	Count of MRN2
1	34	19.4%
2	23	13.1%
3	16	9.1%
4	12	6.9%
5	20	11.4%
6	18	10.3%
7	9	5.1%
8	9	5.1%
9	17	9.7%
10	14	8.0%
(blank)	3	1.7%
Grand Total	**175**	**100.0%**

Gloucestershire Deprivation Decile

1 = most deprived, 10 = least deprived

Row Labels	Count of MRN	Count of MRN2
1	59	33.7%
2	22	12.6%
3	20	11.4%
4	11	6.3%
5	7	4.0%
6	8	4.6%
7	5	2.9%
8	10	5.7%
9	12	6.9%
10	6	3.4%
(blank)	15	8.6%
Grand Total	**175**	**100.0%**

The team continue to use the hospital reports form the business intelligence team (six ED attendances in three months) and the previously mentioned ICB report. Referrals are taken from hospital teams, community teams (SWAST, complex care, GPs, other acute Trusts, voluntary/charitable groups). Work continues with PALS in support of complaints and trying to improve future care planning for individuals.

The HIU team run four planned clinics monthly to assess/support and write personal support plans and provide a central point to coordinate care. Patients are identified by referrals (clinicians, PALS, SWAST etc) and hospital/ICB analyst reporting. A total of 189 patients are active on the caseload for 2024-2025 (have current plans and under review).

Plans for the next year

- Exploring the option of employing social prescribing professionals directly
- Continuing to build on links in Primary care. Networks are contacting the team to build a closer working relationship with further PCN's
- Forging new links/relationship with ED due to current consultant leaving the Trust
- Investigating the best route to employ a clinician into the vacant 0.5 PA into the team
- Building relationships with projects the ICB are investing in to support Mental Health patients in the HIU workstream

- Aligning patient plans with the Gloucestershire Integrated urgent care service
- Working more closely with criminal justice and HIU patient (pilot with NHS England 2025)
- Starting work on a multi-agency plan for transitioning children into adult HIU service
- Working with a new psychologist and managers to embed psychology into the workstream
- Ascertaining next steps to improve service funding

Substance Misuse Specialist Nurse

A key achievement this year has been making the Substance Misuse Specialist Nurse role substantive, despite significant financial pressures. This has led to a marked improvement in the care of drug-using patients, particularly around opioid substitution therapy (OST). Importantly, no patient was discharged without an OST prescription in place, giving confidence to both patients and community drug services. Encouragingly, this has contributed to increased engagement from patients with elective care.

Delays in receiving OST have dropped significantly — from an average of six per month to between zero and one in 2025. VIA, the new community drug team provider, has reported no delays since the role began. A VIA team leader shared: “The support [of the Substance Misuse Specialist Nurse] has been invaluable… you have bridged the gap between VIA and the hospital so we can do what’s necessary and safe for our service users.”

The role’s visibility has grown, with referrals from both nursing and medical teams. Staff are increasingly aware of the complex needs of patients with substance misuse, who often experience the most significant health inequalities. Feedback suggests these patients now feel more recognised and less stigmatised.

However, challenges remain. The absence of on-site drug testing continues to impact discharge planning and legal processes. Current tests must be outsourced, with a 10-day turnaround, which incurs delays and cost. Although existing Point of Care testing options conflict with national guidance, new guidance may offer a solution. Introducing appropriate on-site testing would improve clinical decision-making and reduce the risk of inappropriate prescribing.

Domestic Abuse and Sexual violence report

Overview

Key activity this year included quality-assuring all Domestic Abuse (DA) referrals before submission to MARAC or specialist services, supporting multi-agency information sharing, delivering DA and Sexual Violence training, and maintaining policies, pathways, and staff-accessible resources.

Referrals for DA across Gloucestershire, including from GHFT, have continued to rise. DA remains the highest-risk safeguarding concern across all agencies, particularly in relation to potential fatalities.

Gender patterns remain consistent, with 90% of victims being female. A full year of ethnicity data shows most victims are White British (85%), with a further 5% from other white backgrounds. Of note, several victims of Indian and African origin were overseas-trained female staff. We have worked with EDI and Community Engagement colleagues to position the Safeguarding Team as a safe and supportive contact point and to raise awareness that UK law protects victims. However, further sensitive engagement is needed to build lasting trust in these communities.

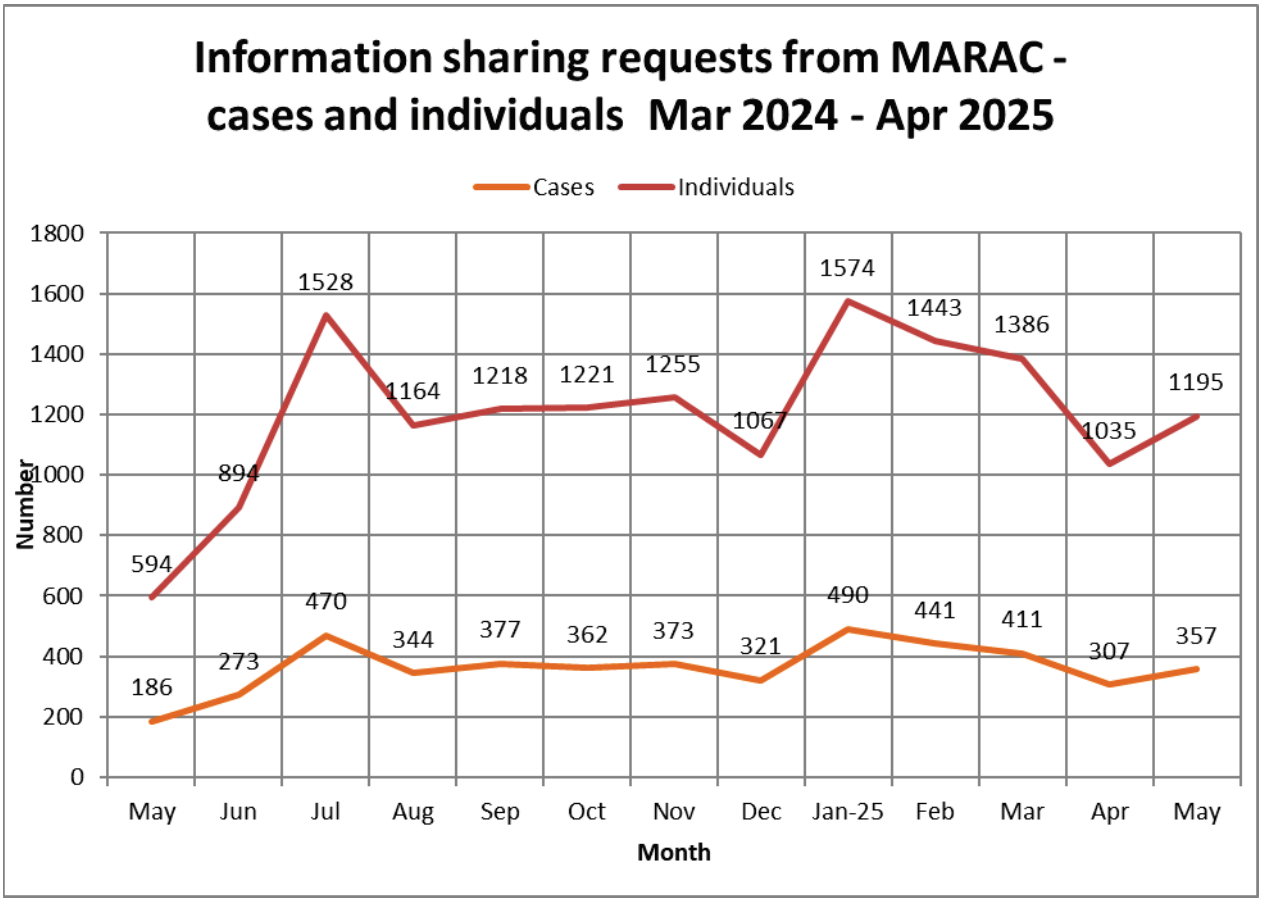
Referrals

Domestic Abuse victims identified by Trust staff have been consistently higher on a monthly basis than all previous years; averaging out at 54 per calendar month. This is 11 more cases **per month** than in 2023/2024. Total referrals processed during 2024/25 were 655, an increase of 22% on 2023/24 figures. The majority of completed DASH assessments continue to come, as we would expect, from our Emergency Departments, which historically accounted for 100% of our referrals. We continue to see an increase in referrals from wards and outpatient areas as a result of inclusion of DA in the mandatory Safeguarding Adults training for all staff; a rolling 3-year programme which commenced in 2021.

As a result of these increases whilst we did achieve our 90% target to quality assure and process referrals within 3 working days of assessment in every month this year, it was harder to do so and had Safeguarding Adults training not moved to a full video plus MCQs package, would have been impossible.

Information-sharing

The information-sharing agreement to which GHFT signed up in 2009 requires us to provide information for each High-Risk referral to MARAC, made by any agency, and to add Safeguarding alerts on our Hospital IT systems within 3 working days. This workload equates to 4,712 High-Risk cases in 2024/25 (a rise of more than 50% on the previous year), involving 15,574 affected individuals.



Thanks to our dedicated group of bank nurses, we are now providing information to MARAC within the required 3 working days and placing the necessary alerts on the Safeguarding Log and Trakcare. They have also cleared the accumulated 3-year backlog of unplaced alerts so that we are now confident that our clinicians have information known to 'the system' when patients present to our services. However, we know that hundreds of women went through entire pregnancies, where we had been provided with information but had not had the capacity to add the alerts for staff awareness of safeguarding concerns. With the help of the Vulnerable Women's Team (VWT) and Business Intelligence (BI), we have now been able to identify 1,570 babies born to women who needed, but did not have, alerts in place and have started work on placing alerts on these babies whilst the VWT midwives are ensuring that all new births to women with Safeguarding alerts have those alerts mirrored on the child's record. Unfortunately, we know that at least one of these babies came to serious harm in the interim. These delays and associated risks were reported regularly via Trust Safeguarding Operation Group Reports and included within risk 60 regarding insufficient resources within the Safeguarding Team.

