



Gloucestershire Hospitals
NHS Foundation Trust

Annual report and accounts

2024 – 2025

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**Gloucestershire Hospitals
NHS Foundation Trust**

**Annual Report and Accounts
2024-2025**

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4)
(a) of the National Health Service Act 2006.

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Foreword by the Chair and Chief Executive

We are pleased to introduce our Annual Report and 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.

The NHS has faced another challenging year, yet our dedicated staff and volunteers have shown remarkable resilience, commitment and compassion. Their work makes a profound difference every day and we extend our heartfelt thanks to them all. We also want to acknowledge the contributions of our volunteers, who support both patients and staff, offering a warm welcome and invaluable assistance across our hospitals.

This year, we have made significant strides in improving services, patient care and staff experience, while also addressing the pressures of increasing demand. 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.

We have also seen continued investment in digital innovation, with the launch of the Patient Portal, making it easier for patients to access their appointment information online. Our new Alstone Urology Clinic has centralised and enhanced care and our acclaimed cardiac services continue to deliver life-changing treatments.

We also want to acknowledge the challenges we have faced. In January 2025, the Care Quality Commission (CQC) published its delayed report on our maternity services, following an unannounced inspection in March 2024 which had resulted in the issuing of an Enforcement Notice pursuant to s31 Health and Social Care Act. The report rated our maternity services as 'inadequate' - a disappointing outcome, but one we are meeting with determination and action as detailed in this report.

We have acted on the feedback from the CQC inspectors and the CQC has been closely involved in supporting and monitoring the issues they identified. There remains more to do and it is essential we keep the safety and experiences of mothers and babies central to our cause so that we can improve confidence in our maternity services. Also important is that we are open and transparent about these challenges and what we are doing to address them and have created a dedicated website to set out our priorities and the work we are doing to improve the service. We are determined to ensure that maternity care at our Trust is something we can all be proud of.

Listening to and supporting our staff remains one of our top priorities. We continue to work closely with colleagues to understand what matters most to them and have implemented several changes in response to the difficult and honest feedback shared with us in last

year's NHS Staff Survey. The 2024 survey results were published in March 2025. With a 65% response rate, while slightly lower than last year, it remains one of the highest response rates in the country.

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. Our Staff Experience Improvement Programme continues to focus on the key issues raised in both the NHS Staff Survey and the National Quarterly Pulse Survey (NQPS). Since its launch in response to the 2022 results when we experienced a significant drop in these scores in the staff survey, many initiatives have now become an integral part of how we operate. 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.

Our Clinical Vision of Flow (CVoF) programme has been a key focus this year, using seasonally themed events to drive the adoption of new ways of working that improve patient flow through our hospitals. This is important because of the impact good flow can have on reducing delays and harm to patients. – particularly those waiting to be admitted. This programme, which is led by our clinical teams, is designed to make a real impact on key performance and patient experience indicators, including reducing ambulance handover delays, minimising discharge delays and shortening the time patients spend in our emergency departments.

We know that staying in hospital longer than necessary can negatively impact health outcomes, particularly for older people. That's why improving flow is about much more than efficiency - it's about ensuring the best possible outcomes for our patients. We are encouraged by the improvements we've seen in ambulance handover times, with average handover delays in December 2024 reduced to around 40 minutes compared to a 120-minute average at the end of the previous year. This improvement demonstrates the consistent impact of our efforts to mitigate this patient safety risk. Our vision for flow is simple: every patient's journey should be efficient, seamless and centred on what's right for them.

This has never been more critical as we continue to face relentless demand across our hospitals and community services. While these pressures are most visible in our urgent and emergency care pathways, they have an impact across every department. In these moments, it truly takes a team effort, from our urgent care colleagues and ward staff to our partners in the community. Their dedication and willingness to go above and beyond ensure that we continue to provide safe, effective and compassionate care, even in the face of sustained challenges.

The spirit of collaboration has been another defining feature of this year. Our partnerships - whether with statutory services, voluntary organisations, or international teams - have been vital in improving healthcare for the people of Gloucestershire and beyond. Our

team's work in Zambia, sharing ENT expertise, is just one example of how our staff are making a global impact.

The pending publication of the NHS Ten Year Plan and national announcements at the end of the financial year 24/25 relating to the reorganisation of key parts of the NHS nationally and locally, mean that significant change is expected in this coming financial year. For all NHS organisations, the challenge and expectation has been set – to live within our means- and therefore tough choices will need to be made across every part of the NHS – including Gloucestershire – to deliver this on behalf of the government.

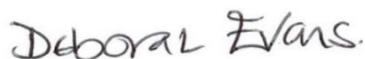
So whilst the NHS remains under significant pressure, our passion and purpose remain undiminished. The privilege of working in the NHS comes with great responsibility and we are committed to ensuring that our hospitals remain places where patients receive outstanding care and staff feel valued and supported and where we are able not only to meet the needs of people today but we create a more sustainable foundation on which our local community benefit from our services for many years to come.

We would like to thank all those who contribute to our shared mission - staff, governors, 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.



Kevin McNamara
Chief Executive

26 June 2025



Deborah Evans
Chair

26 June 2025

Performance report

In this section:

- ▶ Overview
- ▶ Statement from Chief Executive on performance
- ▶ Performance analysis



Overview

Gloucestershire Hospitals NHS Foundation Trust is a provider of local and acute care, delivering good-quality services to over 650,000 people living across the county. We provide whole-life care and are here to support our communities to live healthier lives as well as taking care of them when they need us the most.

We employ almost 9,000 colleagues and together we provide a wide range of inpatient and outpatient services, as well as emergency and planned care at our two main district hospitals.

About Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust received authorisation on 1 July 2004, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. It was formed from Gloucestershire Hospitals NHS Trust, which was established following a reconfiguration of health services in Gloucestershire in 2002.

The Trust has a long and proud history which goes back as far as 1755 when the Gloucestershire Infirmary was constructed and later awarded the title 'Royal' by King Edwards VII in 1909. Similarly, Cheltenham General Hospital dates back to 1813 when it was a dispensary. They both became part of the National Health Service when it was established in 1948 and they have a long history of serving those most in need within our communities. This continues to this day, alongside the work of the Hospitals Charities, with our links to community groups and our focus on eliminating health inequalities.