Reviews of Safeguarding alerts

Three-year reviews of active Safeguarding Alerts have been deprioritised due to Domestic Abuse workload pressures and were only reviewed when prompted by complaints. No routine reviews have occurred in over four years, raising concerns about data compliance. However, with capacity now available in the bank nurse team, reviews of the oldest alerts (dating back to 2010–2012) have resumed.

Training

Mandatory Domestic Abuse (DA) training is now integrated into Safeguarding Adults (SGA) training at all levels. A video package has been developed for Level 3 staff, but Levels 1 and 2 continue to rely on outdated e-learning resources. Face-to-face DA training has been delivered in high-need areas such as ED, gynaecology, and breast care, in response to specific incidents including a Domestic Homicide Review. In light of the Domestic Abuse Act 2021 and IFAS 2024 guidelines, targeted training on Non-Fatal Strangulation (NFS) has been delivered across EDs, and pathways have been updated and promoted internally and externally.

Hospital-based Independent Domestic Violence Advocates (HIDVAs)

The HIDVA service remains active and well-utilised, with two staff members offering education, safety planning, emotional support, and multi-agency liaison for patients and staff affected by DA.

Sexual Assault pathway

Referral links between GHFT and the Sexual Assault Referral Centre (SARC) remain effective. The Trust intranet pages have been updated to support staff and reflect current clinical guidance, including the role of CT angiography in NFS assessment.

Staff as victims of Domestic Abuse

We have been involved in providing support to 31 members of staff (and their managers) who have disclosed that they are victims of Domestic Abuse on the year 2024/25. We have worked alongside the Staff 2020 Hub, our GDASS HIDVAs and People team to ensure that staff who have experienced DA at home have been offered the support they may need in order to reduce risk and ensure their safety at work and at home. This in some instances has also involved the identification and management of perpetrators of abuse who have been identified as working within our Trust.

Domestic Homicide Reviews (DHRs)

During 2024/2025 the Lead for Safeguarding Adults was the panel member representing GHFT on 8 Domestic Homicide Reviews and attended Expert Review panels to determine whether agencies had sufficient information to make a recommendation to take deaths through to DARDR. Gloucestershire ICB is leading on the recommendations which all health partners are required to implement.

Mental Capacity Act compliance report

The Mental Capacity Act (MCA) 2005 applies to individuals aged 16 and over in England and Wales. As part of UK Human Rights legislation, it underpins the right to make informed decisions or to refuse consent and must be considered in every clinical interaction. Its core philosophy is to empower individuals to make as many decisions for themselves as possible and to ensure that, when someone lacks capacity, any decisions or actions are taken in their best interests.

A key development this year was the launch of new MCA assessment and Best Interests documentation within the Electronic Patient Record (EPR), designed to support staff in complex decisions such as serious medical treatment or changes in accommodation. These documents went live in mid-February and address long-standing challenges related to safeguarding risks, particularly risks 51 and 52.

The five statutory principles of the MCA must be applied and evidenced in care planning. Audits have shown that while staff consider these principles, the documentation of them has been inconsistent and scattered across various records. In response, we worked with the Integrated Care System (ICS) MCA lead to adopt a unified assessment document, already in use across other services. While it looks different in EPR, it follows the same structure and includes adaptive logic—unfolding further sections based on responses. This makes the initial form more accessible while encouraging thorough patient-centred assessment.

1	**Presumption of capacity** – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise (by assessment using the 2-stage test) In some situations it is necessary to test this by capacity assessment.
2	**Individuals must be supported to make their own decisions** – give individuals all practicable help before they are treated as lacking capacity.
3	**Unwise decisions** – an individual with decision specific capacity can make, what another may consider to be an unwise decision.
4	**Best interests** – a decision made under the Act on behalf of a person who lacks capacity must be able to be justified and demonstrated as being in their best interests.
5	**Least restrictive option** – decisions taken on behalf of a person who lacks capacity must be chosen and implemented on the basis that it is the choice which least restricts the basic rights and freedoms of the individual and which meets the best interest objectives.

Although a revised MCA Code of Practice was consulted on nationally in 2022, the original 2007 Code remains in force. Current guidance suggests there will be no implementation of the Mental Capacity (Amendment) Act 2019 or Liberty Protection Safeguards (LPS) in the near future. Accordingly, national and regional safeguarding leads have advised trusts to continue strengthening MCA and DoLS practice under the current legislation.

Training on MCA is embedded within all levels of Safeguarding Adults training. Feedback suggests it is positively influencing practice. In addition, the MCA and DoLS Lead delivers tailored sessions for specific clinical teams using relevant case studies. These sessions consistently receive excellent feedback and have helped address local gaps in knowledge and confidence.

To support day-to-day practice, we have developed well-received pocket-sized guides on capacity and consent, giving staff practical prompts to use in clinical discussions.
We have also implemented real-time quarterly audits focused on recent DoLS applications and associated clinical records. This approach ensures timely feedback and better outcomes for patients. While some improvement is evident, these audits show that documentation and consistent application of MCA principles remain areas for further development and remain a key focus for the year ahead.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) apply to adults (18+) who lack capacity to consent to their hospital care arrangements, are not detained under the Mental Health Act, and are required to remain in hospital in their best interests. DoLS is grounded in UK Human Rights legislation and the Care Act 2014, and relies on the application of the Mental Capacity Act 2005—specifically the principle of acting in a person's best interests.

DoLS can apply even if a patient is not attempting to leave and no overt restrictions are in place, as clarified by the 2014 *Cheshire West* Supreme Court ruling. It is a legal detaining power that also provides safeguards: including representation and the right to challenge the deprivation.

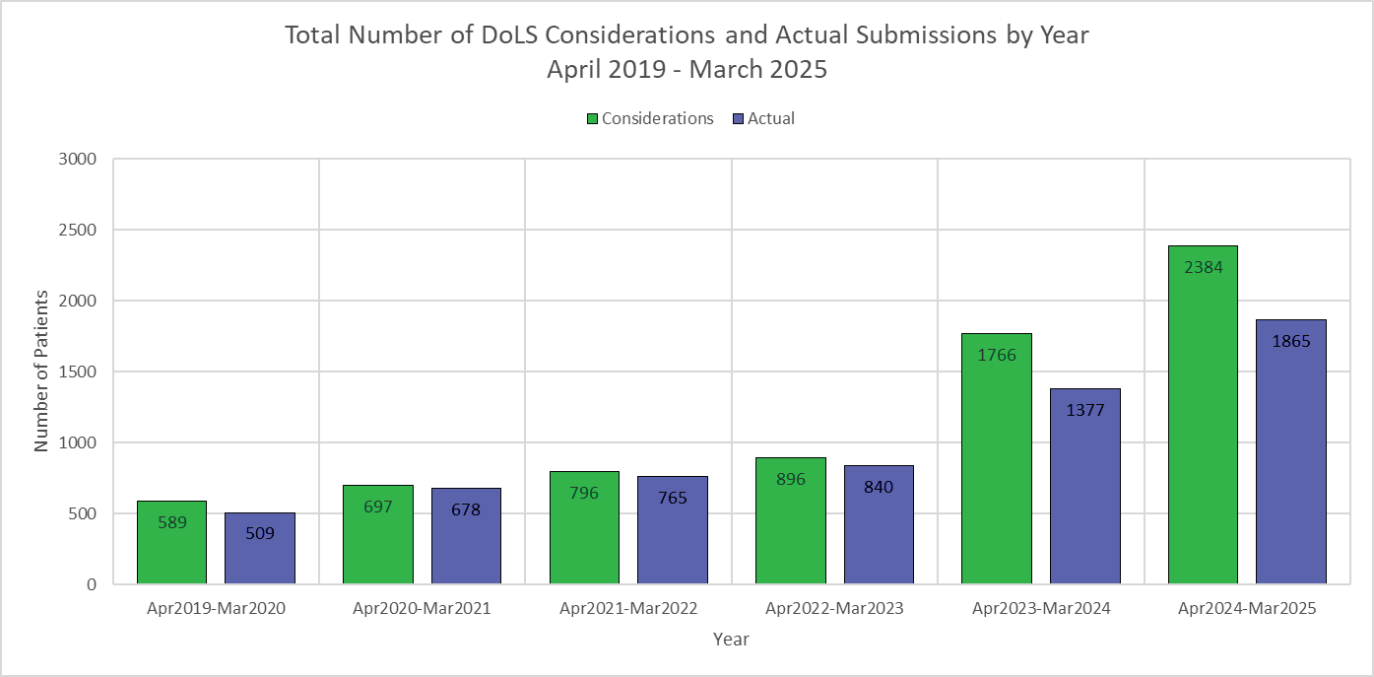
DoLS applications must be completed by clinical teams at the point of need. The Safeguarding Adults Team supports, reviews, and monitors all DoLS activity, with daily follow-up to ensure legal compliance and patient-centred care. This includes reviewing restrictions, objections, and associated risks.

Guidance remains complex. When additional restrictions such as enhanced care or nasal bridles are in place, the need for a DoLS is clear. Conversely, where the *Ferreira* judgment applies—such as in ICU settings—no application is needed. For borderline cases, we continue to take a cautious approach and submit applications unless *Ferreira* clearly applies.

As the Managing Authority, GHFT must submit applications to the relevant Supervisory Body—usually Gloucestershire County Council. Over half of Gloucestershire's monthly DoLS applications originate from GHFT. Most are resolved within 14 days, and local agreement now allows this period without external scrutiny unless escalation is requested. This reduces unnecessary extension requests and ensures assessor time is focused on complex or prolonged cases.

Since the appointment of a dedicated MCA and DoLS lead, application rates from both medical and surgical teams have remained consistently high. From April 2024 to April 2025, GHFT submitted 1,865 DoLS applications. An additional 519 patients were considered under the DoLS pathway but did not meet threshold. Applications were evenly split by gender and aligned with local ethnicity demographics.

This activity reflects strong engagement from clinical teams and effective real-time support from the Safeguarding Adults Team. Improving the quality and consistency of DoLS practice remains a key focus for the year ahead.



GRAPH for Total of DoLS considerations and submissions

Trust DoLS practice and activity is monitored by, and reported to our Regulators, the Care Quality Commission (CQC). The Trust DoLS Team are responsible for the completing and submitting all DoLS CQC Outcome Notification forms, once the outcome of each DoLS application has been determined. DoLS CQC Outcome notification forms are now being completed in the month of the outcome being established.

Learning disabilities and Autism report

Throughout 2024/25, the Trust has maintained 2.6 WTE specialist staff in LD&A roles, including two Learning Disability Nurses and an Autism Liaison Officer (ALO). The ALO, while no longer new, continues to make steady progress, with caseloads weighted slightly toward under-18s and supervision supported by the Named Nurse for Safeguarding Children.

Autistic patients require significant preparation to safely and confidently access hospital services. The ALO now contacts patients ahead of elective appointments to prepare them for what to expect. Personalised support plans have greatly improved care, helping staff adapt environments, communication, and procedures to the individual. Collaborative planning between the ALO, clinical teams, and patients has become a hallmark of this work.

An emerging theme is the high overlap between autistic patients and those with eating disorders—predominantly girls and young women. Adjustments, such as allowing patients to prepare or handle their own food, have proved pivotal in supporting safe nutritional intake and reducing distress.

Challenges have also been identified in the community: some children requiring blood tests must attend hospital due to the lack of training in clinical holding among community teams. We are currently exploring whether IHOT could be trained in this technique to prevent unnecessary hospital visits.

The monthly general anaesthetic list for patients with LD and/or autism is now well established. This initiative has significantly improved access to imaging, including CT and MRI, and supported cancer waiting time targets.

LD&A staff contributed to the design of the new Mental Capacity and Best Interests documentation in EPR, but challenges remain when planning for outpatient or day case procedures. Further work is needed to ensure outpatient documentation fully supports lawful and person-centred best interest decisions.

Commissioners continue to monitor the 90-day inpatient threshold. While relationship-building benefits of this target remain evident, we were deeply disappointed to exceed the threshold in one case. A young man under the responsibility of a neighbouring county's CHC team remained at GRH for the final eight months of his life due to a lack of suitable placement. Despite exceptional care from the GRH team, this situation highlighted a system-wide gap.
We intend to raise concerns with commissioners about the lack of provision for complex young adults transitioning from paediatrics. Without urgent development of secondary care models for this population, adult services risk becoming overwhelmed by patients whose needs are more aligned with those of frail elderly cohorts.

LeDeR

On average there are 1 – 2 deaths per month of a person with a Learning Disability and/or autism. These are all reported to LeDeR. The Learning Disability Team also contribute time to assisting reviewers with interpretation of notes of people who had been in hospital, but died elsewhere.

Deaths of people with LD or autism are not usually evenly spread throughout the year, which can give rise to what appear to be worrying peaks, but the number of deaths over the year is the key data point. For 2024/2025 there have been 30 deaths, which is 6 more than average. However, in 2023/2024 there were fewer deaths than average. This increase is mostly down to 4 'excess' deaths in December 2024 from influenza. Otherwise, causes of death are similar to that of the general population. An overview of findings is available in the appendix.

A new feedback form for anonymous feedback to staff is still being discussed nationally so that feedback on care can be provided without the need for family consent. Without this consent staff do not receive feedback from the review and so never get to understand what was appreciated and what could have been improved.

Quarter	Total number of LD deaths	LeDeR QAs concluded for in-hospital deaths	Ratings
4 2023/2024	6	2	1 x 6 1 x 5 4 outstanding
1 2024/2025	11	4	7 x 5 1 x a/w grade 3 outstanding
2 2024/2025	4	0	1 x 4 (see note) 1 x 6 2 outstanding
3 2024/2025	11	0	1 x 5 10 x outstanding
4 2024/2025	4	0	No reviews concluded yet

Reminder of LeDeR grading of care

Grading of care by LeDeR has to be balanced across Primary Care, Secondary Care and Social Care. Only one grade can be given. Deficits in any area will bring down the overall grading. The review graded 4 above was not as a result of the hospital component.

Grade	Descriptor
6	Excellent care, exceeding expected good practice
5	Good care, meeting expected good practice
4	Satisfactory care, fell short of expected good practice in some areas, but this did not significantly impact on the person's wellbeing
3	Care fell short of expected good practice but did not contribute to the cause of death
2	Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death
1	Care fell far short of expected good practice and this has contributed to the cause of death

Causes of death

Cause of death 1a	Numbers (Q1 – Q4 2024/2025)
Infected leg ulcers	1

Pneumonia	14
Myocardial infarction/ischaemic heart disease	2
Nephrotic syndrome	1
Pulmonary embolism	1
Alzheimers	1
Hypoxic brain injury	1
Sepsis	1
Referred to coroner	3
Cancer	3
Stroke	1
Renal failure	1

These causes of death are in line with those of the general population.

Place of death (within hospital)

Clinical area	No.LD deaths 2024/2025
DCC, GRH	5
Emergency Department, GRH	3
Acute Medical Unit, GRH	4
Medical ward	14
Surgical ward	2

It may be prudent to use this data to target allocation of Oliver McGowan Tier 2 places.

Parallel investigations

It is notable that there have been 3 referrals to the coroner during the year-to-date and one case has been discussed at Patient Safety Review Panel on 20/12/2024 following a death in the Emergency Department at GRH after an extended period there.
None of these have yet produced an outcome.

Feedback from relatives

Relatives of these patient cohorts regularly comment that they would like side rooms as bays are too noisy. The LeDeR QA panel are well aware that our supply of side rooms is very limited and Infection Control has first call on them. Relatives have also commented

very positively on the support they receive from the Learning Disability Liaison Nurses and the Palliative Care team, as well as the bereavement calls which are made by both ED and DCC.

Oliver McGowan training

This nationally mandated training was rolled out during 2023/2024, with considerable national media coverage and clear political direction that the requirements were to be complied without exception. The requirement is for all staff to complete a 2 hour e-learning package on caring for people with Learning Disabilities and/or Autism has not proved taxing and many staff have completed this ahead of their allocated time. Those who have no patient contact are required to attend a 1 hour webinar and those staff who do have patient contact, no matter how infrequently, are required to attend a full day's face-to-face training, including experts by experience. This latter requirement means that numbers at such training are capped at 30, of which GHFT can only ever have 10 places as other organisations in the county also need places on these study days.

The Training Needs Analysis demonstrated a need for 30% of our staff to complete 'Tier 1' (the webinar) and this has not proved too difficult to achieve. However, the 70% of our staff who we have determined need to complete 'Tier 2' (the face-to-face day) has been extremely problematic, for all the anticipated reasons. It is causing large volumes of calls to the Training Records and Safeguarding Teams from staff frustrated that every study day offered seemed to be full and they cannot book a place. Managers are now emailing the Lead for Safeguarding Adults to complain that this is the only training that is preventing their teams from being 100% compliant with mandatory and statutory training. Whilst we do have 3 years to reach 90% compliance, achieving that with the current level of face-to-face training provision will not be possible. Therefore, alternative options for the balance of Tier 1 and Tier 2 training are being explored and a proposal will be brought to Vulnerable Patient Group.

Plans for 2025/2026

We are looking forward to the introduction of the selected SNOMED codes to hospital systems, which will pull Learning Disability and Autism diagnoses through from GP records

to enable GHFT staff to see that Reasonable Adjustments may need to be considered and prevent patients without locally applied alerts in Trakcare being missed by the LD&A staff.

We have been fortunate to have been introduced to a specialist LD physiotherapist who works for GHC and is keen to work with us to deliver positioning guidance to help prevent aspiration during feeding. This work is at the exploratory phase and will develop over the next year.

One of our Learning Disability Liaison Nurses is going on maternity leave again and so we are hoping to be granted permission to advertise for a replacement to cover her absence.

Crime pathway

All Safeguarding Leads have provided weekly support to the Behavioural Standards Panel, ensuring that safeguarding concerns are factored into the decision-making about incidents of violence and aggression, whether these are from patients to staff, relatives to staff or between patients. We have supported GHFT colleagues to make police statements where they have been assaulted and supported police action in the small number of cases that warranted such intervention and accompanied a small number of staff to court to give evidence in these cases.

We fully support the actions that our Health and Safety colleagues are undertaking to make GHFT a safe place for our staff to work and our patients to recover. The Lead for Safeguarding Adults is a co-leader of the Enhanced Care project which is building a substantive, in-house team of Enhanced Care HCAs working to a Team Manager and team of shift leaders who will be allocated to our most vulnerable patients, who are often those to whom the Violence and Aggression Team are called. If this works, a large proportion of patient agitation and aggression will be reduced, improving both patient and staff experience. This should release the security staff to focus on points of arrival where patients are already in a heightened state.