Our hospitals

Gloucestershire Royal Hospital (GRH)

Gloucestershire Royal Hospital (GRH) is located close to the city centre in Gloucester and specialises in unscheduled care, urgent and emergency care, cardiology, renal care, maternity and neonatal care, is also the base for our children's wards and emergency department.

Cheltenham General Hospital (CGH)

Cheltenham General Hospital is located in the east of the county and is our planned care centre, providing specialist cancer and oncology services, Stroke, Urology, Care of the Elderly as well as an emergency department.

Stroud Maternity Hospital

Stroud Maternity Hospital is a midwife-led centre that helps deliver around 150 births every year, supporting births at home and in the unit.

Other community-based services

The Trust also delivered a range of surgery, outpatient clinics, diagnostic and screening services from community hospitals throughout Gloucestershire and the Community Diagnostics Centre (CDC). The Trust also provides services at the satellite oncology centre in Hereford County Hospital.

Our Trust in numbers: a snapshot of our care

On average each year, our teams provide a wide range of care, treatments and services for our communities.



Management Structure

The Trust's management structure is based around Divisions, plus a wholly owned subsidiary company, Gloucestershire Managed Services (GMS), and our Charity, Cheltenham and Gloucester Hospitals Charity administered via a General Charitable Fund.

These are designed to support and facilitate delegation of decision-making to clinical teams and to enable more involvement of clinical leaders in strategic issues.

We have four clinical patient-facing divisions, each comprised of a Chief of Service, Divisional Operations Director, and a Divisional Director of Quality and Nursing and they are supported by our corporate services division.

These are outlined below and full details are on our website:

<https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/>

- Women and Children Division
- Surgery Division
- Medicine Division
- Diagnostics and Specialities Division
- Corporate Division

Vision, mission and values

Our vision: the best care for everyone

Our mission: to improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day.

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 as detailed below. We also work closely with a wide range of diverse community organisations, including Inclusion Gloucestershire, Healthwatch and the VCSE (Voluntary, Community and Social Enterprise) Alliance to ensure we listen and understand the needs of our local population and to ensure we can shape services effectively.

The Trust is a formal member of both the statutory Integrated Care Partnership in Gloucestershire and is represented by the Executive Director of Improvement and Delivery and Deputy Chief Executive and Medical Director. The Trust is also a formal member of NHS Gloucestershire Integrated Care Board ensuring that discussions and decisions have the voice and perspective of acute hospitals.

For both these key statutory forums there is regular and consistent attendance and contribution to both public and confidential board and well as development time which provides opportunities to develop and deepen shared understanding and work across organisational boundaries.

The Trust is also a member of number of formal sub-committees of the ICB including the One Gloucestershire strategic executive and finance committees, groups and forums which support and enhance partnership working on patient safety, quality issues and delivery. These include the system safety committee and system quality group with representation from our Chief Nursing Officer and Director of Quality.

Our engagement with stakeholders and community

Gloucestershire Hospitals NHS Foundation Trust remains committed to engaging with our communities, ensuring their voices shape our services. This year, we have continued to expand our outreach, strengthened partnerships, and delivered impactful projects to improve accessibility and inclusivity in healthcare. Below are several key areas of engagement undertaken in 2024-2025:

Building our new Regional Cancer Centre

The Trust is a designated Regional Cancer Centre. We are in the early stages of sharing our exciting plans and vision for the development of our Cancer Centre in Cheltenham for the future.

We wanted to listen to what matters more to local communities, staff and patients to inform service planning for cancer care. Working closely with the appointed design and construction partners, Exi, the six-month programme of staff and public engagement involved a wide range of community groups, public and staff using a range of communications and engagement methods.

In January and February 2025, the Trust held a number of events across each of the six districts and spoke with more than 600 people to understand what matters most to them and provide valuable insights into patient experiences and expectations for the future of our cancer and oncology services.

Strategy Engagement

Our new strategy is being co-designed by staff, patients, communities and partners.

To gather feedback for our new strategy, we created a toolkit with open-ended questions. The aim was to help understand what matters most to staff and patients about what kind of organisation we should be and our role within local communities. We started by listening to nearly 1500 staff, through a series of more than 55 workshops supported by over 20 trained facilitators. The listening engagement involved large-scale discussions, surveys, focus groups, structured interviews, and workshops.

We also involved a number of partner organisations and groups, including Gloucestershire Managed Services (GMS), our Trust Charity, Governors, One Gloucestershire, Inclusion Gloucestershire, Healthwatch and the VCSE Alliance. There was a series of focused community engagement events with the NHS Information Bus visiting Tewksbury, Forest of Dean, Gloucester, Stroud, Cheltenham and Cotswolds with over 560 people sharing their views with our teams.

Accessible Information Standard (AIS)

The Accessible Information Standard (AIS) ensures that people with disabilities, impairments or sensory loss receive NHS information in formats they can understand. Gloucestershire Hospitals NHS Foundation Trust has implemented AIS by offering patient letters in accessible formats such as Large Print, Braille, and Easy Read.

The Big Space Cancer Appeal

Gloucestershire Hospitals NHS Foundation Trust has supported the Cheltenham and Gloucester Hospitals Charity's 'The Big Space Cancer Appeal' which aims to raise £17.5m for a new cancer centre at Cheltenham General Hospital, enhancing treatment environments for patients and staff.

The new centre will offer a range of services in one place, including a therapeutic garden and private spaces for patients. A unique fundraising event being led by the Cheltenham and Gloucester Hospitals Charity, the "Lions at Large" trail, will feature 30 decorated lions across Gloucestershire, with businesses sponsoring them to raise funds. The charity supports local hospitals and their staff, improving care for the community.

Cheltenham and Gloucester Hospitals Charity is the official charity of Gloucestershire Hospitals NHS Foundation Trust, raising and granting funds to support our work.

Young Influencer Development

The Young Influencer Programme has evolved into a cornerstone of our youth engagement approach. With 19 young people now regularly involved, this group plays a crucial role in bridging the gap between the Trust and younger demographics.

Highlights this year include:

- Providing qualitative feedback to the Gloucester City Council's Preparation for Adulthood Team
- Producing child-friendly video walkthroughs of our Paediatric Assessment Unit (PAU) and Emergency Department, now used in parent and SEND (Special Educational Needs and Disabilities) outreach
- Partnering with Gloucester Council's Cultural Service Team to contribute to Refugee Week activities
- Their insight continues to shape services that reflect the lived experiences and aspirations of future generations.

Inclusive Language Guide: Communication that Reflects Our Values

Language shapes experience. In 2024, we proudly launched our first Inclusive Language Guide, co-developed with diverse staff networks, patient representatives, and local partners.

This guide is more than a document – it's a resource for creating an environment of psychological safety and mutual respect. It equips staff with tools to communicate inclusively, avoid unintentional bias, and reflect the Trust's core values of equity and dignity in every interaction.

Community Playlist for Dementia Awareness: Sounds of the Soul

"Sounds of the Soul" represents a powerful example of community co-creation. Originating from the 2023 Dementia Education event at the Friendship Café, the project has evolved into a culturally meaningful musical resource for Muslim individuals living with dementia.

Working closely with South Asian elders' groups, carers, and community advocates, the playlist features ten carefully selected tracks, including Qur'anic recitations and nasheeds. It is designed to promote spiritual well-being, cultural identity, and emotional connection for patients affected by memory loss.

Bowel Cancer Screening Awareness in 11 Languages

To tackle inequalities in cancer screening uptake, we created a 60-second awareness film in 11 community languages, in partnership with the Integrated Care Board (ICB). We worked with the Trust's Chaplaincy Team and Equality, Diversity and Inclusion (EDI) Council to recruit 11 community members who appeared on camera, helping ensure authentic and inclusive messaging.

The film was showcased at Gloucester Quays and in community venues across the county. We also visited local community groups to screen the video, engage in discussions, and collect feedback to strengthen future outreach and awareness efforts.

The Breast Cancer Awareness

An awareness programme was developed in collaboration with Gloucestershire Hospitals, the ICB and Cheltenham Hebrew Congregation, aimed to empower Jewish women in Gloucestershire with knowledge about early detection and culturally-sensitive breast cancer care.

The event addressed the community's specific health concerns, particularly around genetic risk factors and breast cancer in the Jewish population. Attendees learned about self-check techniques, symptoms, and the national screening programme. Delivered by local healthcare professionals, the session also highlighted available support services.

Saluting Our Sisters Exhibition

Saluting Our Sisters is a powerful exhibition celebrating the achievements of Black and ethnic minority women in Gloucestershire. It has been showcased during Black History Month, International Women's Day, and community events in both Cheltenham and Gloucester. Developed in partnership with the University of Gloucestershire, local councils, NHS bodies, and community groups.

Recruitment Support for Migrant Communities

As part of our commitment to inclusion, we've partnered with the ICB's "We Want You" careers team, Gloucestershire Managed Services (GMS), and GARAS (Gloucestershire Action for Refugees and Asylum Seekers) to support refugees and asylum seekers into employment. GARAS plays a vital role in engaging with migrant families, identifying needs, signposting to support, and helping individuals access volunteering roles at GHT.

Together, we offer CV-writing, NHS application skills workshops, English language support, and confidence-building. In December and March, we held a tailored event for the migrant community to boost career readiness and understanding of NHS roles.

Maternity Community Engagement

The Trust partnered with Black Maternity Matters and FiveXMore in a powerful campaign to address racial disparities in maternity care. As part of this collaboration, maternity staff from the Trust had the opportunity to participate in an immersive learning journey focused on anti-racism education and quality improvement.

These staff members are bringing their learning objectives back to the Trust to help inform and shape inclusive, equitable maternity policies. A highlight of the campaign was the unveiling of a rare sculpture of a black baby, symbolising Black motherhood and sparking community dialogue. FiveXMore has led vital work addressing harmful racial stereotypes and improving understanding of Black women's health. The partnership also empowered Black women to advocate for their care, aiming to create safer, more respectful maternity

experiences. This initiative marks a step forward in tackling systemic health inequalities and promoting lasting change.

Stroud Community Engagement

To find out what maternity support matters most to those using our maternity services, their babies and families in Stroud we conducted an online survey designed in partnership with Stroud Motherhood Collective and Stroud Hospitals League of Friends. Consulting with the community, will help us to offer a range of high-quality interventions that are known to make a tangible improvement to the care of new mothers/birthing people and their babies and strengthen access to support for families during pregnancy and the postnatal period.

Maternity Services

We are planning to give the public an open and transparent look into the journey of improvement of our maternity services. With a section of the public website dedicated to sharing information about the improvements we have made to our service provision, we will also provide opportunities for families to share their feedback with us, helping to shape future provision.

Bloodborne Viruses – Hepatitis C Screening Initiative

As part of NHS England's Hepatitis C elimination goal, we collaborated closely with the Hep C team to plan and implement engagement strategies with high-risk communities, including the Polish community. To address language needs, we supported the launch of Polish-language leaflets. We also introduced the Hep C team to local community groups, helping them build valuable connections.

Together, we developed a comprehensive community engagement plan to ensure effective outreach across all affected communities. Our culturally tailored programmes included materials in multiple languages and were delivered through health stalls, pop-up clinics, and trusted local networks.