Separately, the Homeless Specialist Nurse and Substance Misuse Specialist Nurse actively support staff to provide statements for Criminal Behaviour Order (CBO) applications, which we make at the same time as police are taking individuals to court. This approach is clearly positive as there were 9 CBOs granted in 2023/2024, but we only needed to apply for 2 CBOs in 2024/2025, only 1 of which was granted and the subject of the other application was an in-patient at the time of the court hearing.

PREVENT report

PREVENT is a community safeguarding programme aimed at safeguarding people and communities from the threat of terrorism. It is 1 of the 4 elements of CONTEST, the Government's counter-terrorism strategy. PREVENT aims to stop people being exploited by others and groomed to accept extremist viewpoints. The South-West, and Gloucestershire as a county, continue to be considered to be low risk for PREVENT. Gloucestershire's PREVENT Partnership Board is attended by the Trust Lead for Safeguarding Adults, along with representatives from the ICB and GHC.

PREVENT is a Safeguarding Pathway for all ages, but predominantly for those of secondary school age and adults. There has been no change in the age profile over the last year. Within the South-West radicalisation is towards fundamentalist Islamic groups and extreme right-wing groups and predominantly amongst males aged 17 – 25 years. Primary Care and the Acute Trust have again been challenged for referring fewer individuals than Education, Mental Health or Police, but as this is a demographic which has very low contact with GHFT, it is difficult to see how this could be done. There have been no PREVENT referrals of GHFT patients or staff this year.

As part of NHS England's changes in Safeguarding training instructions, training related to PREVENT had to be stand-alone and using the national content, from October 2024. This was changed and the majority of staff are required to complete the awareness training only. Staff at band 8A and above are required to do the intermediate training. Compliance rates are poorer amongst more senior staff, possibly reflective of their workload and endeavours to ensure that their staff are trained first.

Allegations management

During the year under report, 20 safeguarding allegations against GHFT staff have been received. Of these, 10 were also subject of LADO Allegations Management meetings.

These were all investigated jointly with the HR advisors and the outcomes were as follows:

Outcome	**Number**	**LADO involved**
Criminal	4	2
Illness of member of staff	3	2
Member of staff is a victim of Domestic Abuse	1 – working with GHFT support 1 – declining support offers	2
Cultural differences caused different understanding of what is permitted in the UK	2	2
Progressing through Disciplinary process	4	1
Progressing as a complaint	1	0
Staff to staff issue	1	0
Inconclusive	3	1

Of these, only 4 are male. The other 16 are female.

Safeguarding training

Safeguarding, in common with Infection Prevention and Control, is a statutory requirement of all NHS Providers and core to all service delivery. The national requirements for Safeguarding training are set out in the respective Intercollegiate Documents (ICDs). Whilst it is challenging to meet these requirements, the training provided has met all the requirements of the ICDs and the CTSF competencies and the effectiveness of this training is shown in the increased reporting of safeguarding concerns evidenced above. Achieving training compliance has improved over the year, but it is challenging to fit into rotas, particularly at the higher levels which require a greater number of hours than is factored into the 4% headroom of workforce establishments. It is disappointing to have to report that a large number of our most senior staff are those who remained non-compliant by the end of the year. This may well be reflective of their job plans not having sufficient time built in for all types of training.

Roles and responsibilities

Role	Responsibilities
Safeguarding leads	Advise on training content Advise on compliance with Intercollegiate Documents and CTSF Complete Trustwide Training Needs Analysis Facilitate access to approved training Report on training compliance
Line managers	Monitor staff compliance with mandatory training Follow-up as necessary
Members of staff	Complete allocated mandatory training
Board member	Challenge senior managers in areas with persistent poor compliance levels

Training provision - Safeguarding Adults

Safeguarding Adults training was provided in line with the 2019 Intercollegiate Document (ICD) guidance and complied with the required CTSF competencies. However, NHS England required Level 1 and Level 2 to move to the e-learning for Health e-learning package in November 2024. This was done, whilst formally noting that these packages were shorter than the training time specified in the ICD and content was out-of-date.

It was already planned that content would be replaced in November 2024 as it needed to be updated. The national offer at Level 3 training was both too short and too logistically challenging to work in a large acute trust, so videos were recorded for all Safeguarding specialisms with post-video MCQs, as attendance at live Teams sessions had proved difficult for many staff to achieve. This has provided content across the full range of safeguarding with the added benefit that it can be done in sections at the convenience of the individual staff member and rewound and replayed as necessary for understanding.

Level and hours required	**Training provided**
Level 1 – 2 hours Non-clinical and non-patient facing roles	1 x 2 hour video 'Foundations of Safeguarding Adults' - accessible via ESR, followed by MCQs to test learning **After November 2024:** e-lfH e-learning package
Level 2 – 4 hours Non-registered clinical patient-facing roles and junior registered staff in predominantly Paediatric areas	1 x 2 hour video 'Foundations of Safeguarding Adults' 1 x 1 hour video on Mental Capacity assessment Both accessible via ESR, followed by MCQs to test learning 1 x live Teams session from a choice of 4 subjects **After November 2024:** e-lfH e-learning package
Level 3 – 8 hours Registered clinical staff in adult patient-facing roles and senior registered staff in predominantly Paediatric areas	1 x 2 hour video 'Foundations of Safeguarding Adults' 1 x 1 hour video on Mental Capacity assessment 1 x 2 hour video on Safeguarding Adults with Care and Support Needs All accessible via ESR, followed by MCQs to test learning 1 x 2 hour live Teams session on risk assessing Domestic Abuse 1 x 1 hour live Teams session from a choice of 6 specialist Safeguarding subjects **After November 2024, video + MCQ packages available via ESR on:** Introduction to Safeguarding Adults Mental Capacity and Deprivation of Liberty Safeguards Domestic Abuse Health Inequalities – Homeless patients, Substance Users, HIU patients, including Modern Slavery and Human Trafficking Female Genital Mutilation Safeguarding Adolescents

The Lead for Safeguarding Adults and the MCA Lead are both on the national group of Subject Matter Experts advising NHS England on content for their revised Mandatory and

Statutory Learning (MaSL) Safeguarding offer. This commitment will extend through the summer of 2025 with a likely change to 'All age Safeguarding' training before the end of the calendar year, at least at level 1, possibly level 2. The Lead for Safeguarding Adults is one of 5 provider representatives on a smaller advisory group for the national training offer.

Training provision – Safeguarding Children

Compliance with Level 1 and 2 training has remained reasonably high; these can be accessed on-line at a time to suit staff with no requirement to book. Level 3 training compliance has increased slightly from 59% to 65% but still needs significant improvement.

The Women's and Children Division have their own plans for increasing their staff compliance and prioritising shift leaders to complete the training first. Our current safeguarding training offer has been simplified in poster form. There is considerable effort being exercised in Paediatrics for staff to reach 90% compliance with level 3 training by the end of August 2025. Recent interpretation of the Intercollegiate Document (ICD) in Midwifery has identified that additional training is required in Paediatrics. Paediatricians and Children's nurses are identified in the ICD as those requiring additional knowledge and skills. Initially these roles would be required to undertake a minimum of 16 hours in their first year, followed by 12 - 16 hours in the next 3 years. This would be a significant increase in the training offer. This new training offer was launched in Paediatrics in November 2024 for full intercollegiate training compliance. Training has been promoted and QR codes have been displayed within Paediatrics to take staff to the relevant training pages.

However, Health Education England have instructed that all mandatory training is moved over to national training packages. These will be free e-learning accessed via E-learning for Health and will be shorter than the current packages. This change was mandated to be completed by October 2024. Local Level 3 training provided by the GSCP contains local learning from practice reviews, this rich content will be lost in centralising training. There are also concerns that the new Health Education England guidelines are at odds with the guidance included in the ICD. Clarification is being sought from CQC as to which guidelines they will use for inspections.

Safeguarding training compliance by year end

Level	Safeguarding children	Safeguarding adults
1	**92%** (4746/5159)	**94%** (3724/3962)
2	**89%** (5332/5991)	**90%** (2660/2956)
3	**68%** (638/938)	**79%** (3377/4275)

Safeguarding Delivery against Plan 2024/2025

Key for BRAG rating score

RED	AMBER	GREEN	BLUE
Red missed target date and delivery at risk (escalate and request support).	Likely to miss delivery date and so at risk	Will deliver on time and assurance will be gained	Full delivery of action and assurance gained

Theme	Actions	Responsible lead	Projected completion	BRAG Status	Update for month
Safeguarding training	1. Review Training Needs Analyses for all Safeguarding-related training	Safeguarding leads with ESR lead	31/08/2024		
	2. Ensure that Divisional Directors have a plan for monitoring training compliance	Safeguarding leads	31/03/2025		
	3. Support Divisional Directors with remedial action where training compliance falls into amber	Safeguarding leads	31/03/2025		

	4. Review training in line with mandated programmes from Health Education England (HEE)	Safeguarding leads	31/08/2024		
	5. Ensure all safeguarding training reflects the need for staff to be trauma aware	Safeguarding leads	31/08/2024		
Digital	6. Complete an annual audit of domestic abuse enquiry and disclosure within maternity	VWT	31/03/2025		
	7. Clear c.2000 backlog of notifications of high-risk domestic abuse related to victims and their children awaiting alerts on patient records	GR	31/03/2025		
	8. Establish a means to warn staff about potentially aggressive/violent friends of family likely to accompany a patient	Safeguarding leads and TT	31/03/2025		Request I2311-15099 28/11/2023 Remains a difficult area to resolve
	9. Digitise DASH form	GR & CNIO	31/03/2025		Request I2312-00510 01/12/2023 Currently in development