Engagement with Seldom-Heard Groups

We took steps to deepen relationships with underrepresented groups, building trust and promoting equitable access to care. Activities included:

- Wellness talks with the Hindu Community Group in Cheltenham
- Women's health sessions with Sahara Saheli and South Asian Elderly Women's Groups
- Walk and Talk groups in partnership with Active Gloucestershire
- Health outreach via Gloucestershire Action for Refugees and Asylum Seekers (GARAS)
- Community events in Cinderford and the Forest of Dean

Building our Trust Membership

The Community Engagement Team continues to support a wide range of community events, often joining colleagues from other organisations and the NHS Information Bus, to talk to local communities about what matters most to them and to encourage people to become Members of the Trust and share other ways they can get involved, including volunteering, our Young Influencers and answering questions. More information about the programme is available here: [Information Bus: NHS Gloucestershire ICB](#)

Watch our Governors talk about their experience when they joined us at last year's Community Events https://youtu.be/_FoHhSvkYPo

Our Strategy and Future priorities

The Trust's current strategic plan came to its natural conclusion at the end of 2024.

An extensive engagement programme is well underway to listen to the views of patients, staff and partners as to the type of organisation we should be and the strategic objectives that we adopt to mirror our ambitions for the next 5 years.

During this engagement we are revisiting our vision, values and behaviours that we will all work towards as well as spending time reflecting on what has been delivered since the previous plan was published back in 2019 and the significant challenges that all healthcare organisations have overcome in recent years.

The engagement for the new strategic plan will continue over May and June with engagement of key stakeholder originations including the Integrated Care Board, Gloucester Health and Care, Gloucester County council and wider health and care organisations across Gloucestershire. We will align our narrative and objectives with the National and local priorities including the 10-Year Health Plan, the ICS strategy and Joint Forward Plan and seek to publish our new strategic plan during the summer 2025. We will develop our refreshed strategy framework setting out our purpose and vision, values and behaviours and strategic objectives.

Our current strategic objectives are:

- Flourishing Workforce,
- Care Delivery and
- Productivity and Sustainability.

These priorities were set following a review of the Board Assurance Framework and the strategic risk profile, Quality and Performance Report, Trust Risk Register and in consultation with colleagues and partners. The priority objectives were used to inform operational planning, priority projects and programmes, decision making, and team and individual objectives throughout the year.

Principal Strategic Risks

Our principal risks are mapped to our strategic objectives, and are regularly reviewed by the Board, Committees, and Executives through our Board Assurance Framework (BAF) and are set out within the Annual Governance Statement. As of 31 March 2025, our principal risks are:

- Effective emergency care (Strategic Risk 1)
- Digital risks – cyber security and digital progress (Strategic Risks 12 and 13)
- Effective estates (Strategic Risk 10)
- Financial sustainability (Strategic Risk 9)
- Recruitment, retention and culture (Strategic Risks 16 and 17)
- Good governance (Strategic Risk 2)
- Effective engagement with patients and the public (Strategic Risks 6 and 7)
- Sustainability and achieving environmental targets (Strategic Risk 11)
- Successful change management (Strategic Risk 5)
- Research and development (Strategic Risk 14)

An emerging risk for 2025-2026 relates to the governance of health and safety across the Trust, its subsidiary and other partner organisations.

Further information on our risk and control framework is provided in the annual governance statement.

Going Concern Disclosure

The Board of Directors is clear about its responsibility for preparing the Annual Report and Accounts. The Board sees the Annual Report and Accounts considered as a whole, as fair, balanced and understandable, and as providing the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. The Board also describes some of the principal risks and uncertainties facing the Trust in the Annual Governance Statement. The Trust has prepared its 2024/2025 accounts on a going concern basis.

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future, being at least 12 months from the end of the reporting period. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Statement from Chief Executive on performance

Patient and staff experience is an important part of our performance and often brings to life our achievements and challenges in meeting the national targets. During this, my first full year as Chief Executive, I have frequently had cause to be proud of the remarkable work of our amazing staff and volunteers and the achievements which are detailed within this report.

We continue to focus on improving services, patient care and staff experience, while also addressing the pressures of increasing demand. We recognise that many parts of our estate also require attention, with urgent maintenance on some buildings that are over 175 years old impacting on service delivery. We have continued our efforts on recovering performance across the national standards for urgent and emergency care (UEC) with progress being made in providing access to alternative direct access services, negating the need for patients to attend our busy emergency departments. Last year over 155,000 people used our two emergency departments, but a further 33,000 were able to be treated in our Same Day Emergency Care units, reducing some pressure and helping patients to be seen in the right place.

Whilst we continue to experience a high volume of demand for urgent care we have seen, over the course of the year, a significant reduction in the time spent by patients waiting in ambulances outside our Emergency Departments. We received over 36,000 ambulances last year, and our work with South West Ambulance Trust has helped to reduce the average wait by almost half, despite the increased numbers of both ambulance and ambulatory patients attending for assessment and treatment.

Our Clinical Vision of Flow (CVoF) programme has been a key focus this year as we recognise the impact good flow can have on reducing delays and harm to patients – particularly those waiting to be admitted. This programme, which is led by our clinical teams, is designed to make a real impact on key performance and patient experience indicators, including reducing ambulance handover delays, minimising discharge delays and shortening the time patients spend in our emergency departments. Our vision is simple: every patient's journey should be efficient, seamless and centred on what's right for them. I recognise that, whilst there has been progress in areas of the Trust's performance, this remains very much a journey of improvement and it is a journey which I, alongside my colleagues, are committed to.

In terms of elective care, I recognise that for some patients they are still experiencing long delays to be seen, treated, and discharged, but progress has been made, particularly towards the end of the year. The Trust was identified in early 2025 as one of twenty organisations across the UK that had demonstrated excellent progress in supporting patients on a waiting list to be seen more quickly than in other parts of the country. We are particularly proud that, the number of patients who were waiting longer than 52 weeks for treatment has reduced from over 2,800 patients to only 113 by the end of March 2025. This represents a tremendous achievement for our teams.

Alongside the positive progress we have made, it is important that I acknowledge the challenges that we have faced. In January 2025, the Care Quality Commission (CQC) published its delayed report on our maternity services, following an unannounced inspection in March 2024. The report rated our maternity services as 'inadequate'. I recognise the anxiety that this may have caused but I am also clear that our Maternity Service, and indeed the wider Trust, has been working hard to address the issues identified. It was and continues to be a priority for us all. We have acted on the feedback from the CQC inspectors and both the CQC and our Integrated Care Board colleagues has been closely involved in supporting and monitoring the issues identified. There remains more to do and it is essential we continue our focus on the safety and experiences of mothers and babies.