	10. Digitise Mental Health Act documentation	Safeguarding Leads/CNIO	31/03/2025		
Patient experience	11. Devise an audit to evidence of 'Voice of the Patient' in patient documentation	MCA & DoLS lead/Admiral Nurse/CF	31/03/2025		In audit plan
	12. Devise and audit to evidence of patient understanding of why they are in hospital and what will be happening to them here	MCA & DoLS lead/ Admiral Nurse/CF/SM	31/03/2025		In audit plan
	13. Promote Trust Behavioural Standards charter, particularly within elective care where patients and their relatives have the opportunity to understand the expected standard of behaviour to reduce levels of fear and anxiety resulting from adverse incidents	Safeguarding Leads	31/03/2025		In development
	14. Develop accessible information to support the participation of the affected person in safeguarding enquiries	Safeguarding Leads	31/03/2025		In countywide plan
Staff experience	15. Evaluate the introduction of Vulnerabilities Framework	Safeguarding Team	31/03/2025		

	16. Undertake a service evaluation of HIU work	Rachel Torrington	31/03/2025		In Masters dissertation – due for completion in September 2025
Family/carer experience	17. Devise an audit to evidence decisions about who is to be first point of contact – NoK or residential home	Safeguarding leads & BI	31/03/2025		In audit plan
	18. Devise an audit of identification of the person accompanying patient, including name and role in patient's life	Safeguarding leads & BI	31/03/2025		In audit plan
	19. Devise an audit of whether there is confirmation of who, if anyone, holds Power of Attorney (PoA) for Health and Wellbeing or there is a Court-appointed Deputy	MCA & DoLS lead/Admiral nurse/LD liaison nurses	31/03/2025		In audit plan
Clinical effectiveness	20. Ensure Trust safeguarding practice is fully aligned with revised national Safeguarding Accountability and Assurance Framework	Safeguarding leads	31/03/2025		

Recommendations

The Quality and Performance Committee is asked to:

1) Note the progress made against the previous year's Safeguarding and Learning Disability Improvement plans.

2) Note that workloads remain persistently in excess of resources in all Safeguarding workstreams.

3) Support senior staff to prioritise completing their own mandatory and statutory learning (MaSL) before being held to account for the compliance with MaSL of their staff.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

April 2025 Safer Staffing Report for Nursing

Report to the Board of Directors	
Date	10 July 2025
Title	**Safer Staffing Report for Nursing**
Author **Director/Presenter**	Ana Gleghorn, Associate Chief Nurse for Workforce & Education Matt Holdaway, Chief Nurse and Director of Quality

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 Safer Staffing Report for Nursing was presented to the Quality & Performance Committee in May 2025. The Committee accepted the recommendations to note the report. The paper was not seeking financial approval. The Chief Nurse and Director of Quality delivered the report to Committee members giving an overview of the Trust's arrangements for safer staffing within nursing

The report provides an assessment of the nursing staffing levels at Gloucestershire Hospitals NHS Foundation Trust and assess compliance with Developing Workforce Safeguards (NHSI, 2018) which builds on the National Quality Board (NQB 2016) standards and the National Institute of Health and Care Excellence Guidance (DH, 2014).

This paper provides an account of the process used to review staffing levels, the findings of the review and outlines the actions required by the Trust to ensure the right level of nursing care is provided by our inpatient's wards, Department of Critical Care and the Emergency Department.

This paper surfaces a number of nursing workforce risks which have been categorised as either a cost pressures or new investment and details funding sources where available.

Triangulation with nurse sensitive indicators and data from model health system are included.

Risks or Concerns

Financial Implications

The review highlights areas where at times there are shortfalls in nursing time available on our inpatient wards to be at optimum levels. Some of these issues are in the process of being resolved within financial envelope. The paper did not request any additional funding.

Recommendation

The board are asked to:
Receive this report noting it has been received by the Quality and Performance Committee.

Enclosures
No enclosures

SAFER STAFFING REPORT FOR NURSING – APRIL 2025

1.0 Purpose of the paper

The purpose of this paper is to provide the Quality & Performance Committee with an assessment of nursing staffing levels at Gloucestershire Hospitals NHS Foundation Trust and evaluate compliance with Developing Workforce Safeguards (NHSI, 2018). This framework builds on the National Quality Board (NQB) standards and the National Institute for Health and Care Excellence (NICE) guidance (DH, 2014).

This paper outlines the process used to review staffing levels, presents the findings, and details the actions required to ensure appropriate nursing care across inpatient wards, the Department of Critical Care, and the Emergency Department.

It does not include an analysis of temporary staffing within nursing.

2.0 Celebrations in Nursing

We are very proud to be in a position of having very few nursing vacancies on our inpatient wards. Vacancies on adult inpatient wards at the end of February 2025 were 10.73 wte, on the paediatric ward there were 16 wte vacancies and 8.8 wte in the Emergency Department. By way of comparison there were 434 wte nursing vacancies in September 2022. Our international recruitment campaign has been very successful and brought many new colleagues to work with us from India and the Philippines. Our focus now moves to increasing support for staff in post making retention a key priority.

Welcoming internationally educated colleagues to Gloucestershire Hospitals

- Successful domestic and international recruitment programme, resulting in a reduction in nurse vacancies on inpatient wards to single figures.
- Successful realignment of inpatient nursing budgets following the previous Safer Staffing Report with increased oversight of daily deployment by the Divisional

Directors of Nursing.

- Reducing the reliance on temporary workers to support patient care and the associated costs whilst noting the need to continuously monitor the potential adverse impact on patient care.
- Increased oversight of the deployment of registered mental health nurses by the Mental Health Liaison Team has improved not only spend but importantly quality with fewer patients needing restrictive observation.

3.0 Challenges for Nursing

- Increasing complexity of the patient population and being able to meet this need with a skilled, stable workforce.
- Growth in services which requires a constant focus on finding new and creative ways to recruit and retain.
- Safer staffing across a 24-hour period whilst supporting flexible working.
- Changes in the workforce because of role development and the blurring of traditional boundaries.
- Reshaping the workforce to reflect the growth in Nursing Associates whilst providing an effective career development programme for those wishing to become Registered Nurses.
- Cost of living and working in Gloucestershire, with affordable housing being a significant challenge.
- Local competitors offering different opportunities including higher banding opportunities.
- An aging workforce where health and wellbeing and opportunities for flexibility are important.

4.0 Methodology - inpatient wards and assessment areas

A review was undertaken with each department led by the Associate Chief Nurse for Workforce and Education supported by the Divisional Directors of Nursing and the Finance Business Partners.

Each nursing establishment review considered key workforce metrics and where appropriate Safer Nursing Care Tool (SNCT) audit results. As the Trust has only undertaken two cycles of the new SNCT model to date (November 2023), the findings were used in a small number of cases where professional judgement supports an increase in nursing establishment was required for patient safety reasons.

The key workforce metrics were:

- Vacancies
- Turnover
- Recruitment
- Age Profile
- Length of Service (Trust)
- Maternity leave impact in 2023-24
- Study leave requirement to meet local needs and national guidance

In addition, the review captured any other role currently not funded, where there was a substantive member of staff in post. Furthermore, the review took into consideration any national guidance, specifically focusing on headroom. Appendix 1 details a high level of summary of findings.

Areas excluded from the review due to the SNCT not applying are:

- Theatres
- Outpatient settings
- Day case settings

5.0 National Benchmarking

Weighted activity Unit (WAU) and Care Hours per Patient Day (CHpPD) continue to be the main source of external benchmarking in the NHS Model Health system.

The Model Health system data has a lag and may not be directly comparable with other Trusts. While useful, it should be verified against other sources, intelligence, and professional judgment.

In addition, the Trust plans to carry out a survey to compare headroom allocation within Trusts in England. Support from NHS England has been agreed and the survey developed, and the plan is to present the findings in the next report.

5.1 Weighted Activity Unit (WAU)

The cost per WAU is the primary productivity measure used within Model Health system and compares organisational costs to the amount of output. A higher-than-average nursing staff cost per WAU suggests the organisation spends more on this staff group per unit of activity than a typical organisation. A lower-than-average nursing staff cost per WAU suggests the organisation spends less on this staff group per unit of activity than a typical organisation.

WAU is a measure of efficiency; more productive Trusts will have a lower cost per WAU and less productive Trusts will have a higher cost per WAU. The WAU metric does not directly correlate to the quality of care.

The cost per WAU detailed below (chart 1) shows the Trust in the first quartile with a nursing staff cost per WAU of £840 which is £25 lower than previously reported (March 2024), this is equal to the regional peer median yet lower than the provider median of £982. Suggesting the Trust has an efficient nursing workforce.