Listening to and supporting our staff remains a top priority. We continue to work closely with colleagues to understand what matters most to them and have implemented several changes in response to the difficult and honest feedback shared with us in last year's NHS Staff Survey. The 2024 survey results were published in March 2025. There are green shoots of progress, with again more colleagues recommending our Trust as both a place to work and a place to receive care compared to 2022 and 2023. but we remain significantly below the national average and where we ourselves want to be as an organisation. Our Staff Experience Improvement Programme continues to focus on the key issues raised in both the NHS Staff Survey and the National Quarterly Pulse Survey (NQPS). 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.

I would like to take this opportunity to thank all of our staff for their commitment and dedication in providing care and support to our patients, our communities and to one another.

A handwritten signature in blue ink, reading "K. McNamara." with a horizontal line underneath.

Kevin McNamara
Chief Executive

Date: 26 June 2025

Proud to care – our highlights of the year

April 2024

Gloves off for Earth Day

On Earth Day on 22 April, we joined colleagues from across the Gloucestershire Health system in the "Gloves Are Off" campaign to promote correct glove usage in healthcare. The initiative aimed to reduce unnecessary glove use, helping both the environment and patient safety.

Excessive glove use contributes significantly to plastic waste, with millions of gloves discarded daily in UK hospitals. Research has shown that over-reliance on gloves can lead to fewer opportunities for proper hand hygiene, increasing the risk of infection. By making this change, we aimed to improve infection control, ensure safer patient care and reduce environmental harm.

The campaign highlighted that clean hands protect better than gloves, reinforcing best practices in hygiene. The Trust's participation reflected a wider commitment within the NHS to sustainable healthcare and improved infection prevention.

Sharing expertise in Zambia

In April 2024, a team of ear, nose and throat (ENT) surgeons from the Trust travelled to Zambia to help develop local ENT services. Their goal was to enhance healthcare by providing specialist training and resources to Zambian medical staff.

During their visit, the team worked alongside local healthcare professionals, sharing expertise and conducting joint surgeries. This hands-on approach allowed Zambian staff to gain valuable skills and confidence in managing complex ENT cases. The initiative also focused on establishing sustainable practices to ensure lasting improvements in patient care.

The collaboration highlights the importance of international partnerships in addressing global health challenges. By supporting local capacity building, the project helps reduce healthcare disparities and promotes self-sufficiency within the Zambian medical community. Gloucestershire Hospitals' involvement reflects a wider commitment to sharing medical expertise worldwide, benefiting both the recipient healthcare system and the professional development of UK clinicians.

May 2024

Digital Future Becomes a Reality for Learners at Gloucestershire Hospitals

We are introducing immersive technologies including virtual reality (VR), to enhance learning for healthcare professionals. This initiative supports a more interactive and engaging approach to training, bridging the gap between theory and practice.

The Trust has long used simulation-based education (SBE) with life-like manikins, but immersive technology now adds 3D, interactive experiences to improve learning. Research suggests this method enhances engagement and improves performance.

New Patient Portal Goes Live with Digital Letters

Our new Patient Portal launched in May, the first phase of which allowed patients over 18 to access their appointment letters digitally. As of 14 May, when a new appointment is scheduled, patients received a text message from *DrDoctor* with a secure link. By entering a few details, they can view their digital letter on any internet-connected device, such as a smartphone, tablet or computer. In July, this was integrated with the NHS App and extended to allow patients to view past and future appointments.

Those who prefer paper letters or do not have the NHS App can simply delete the text message and inform their care team at their next hospital visit.

Alstone Urology Clinic opens

May 2024 saw the opening of the Alstone Urology Clinic, a state-of-the-art facility designed to enhance patient care and improve overall experience.

The new clinic, located at the College Road Wing at Cheltenham General Hospital, centralised and expanded urology services previously located at Oakley Ward. It brought together essential services under one roof, including 10 modern clinic rooms, administrative offices, nursing teams, and Clinical Nurse Specialists (CNS), all aimed at providing comprehensive and efficient care for patients.

June 2024

Top Cancer award for Myeloma team

Our haematology team was presented with the Myeloma UK Clinical Service Excellence Programme (CSEP) Award in recognition of its outstanding care and dedication to patients with myeloma, an incurable blood cancer which claims the lives of 3,000 people in the UK each year.

Staff were praised for their efforts to improve patients' quality of life and eagerness to listen to their needs. The accolade, awarded by blood cancer charity Myeloma UK, recognises hospitals' commitment to raising the bar for treatment and providing compassionate care.

50 years of nursing service: a lifetime of care

Emergency Nurse Practitioner (ENP) Tom Haswell from Gloucestershire Royal Hospital's Emergency Department marked a major milestone in June of 50 years' nursing service. Tom is most proud of the fact he has remained working in a clinical role throughout his career, sharing his knowledge and experience with others. He is very much known for his storytelling, bringing humour to work and sharing his wealth of experience with more junior doctors and nurses.

Tom won the Lifetime Achievement award at our 2024 Staff Awards in acknowledgement of the many thousands of lives he has touched during his long career.

July 2024

Acute Medical Take Centralised

The Acute Medical Take is the process of coordinating medical assessments for patients to determine if they need hospital admission, can be seen by a specialist service or can return home after treatment in one of the walk-in units.

The Acute Medical Take was centralised at Gloucestershire Royal Hospital on 23 July 2024. This previously formed part of the public consultation in 2020 and further engagement between 2022 and 2023 on shaping the future of our hospital services.

Centralising the Acute Medical Take at GRH had several benefits, including:

- Patients are seen more quickly by the most appropriate specialist teams
- Patients experience more rapid diagnoses and shorter hospital stays
- Improved patient flow, shorter patient waiting times and faster ambulance handover times
- Health outcomes and the overall patient experience are improved.

Revolutionary Drug for patients with hypertrophic cardiomyopathy at Gloucestershire Hospitals

From July 2024, patients with hypertrophic cardiomyopathy (HCM) being treated at Gloucestershire Hospitals had the option to be treated with a new drug for the condition.

Hypertrophic cardiomyopathy (HCM) is the most common inherited heart condition and affects around one in 500 people in the UK. This chronic condition causes the heart muscle wall to become thickened and stiff, making it more difficult for the heart to pump blood around the body.

The Cardiology department at Gloucestershire Hospitals is one of handful of units in the UK, currently granted permission to prescribe the new drug, *Camyzos*. This revolutionary treatment option results in a significantly improved quality of life in 93% of patients who take it and a reduction in the need for surgery by 83%.

August 2024

Youth Workers Bring Vital Support to Children's Ward

The introduction of specialist Youth Workers was designed to improve the experience of young people who are admitted to the Children's inpatient unit at GRH with mental health issues. The project, in partnership with charity Young Gloucestershire, has made fundamental improvements to the experience of these young patients, as well as the experience of staff who work on the unit.

For colleagues on the unit, 2023 was characterised by numerous and frequent Violence and Aggression (V&A) calls with the consequent stress on everyone involved. Working in partnership with staff on the unit and mental health colleagues, the Youth Workers support young patients with mental health and emotional needs, allowing them to feel heard and supported during their admission and beyond.

September 2024

Forget-me-not garden opens

The new Forget-me-not Garden for parents and loved ones affected by baby loss officially opened at Gloucestershire Royal Hospital in September 2024, offering a calming environment for families to visit and find solace.

The concept for the garden was initiated by midwives at Gloucestershire Hospitals, who recognised the need for a space where families could honour and remember their lost babies. This project was then made possible by Cheltenham and Gloucester Hospitals Charity, with fundraising support from the Forget-me-not Parent Bereavement Group, Bereavement Specialist Midwife Nikki Dobson, the Maternity Teams and the unwavering commitment of our fundraisers within the community.

Two new state-of-the-art theatres open at Gloucestershire Royal Hospital

The completion of Theatres three and four in September marked a significant milestone in establishing a flagship service, Image Guided Interventional Surgery (IGIS), at our hospitals.

Theatre four has been fully refurbished and extended to incorporate an Interventional Radiology (IR) theatre enabling the Vascular team to perform procedures using live camera images to guide the procedure. This means the surgeon no longer has to make a large, open cut and can instead perform surgery via a small 'keyhole', which means the patient heals and recovers more quickly.

This also reduces the risk to the patient, the amount of time the person needs to stay in the hospital and their recovery time.

Bringing the wild to life

The Children's Emergency Department at Gloucestershire Royal Hospital was transformed into a vibrant and comforting space thanks to new jungle-themed artwork created by artist and illustrator Alice Humphreys.

Commissioned through a generous donation from the Pied Piper Appeal, the stunning artwork features a variety of animals including monkeys, hippos, giraffes, zebras, elephants, flamingos and turtles, designed to bring comfort and a sense of adventure to young patients and their families.

October 2024

Baby Loss Awareness week

Baby Loss Awareness week took place between 9 and 15 October. We not only lit up the exterior of our Women's Centre in solidarity with all those who have suffered loss, but also the new Forget-me-not Garden, which opened in September 2024 to provide a calming environment for remembrance and reflection.

Gloucestershire Hospitals Nurse Embarks on Voluntary Mission to Sierra Leone

Ali Brown, a dedicated nurse from Gloucestershire Hospitals, travelled to Sierra Leone in November to provide vital voluntary aid with the Kambia District Foundation Charity. Having supported the charity for many years, Ali wanted to take her skills and experience directly into the field, helping to improve access to healthcare in one of the most underserved regions of the country.

November 2024

Hepatitis C – get tested, get treated, get cured

November and December saw the latest community events in the Hepatitis C outreach programme, which ran from April 2024. The World Health Organisation has set a target to end Hepatitis C worldwide by 2030. It's estimated around 118,000 people in the UK had chronic Hepatitis C in 2019.

Viral Hepatitis Nurse Specialist team visited community events in every corner of the county, as well as setting up dedicated testing events, with simple cards being designed to raise awareness and communicate how modern treatments can cure the infection. These were translated into 5 languages for use at different events. Their work continues into 2025.

December 2024

Improved Medical Day Unit

Christmas Eve marked a fresh chapter for Cheltenham General Hospital's Medical Day Unit (MDU), as it opened in its new home on Oakley Ward, Centre Block, after relocating

from its previous site near A&E. The new location has been completely refurbished to meet modern healthcare standards.

The MDU provides vital intravenous (IV) therapies for conditions such as multiple sclerosis, rheumatoid arthritis, inflammatory bowel disease, osteoporosis, iron deficiency anaemia, asthma and renal issues. Many patients attend regularly for IV infusions, while others complete their course of treatment after being discharged from hospital.

Big Space Cancer Appeal and our Vision for Cancer Care

We've been delivering cancer care for more than 60 years. Every year the staff team care for 5,000 patients and work tirelessly, under immense pressure, ensuring patients receive compassionate care that is truly personalised to their needs. The building is nearly 25 years old and is now getting in the way of the needs of modern cancer care – and does not help the team deliver the quality of care they want to provide.

Our vision is to improve cancer care by creating a spacious, modern, welcoming environment for patients and staff, with digital consulting rooms, multidisciplinary clinics and quiet rooms, that are well lit and connected to the therapeutic outside space.

Cheltenham and Gloucester Hospitals Charity launched the Big Space Cancer Appeal to transform cancer care at Cheltenham General Hospital (CGH) through the development of a modern, new state-of-the-art facility that will make a lasting impact on thousands of patients across the region who rely on our specialist services. The vision aligns with the Hospitals Trust's wider vision of establishing centres of excellence at each hospital that deliver a range of specialist services.

British Empire Medal for Dementia nurse Asma

Asma Pandor, an Admiral Nurse renowned for her dedication to dementia care at Gloucestershire Hospitals was awarded the British Empire Medal in the New Year's Honours for her outstanding services to nursing.