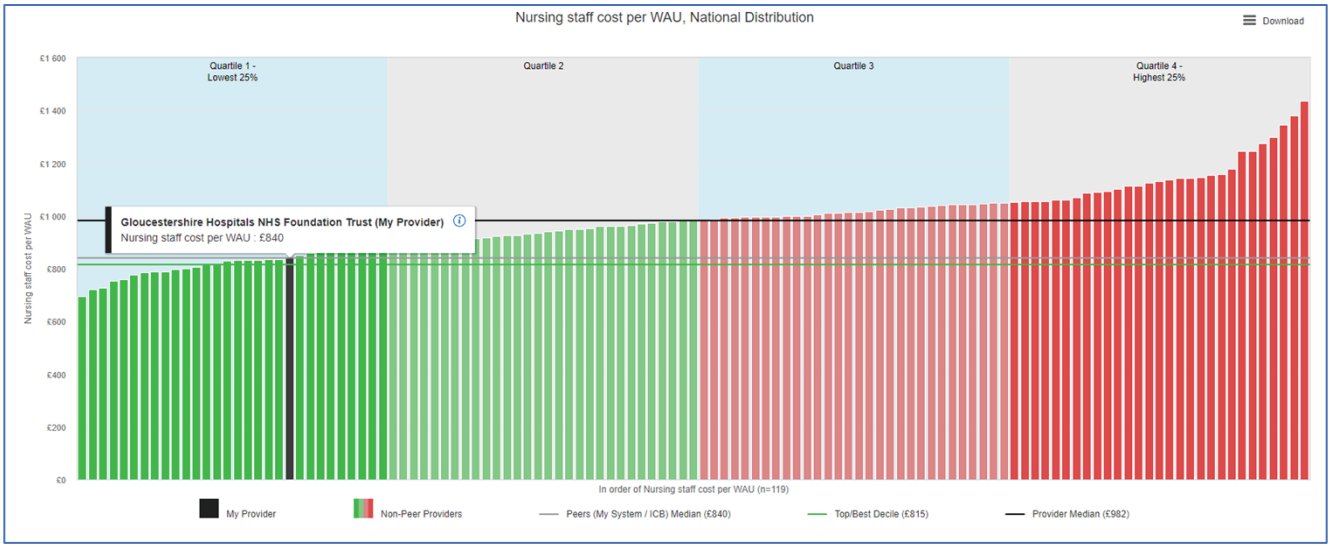


Chart 1: Nursing staff costs per WAU.

5.2 Care Hours per Patient Day (CHpPD)

The CHpPD is a measure of actual daily nursing staffing levels in relation to daily patient numbers on inpatient wards.

CHpPD provided in the Model Health System as a standardised model for Trusts to benchmark and is calculated by taking the total care hours worked by nursing staff divided by the total patient bed days. Very low rates indicate a potential risk to patient safety with very high rates being suggestive of inefficient rostering.

The information presented below relates to September 2024 (chart 2), detailing the Trust in the upper third quartile and above the provider median. The Trust CHpPD is at 8.9, peers at 8.9 and national median at 8.6.

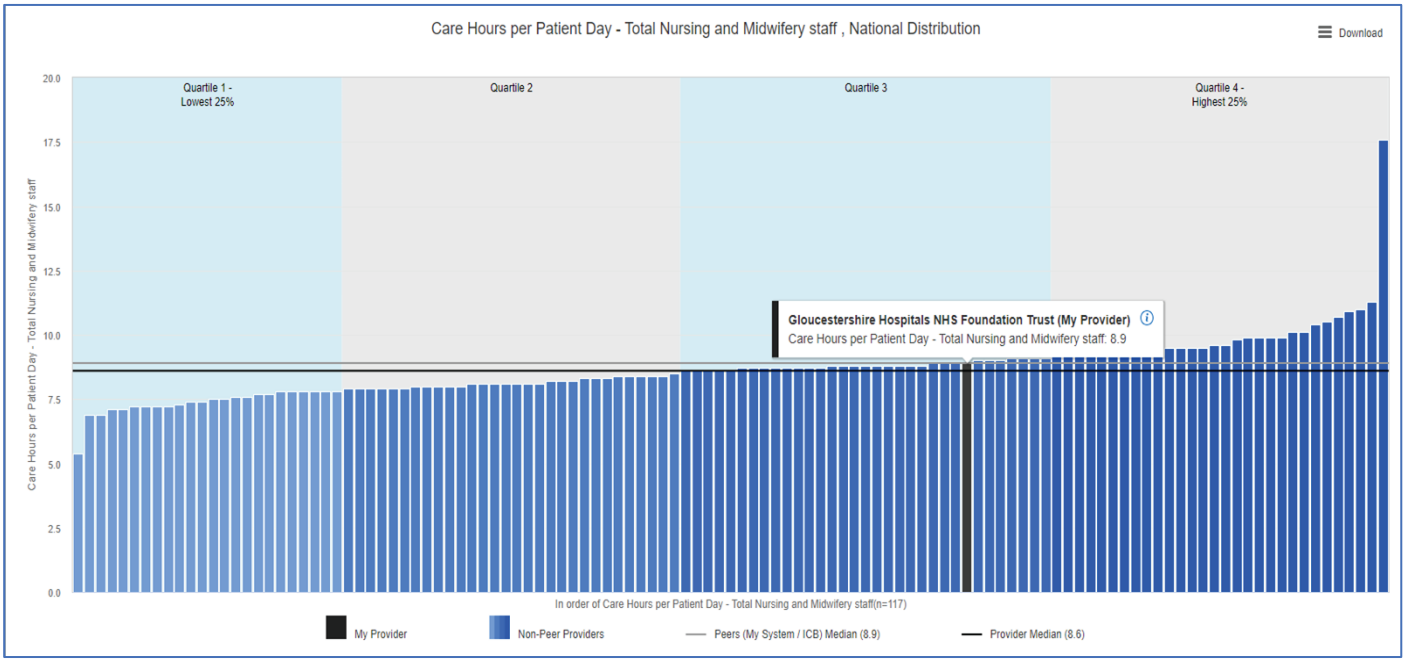


Chart 2: CHPPD benchmark at a national level.

5.2.1 Local CHpPD data

A review of the Trust level data illustrates how this translates to local level when comparing planned CHpPD to actual (chart 3).

In five wards, the total CHpPD was less than planned and for three wards more than planned, using +/- 0.5 as the trigger. Of the five wards with a total CHpPD below plan, three had less registered nurses' hours than planned and of the three wards with a total CHpPD above plan, two of the wards had additional registered nurses' hours.

The reasons for this variation vary between departments ranging from vacancies, unfilled temporary worker demand to variation in patient activity.

ANNEX A
NURSING STAFF FILL RATES

Sep-24

		Acutal CHPPD				Planned CHPPD			Variance		
		Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall	Registered nurses/ midwives	Care staff	Overall	Registered nurses/ midwives	Care staff	Overall
	HASU	407	11.4	3.2	14.7	11.1	3.1	14.2	0.4	0.1	0.5
	BIBURY/SNOWSHILL	486	6.6	2.0	8.6	6.5	2.4	8.8	0.1	-0.4	-0.2
	GUITING	868	4.9	3.6	8.5	4.8	3.1	7.9	0.0	0.5	0.5
	TIVOLI	445	5.8	4.0	9.8	6.1	4.4	10.4	-0.2	-0.4	-0.7
	KNIGHTSBRIDGE	504	5.4	2.8	8.3	5.4	3.0	8.3	0.1	-0.1	-0.1
	LILLEYBROOK	425	5.4	2.2	7.6	5.3	2.8	8.1	0.1	-0.6	-0.5
	RENDCOMB	568	6.1	2.0	8.1	6.1	2.1	8.2	0.0	-0.1	-0.1
	RYEWORTH	939	4.1	3.2	7.3	4.2	3.2	7.3	0.0	0.0	0.0
	WOODMANCOTE	915	4.5	3.4	8.0	4.6	3.3	7.9	0.0	0.1	0.1
GRH	AMU	1562	5.5	2.5	8.0	5.1	2.7	7.8	0.4	-0.2	0.2
	FRAILTY UNIT	409	6.9	3.2	10.1	6.6	3.7	10.3	0.3	-0.5	-0.2
	CARDIOLOGY	726	12.5	2.5	15.0	11.6	2.7	14.3	1.0	-0.2	0.7
	DCC	414	29.7	1.7	31.5	36.2	1.8	38.0	-6.5	-0.1	-6.6
	SCBU	517	11.6	1.7	13.3	11.6	1.5	13.1	0.0	0.2	0.2
	CIPD	459	12.6	3.6	16.2	16.3	4.5	20.9	-3.7	-0.9	-4.6
	2A	596	5.6	3.9	9.6	5.8	4.2	9.9	-0.1	-0.2	-0.4
	2B	611	4.4	3.1	7.6	4.4	3.2	7.6	0.0	-0.1	0.0
	3A	881	3.4	3.4	6.8	3.1	3.4	6.5	0.3	0.0	0.3
	3B	851	4.1	3.0	7.1	4.2	3.2	7.4	-0.1	-0.2	-0.3
	4A	872	3.9	2.7	6.6	4.2	2.8	7.1	-0.3	-0.1	-0.4
	4B	822	4.1	3.0	7.1	4.2	3.3	7.5	-0.1	-0.3	-0.3
	5A / SAU	869	4.1	2.9	6.9	4.0	3.0	7.0	0.1	-0.1	-0.1
	5B	541	6.9	3.5	10.3	7.2	3.6	10.8	-0.3	-0.1	-0.5
	6A	685	5.2	4.3	9.5	5.0	4.4	9.4	0.1	-0.1	0.0
	6B	1031	4.1	3.1	7.2	4.1	2.9	7.0	0.0	0.2	0.2
	7A	890	4.5	2.5	7.0	5.0	2.6	7.6	-0.5	-0.1	-0.6
	7B	655	4.7	2.1	6.8	4.8	2.3	7.1	-0.1	-0.2	-0.3
	8A	1649	5.0	2.9	7.9	5.0	3.1	8.1	0.0	-0.2	-0.2
	9A / AMU3	336	4.5	2.1	6.5	4.5	2.2	6.7	0.0	-0.2	-0.2
	9B	807	4.8	3.1	8.0	4.8	3.3	8.2	0.0	-0.2	-0.2
	GALLERY WING 1	710	4.2	2.9	7.1	3.7	3.2	6.8	0.6	-0.3	0.3
	GALLERY WING 2	712	3.8	3.1	6.9	3.8	3.2	7.0	0.0	-0.1	-0.1

Chart 3: Planned versus Actual CHpPD (Trust).