Asma's achievement stands as a testament to the transformative impact that healthcare professionals can have on their communities. It also serves as an inspiration for others in nursing to pursue excellence and compassion in their practice.

January 2025

Critical Incident declared

Health and care services across Gloucestershire declared a critical incident due to a combination of factors, including high levels of flu and norovirus combined with exceptionally high levels of need.

Declaring a critical incident allowed the NHS in Gloucestershire to take additional, immediate steps to create capacity, help discharge patients, relieve pressure on the emergency departments and also release ambulances and their crews to care for patients in need.

Groundbreaking Cancer Surgery

An expert multidisciplinary team at Cheltenham General Hospital performed the first keyhole total pelvic exenteration in the South West region on 14 January 2025.

A team of highly skilled experts were involved in the operation. Pelvic exenteration is one of the most complex surgical procedures in the field of surgical oncology and involves the removal of multiple organs from the pelvic cavity, such as the bladder, bowel and reproductive organs, depending on the extent of the disease.

This breakthrough not only highlights our expertise in robotic and laparoscopic surgery but also marks a significant step forward in the treatment of complex cancer cases, offering patients new hope and a faster return to health.

February 2025

New Hyper-Acute Stroke Unit opens

The Hyper-Acute Stroke Unit (HASU) at Cheltenham General Hospital moved to a newly refurbished location named Hatherley Ward on 5 February 2025. This significant development brought enhanced facilities and a consolidated specialist team, ensuring first-class care for stroke patients across Gloucestershire and beyond.

Stroke is a leading cause of death and disability, caused by an interruption to the brain's blood supply or a rupture of a blood vessel. Rapid and expert intervention is critical to improving outcomes, and the HASU at Cheltenham General is designed to deliver life-saving treatment 24 hours a day. The new HASU consolidates expertise, bringing together specialists and state-of-the-art equipment to provide first-class stroke treatment.

Research shows that patients treated in dedicated stroke units experience better outcomes, including reduced mortality rates and fewer long-term disabilities, compared to care provided in general medical wards. Since the centralisation of this essential service, 37 more lives impacted by stroke have been saved in Gloucestershire.

Carers' Charter launched

In February 2025, we launched our Carers' Charter to outline how the Trust and local community can work together as partners in delivering exceptional patient care. The Carers' Charter recognises the valuable role of carers and sets out how we can best support them. Importantly, it appreciates the essential knowledge that carers have about the person in their care. The charter runs alongside existing initiatives like carers' passports and carers' boxes.

New Linac for Cheltenham General Hospital

Our Oncology Centre continued its focus on excellence in cancer care with the installation of a state-of-the-art TrueBeam Linear Accelerator (Linac) named 'Oak'. Linacs are major investments, costing at least £2 million each.

Continuing a tradition at Cheltenham General Hospital, radiotherapy treatment units are named after the tree pictured in their sky ceiling – calming ceiling panels designed to create a more soothing environment for patients undergoing treatment. This latest unit has been named 'Oak', symbolising strength and resilience.

Cheltenham General Hospital now operates four high-energy treatment Linacs, running from 8am to 6pm, 5 days a week. The Medical Physics team also calibrates each machine every month to maintain precision and safety.

March 2025

New 'Movements Matter' campaign encourages expectant parents to stay vigilant

The Gloucestershire Local Maternity and Neonatal System launched a new partnership campaign, #MovementsMatter, to highlight the importance of monitoring baby movements during pregnancy. The initiative urges parents-to-be, along with their families and friends, to contact our Maternity Triage line immediately if they notice any changes.

Babies develop a movement pattern between 16 and 24 weeks of pregnancy, which should remain consistent. A decrease, change or absence of movement can be an early sign of potential health concerns, making early intervention crucial. This important safety campaign has been promoted by all health partners in Gloucestershire, also appearing on buses across the county.

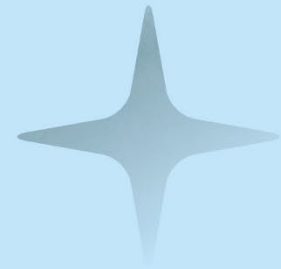
Iftar events during Ramadan

Once again this year, Iftar events were held during Ramadan at both hospitals. Iftar is the meal served at the end of the day during Ramadan to break the day's fast. The events were attended by both Muslim and non-Muslim colleagues who shared the experience together.

The GMS Catering Team helps to create inclusive dining experiences that reflect the diverse backgrounds of staff, patients and visitors. Throughout the year, they have hosted special events celebrating cultural traditions through food, including the Keralan harvest festival Onam in September, as well as Diwali and Back History Month in October.

Performance report:

Performance analysis



Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) provides a range of services beyond Gloucestershire Royal Hospital and Cheltenham General Hospital. We are proud to be at the forefront of health research and innovation. Our services include emergency and critical care departments, inpatient wards, outpatient facilities, and an integrated flow hub where we work closely with colleagues from community and social care settings to provide patients with timely support to return to the community.

Throughout 2024/25, we have continued to focus our efforts on recovering performance across the national standards for urgent and emergency care (UEC) and elective care. There remains a legacy from the days of the Covid-19 pandemic, with patients waiting excessive lengths of time to be seen, treated, and discharged. However, progress is being made as set out in the report below. The Trust was identified in early 2025 as one of 20 organisations across the UK that demonstrated excellent progress in supporting patients on a waiting list to be seen more quickly than in other parts of the country, while maintaining a focus on patient safety and access throughout multiple and sustained periods of industrial action. This work has meant that at the start of the year (April 2024) approximately 2,800 patients were waiting longer than 52 weeks for treatment but by the end of the year (March 2025) this figure was down to 113 patients.

Demand for our urgent and emergency care services has remained high, with increasing numbers of patients accessing the Trust's emergency departments for three years in a row – particularly walk in patients. This is despite increased direct access to services such as Same Day Emergency Care (SDEC) and direct referrals to speciality teams by our county's General Practitioners via a system called *Cinapsis*. On average, we are seeing in excess of 400 patients a day in our emergency departments at Gloucestershire Royal Hospital and Cheltenham General Hospital.