6.0 Patient harms sensitive to nurse staffing levels

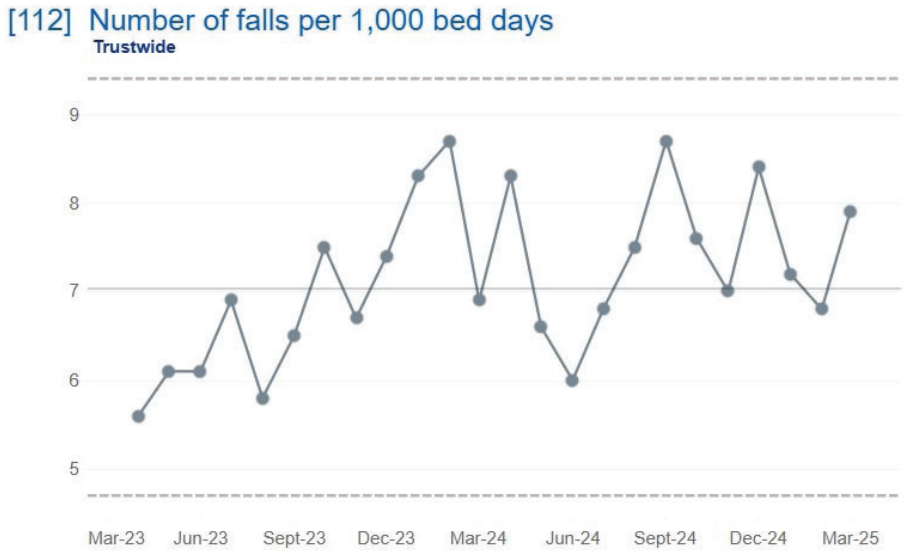
There is a strong correlation between the number of care hours registered nurses can provide patients and patient safety incidents such as falls, pressure ulcers and hospital acquired infections. The following graphs show the run rates in a number of nurse sensitive indicators during 2024/25. Note the census period of September 2024.

6.1 Patient Falls

In March 2025 the number of falls per 1000 bed days over the previous 12-months was 7.4, this compares to a rate of 6.8 in the 12-months before. The increase correlates with additional controls on the deployment of Healthcare Support Workers to provide 1:1 supervision.

A gap in the updating of falls risk assessments following a fall and on admission has been identified and is a focus of the education and training programme and a key target for improvement. In addition, the falls team support two further quality improvements, to improve patient footwear and to improve lying and standing blood pressure.

The falls team continue to deliver a comprehensive training and education programme for staff.



Graph 1:Falls per 1,000 days - Trust Level

6.2 Healthcare Acquired Infections

The Trust monitors healthcare associated infection closely. There is a link between staffing levels and the burden of HCAI. Gloucestershire is the system with the least healthcare associated infection in the Southwest, recently having the lowest rates for all monitored organisms except for *C. difficile*, which the county was second after Somerset.

6.2.1 MRSA Bacteraemia

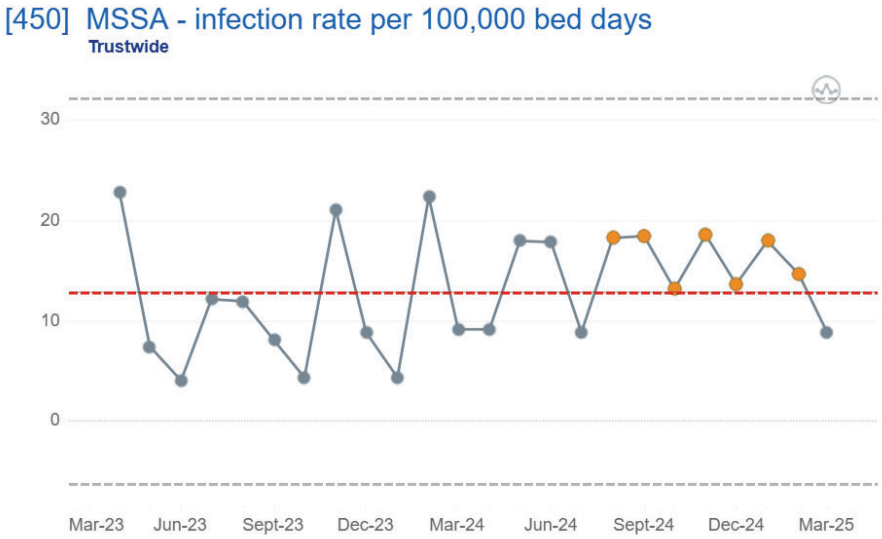
During 2024/25 there were no MRSA bacteremias reported, in keeping with previous months.

6.2.2 MSSA Data

The Trust reported 8.8 infections per 100,000 beds days in March 2025 (graph 3).

Gloucestershire has the lowest MSSA rate in the Southwest.

Whilst there is no nationally set reduction target for MSSA bacteraemias for the integrated care system (ICS) and/or acute NHS Trusts, the Infection Prevention and Control Team (IPCT) have included a programme of activities within the annual plan to support the reduction of blood stream infections.

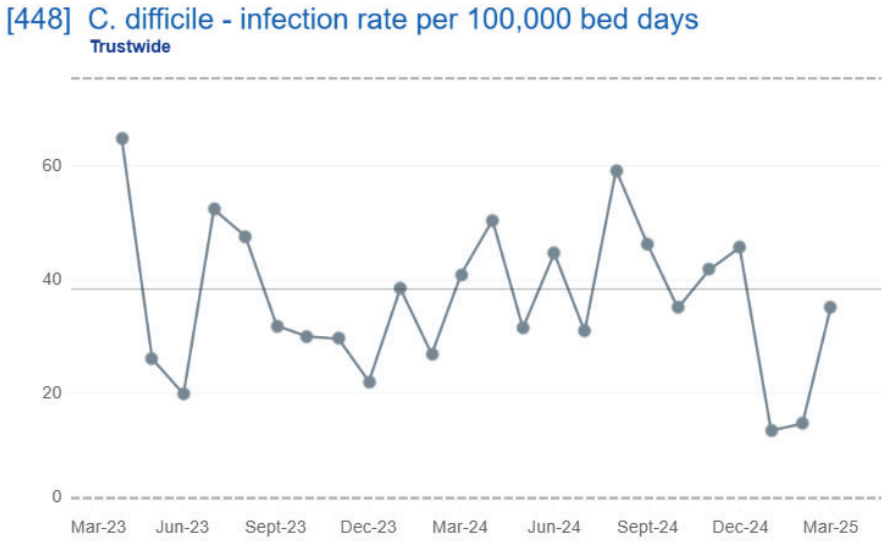


Graph 3: MSSA per 100,00 bed days – Trust level

6.2.3 *C. difficile* Data

During 2024/25 the Trust met the reduction target set by NHS England. Gloucestershire has the second lowest rate of *C. difficile* infection in the Southwest.

The Trust *C. difficile* reduction plan for 2024/25 focuses on actions to address cleaning; equipment and environment (delivery of National Standards of Healthcare Cleanliness), antimicrobial stewardship, timeliness of stool sampling, prompt isolation of patients and optimising management of patients with *C. difficile*. There is a particular focus on delivering the national cleaning standards and move towards peracetic acid cleaning of inpatient wards.



Graph 4: C. *difficile* per 100,000 bed days – Trust Level

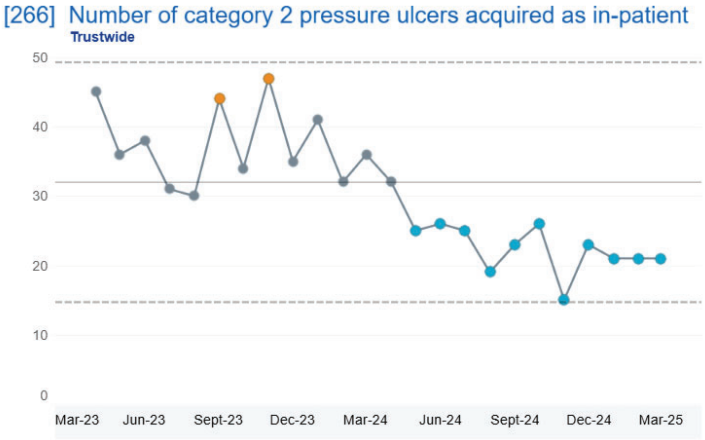
6.3 Healthcare Acquired Harm

The number of category 2 pressure ulcers has decreased since May 2024 as the nursing vacancy rate has substantially reduced and the Tissue Viability Team have focussed on validation and seeing all patients with Category 2 pressure ulcers. There were only 2 category 4 pressure ulcers recorded in 2024/25 and therefore the graph is excluded.

Pressure ulcer prevention remains a priority for the Trust and the team have been implementing a number of measures to improve pressure ulcer risk assessment (PURAT). The improvement strategy focuses on understanding the barriers to completion of PURAT, Pressure Ulcer Prevention (PUP) stimulation to support staff education and the re-introduction of the pressure ulcer steering group.

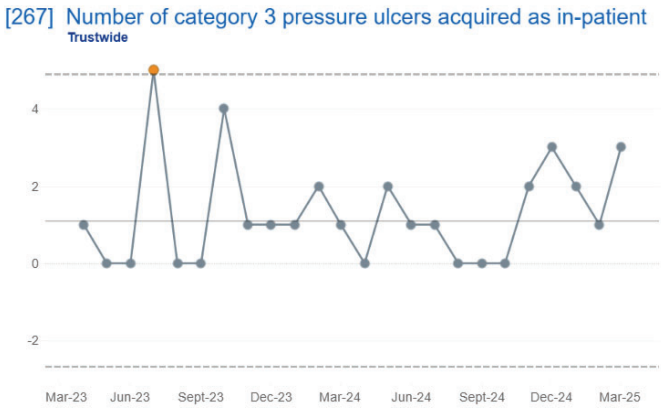
Further to this the implementation of the patient safety incident response framework for pressure ulcers (prevention and learning) has been identified as an opportunity for quality improvements and a working group has been established to embed processes around identification and investigation of incidents.

Category 2 Pressure Ulcers



Graph 5 – Category 2 pressure Ulcers – Trust wide

Category 3 Pressure Ulcers



Graph 6 – Category 3 pressure Ulcers – Trust wide

7.0 Emergency department

For this review, the Emergency Department was assessed using an alternative methodology that is compliant with SNCT.

Nurse staffing requirements were determined using attendance-only data from the past 12 months alongside the ED SNCT tool. This tool's attendance-only function applies the national average percentage distribution of patients across various acuity and dependency levels.

To ensure accuracy, adjustments were made to reflect current practices, including updates to headroom, skill mix, and COVID-19 data. Between December 2023 and November 2024, there were 152,985 attendances across the two sites, an increase of 2,399 from the previous audit period.

While the SNCT indicates the workforce size is appropriate, professional judgment and unit layout considerations suggest additional investment is needed. The department has introduced the role of a streaming nurse, which has been effective in improving patient flow. It is therefore proposed that this role be made permanent, however this requires a case to be presented by the Medicine Division. Benefits already observed include reduced triage times, faster first assessments, improved ambulance offload times, and more efficient patient redirection to appropriate care pathways.

In the next report ED staffing will be reported against an actual patient census rather than attendance data.

8.0 Department of Critical Care

Within the Department of Critical Care, the review surfaced the need for Healthcare Support Worker cover on both sites 24 hours per day which resulted in an increase in the nursing establishment of 3.76 wte.

Healthcare Support Workers (HCSWs) play a crucial role in patient care by assisting trained staff with hygiene needs for Level 2 and 3 patients. They are integral to rehabilitation efforts, especially in settings with limited Allied Health Professionals (AHPs), as they help mobilize patients and adhere to ERAS protocols. This is particularly essential in Cheltenham, where fewer patients often mean fewer nurses, and many patients require extensive rehabilitation. HCSWs also provide vital support in areas where lone working is a challenge.

Without a HCSW, staffing may need to be adjusted, impacting overall care. Additionally, HCSWs help maintain safe stock levels, complete critical care competencies (such as CC3N HCSW steps), and provide essential support for nutrition, hydration, and pressure area care, which is crucial given the high incidence of related issues. They also assist in side-room care to prevent lone working, which may otherwise require an additional Band 5 nurse. In many cases, this role is initially covered by the admitting nurse until a patient is admitted.

9.0 Paediatrics and Neonates

The review captured the current workforce model and surfaced a number of roles previously not funded despite there being a service requirement.

10.0 Key findings for inpatients, Critical Care, Paediatrics, Neonates and the Emergency Department

Overall, the finding for most of the wards was to maintain the current nursing establishment and skill mix however there is a requirement to recognise the following for all the departments in scope:

1. Budgets to be set reflecting actual staff pay point and any in year incremental drift. Whilst this may surface a cost pressure overall because of the accounting anomaly, there will be no growth in workforce. Some department will see a reduction in budget reflecting the more junior workforce whilst others will need fund to service the cost pressure. The additional budget required to ensure that inpatient nursing areas are set to reflect actual staff pay point has been included as a cost pressure as part of 2025/26 budget setting.

2. 100% Backfill for maternity leave cover. Whilst this requires a Trust wide review and supporting process, for the inpatient areas the staffing gaps created by this planned absence is significant and requires back fill to maintain appropriate staffing levels. Current practice is to fill these nursing gaps with bank and agency resulting in a significant local budget overspend. The additional budget required to ensure that 100% of maternity backfill is funding has been included as a cost pressure as part of 2025/26 budget setting.

3. Band 6 Nurse in Charge cover 24/7 consistently across all departments. There is a disparity within the Divisions relating to senior nurse cover at night. A significant number of the departments are managed at night by a band 5 Nurse in Charge with limited access to other senior nurses or clinical staff. This is a particular concern at Cheltenham which has seen a significant change in patient acuity and dependency following the changes in the acute take. The cost of the uplift from band 5 to band 6 at night is £328k and is an aspiration for future budget setting.

The following departments require an establishment uplift having taken into account the findings from two SNCT audits and professional judgement.

1. Guiting and Ryeworth have been remodelled to reflect the changes in patient acuity which have resulted following the changes to the acute take. Whilst the number of patients requiring enhanced care support remain relatively stable, they are now being cared for in Guiting and Ryeworth rather than spread across more wards. In addition, the Guiting model takes into consideration the nurse requirement for the three escalation beds that are used consistently. **The investment required to address this workforce model is £617k which will result in a growth in the workforce of 14.09 wte.**

2. Ward 3a and Ward 3b have been remodelled to reflect the changes in patient acuity. Over the last year, both wards have required additional staff 24/7 to support the growing need for psychological support and increasing complexities of care associated with an aging population. The patient profile aligns with that of a care of the elderly ward with the added complication of a traumatic injury requiring surgical intervention. **The investment required to address this workforce model has been approved at Trust Leadership Team following a request from the Surgery Division to re-allocate funds from another budget.**

3. Department of Critical Care reflecting the need to have the HCA role on both sites. **The investment required for this workforce model is £150k which will result in a growth in the workforce 4.77 wte.**

Furthermore, a review of national guidance highlighted the need to review the headroom percentage in several departments. The national guidance recognises the growing training and development expectations of staff working in the following department. Ensuring staff have the right knowledge and skills is key in the delivery of safe effective care. These investments are aspirations for future investment considerations:

1. Department of Critical Care – 28% as per the Guidelines for the Provision of Intensive Care Services (GPICS). **The investment required is £338k which will result in a growth in the workforce 6.2 wte.**

2. Emergency Department – 27% as per the Royal College of Emergency Nursing Workforce standards (RCEM). **The investment required is £404k which will result in a growth in the workforce 11.72 wte**

3. Paediatrics and Neonates – 25% as per the Royal College of Nursing and Neonatal Nursing Workforce tool respectively. **The investment and workforce growth required is yet to be confirmed with finance.**

11.0 Recommendations

The QPC is asked to note the findings, including the elements that require investment both as a shortfall of nursing time and aspirational. Research consistently shows increased RN staffing is associated with improved patient safety, lower mortality rates, and better overall hospital efficiency. Systematic reviews, such as the one by Needleman et al (2011), have shown higher RN staffing is linked to fewer complications, including pressure ulcers, infections, and falls and the associated costs.

QPC are asked to note the high priority actions following this review and the considerations for future investment when the financial landscape in the NHS becomes clearer.

Focusing on leadership, staffing, and training directly enhances patient safety, satisfaction, and clinical outcomes. Investment in these areas leads to lower mortality, fewer errors, better

efficiency, and a more positive care experience for both patients and staff.

High priority actions

1. Cost pressures in nursing budgets to be set reflecting actual staff pay point and any in year incremental drift.
2. Maternity leave to be back filled 100% for inpatient departments.
3. Guiting, Ryeworth, Ward 3a and Ward 3b budgets to be set to reflect the changes in patient acuity.

Considerations for future investment

1. Band 6 Nurse in Charge cover 24/7 consistently across all departments.
2. Department of Critical Care reflecting the need to have HCA cover on both sites, 24/7.
3. Department of Critical Care – 28% as per the Guidelines for the Provision of Intensive care Services (GPICS).
4. Emergency Department – 27% as per the Royal College of Emergency Nursing Workforce standards (RCEM).
5. Paediatrics and Neonates – 25% as per the Royal College of Nursing and Neonatal Nursing Workforce tool respectively.

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Appendix 1

							Other Roles / Budget Corrections					
Ward	Budget set to pay point	Maternity Leave back fill 100%	Band 4 to 5 Day	Band 6 24/7 Cover (inc. 1x band 5 to band 6 overnight)	Establishment Uplift	Headroom Uplift	Sister	Band	WTE	Role	Band	WTE
AMU	√	√					√	7	0.8	Technician	3	0.8
Cardiology	√	√					√	7	1.0			
Department of Critical Care	√	√			√	√						
Emergency Department	√	√				√				Flow Coordintors	4	2.0
FAU	√	√										
Gallery Ward 1	√	√										
Gallery Ward 2	√	√										
Guiting	√	√			√							
HASU	√	√										
Knightsbridge	√	√										
Lilleybrook	√	√		√								
Neonates	√	√				√						
Paediatrics	√	√				√						
Rendcombe	√	√										
Respiratory	√	√					√	7	0.2	Admin	3	1.0
Ryeworth	√	√			√							
Snowshill/Bibury	√	√		√						Lead HCSW	4	1.0
Tivoli	√	√		√								
Ward 2a	√	√	√									
Ward 2b	√	√		√								
Ward 3a	√	√		√	√					Nutrition Support workers		2.0
Ward 3b	√	√		√	√					Lead HCSW	4	1.0
Ward 4a	√	√		√								
Ward 4b	√	√		√								
Ward 5a	√	√		√								
Ward 5b	√	√		√						Lead HCSW	4	1.0
Ward 6a	√	√										
ward 6b	√	√								Lead HCSW	4	1.0
Ward 7a	√	√										
Ward 7b	√	√										
Ward 9a	√	√								RNA	4	0.92
Ward 9b	√	√										
Woodmancote	√	√								Lead HCSW	4	0.9

√ - Indicates a Requirement