We continue to receive on average 3000 ambulances each month, but have made significant progress during this year, ensuring that patients do not wait outside the department for as long as they did the previous year. We have almost halved the time spent on an ambulance outside the Emergency Department in the last twelve months, whilst seeing more ambulances overall.

Monitoring Performance

The Board of Directors is responsible for the performance of the Trust, to ensure that resources are secured and utilised to provide safe, effective, and high-quality care to the population it serves. To this end, the Board oversees a set of key performance indicators, comprising quality and safety measures determined internally in response to known risks and priorities, as well as priorities determined by external regulators, commissioners, and partner organisations from across the health and care economy.

The Board receives a monthly Integrated Performance Report with supporting explanatory narrative. This has been scrutinised by the Quality and Performance Committee. This

report ensures that key metrics and constitutional standards are reported and deviations can be explored and responses developed.

This is complemented by Quarterly thematic deep-dives covering Urgent and Emergency Care; Diagnostic Services; Planned Care and Cancer Performance. The table on the next page summarises the Trust's performance in respect of the Single Oversight Framework.

Trust's performance in respect of the Single Oversight Framework

		Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes	0%	58.3%	56.3%	58.8%	49.4%	45.8%	51.7%	58.7%	45.4%	53.6%	52.8%	48.6%	45.5%
	Proportion of patients spending more than 12 hours in an emergency department	0%	13.9%	13.0%	12.8%	11.0%	10.7%	11.0%	11.8%	11.1%	11.4%	11.9%	11.5%	10.7%
Elective Care	Total elective activity undertaken compared with 2019/20 baseline		115%	110%	105%	108%	110%	112%	108%	109%	109%	106%	108%	128%
	Total diagnostic activity undertaken compared with 2019/20 baseline		145%	135%	150%	135%	142%	136%	133%	138%	128%	133%	133%	164%
Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	No Target	159	203	217	201	188	197	191	181	190	185	200	159
	Total patients waiting over 62 days to begin cancer treatment compared with baseline	<=6%	6.93%	8.21%	8.73%	7.64%	7.34%	7.47%	7.69%	7.55%	8.44%	8.36%	8.77%	7.45%
	Proportion of patients meeting the faster cancer diagnosis standard	75%	75.3%	77.9%	75.6%	76.2%	72.3%	70.1%	73.9%	72.6%	72.28%	70.26%	80%	82%
	Total patients treated for cancer compared with the same point in 2019/20	No Target	339	344	323	364	353	312	325	314	341	386	303	282
Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		117.2%	111.2%	104.3%	109.1%	110.5%	114.5%	110.8%	109.8%	108.2%	105.8%	105.10%	119.10%
Primary Care	Proportion of patients discharged from hospital to their usual place of residence	No Target	97.47%	97.16%	97.38%	97.22%	97.47%	97.25%	97.25%	97.06%	96.92%	96.93%	97.46%	97.32%
Safe Care	Summary Hospital -level Mortality Indicator	No Target	1.135	1.144	1.149	1.137	1.158	1.150	1.156	1.175	1.173	1.168	1.164	1.147
	Clostridium difficile infection rate per 100,000 bed days	104	50.3	31.4	44.5	30.8	59.1	46.1	34.9	41.6	45.5	13.4	14.6	35.1
	E. coli bloodstream infection rate per 100,000 bed days	71	36.6	31.4	22.3	26.4	27.3	27.7	26.2	4.6	40.9	13.4	39	26.4

Operational Performance analysis 2024-25

The following section provides analysis of key areas of Trust performance, and complements the earlier narrative on key risks and Constitutional Standards are monitored and delivered as two thematic portfolios; Planned Care and Urgent and Emergency Care.

The 2024/25 year proved challenging in all the key performance domains:

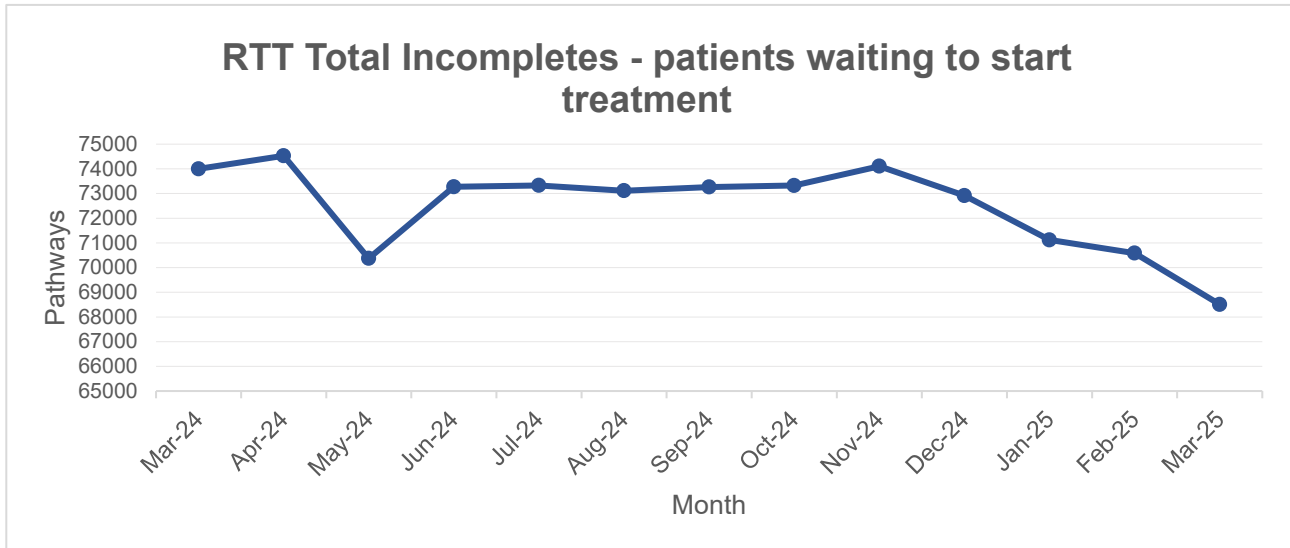
Referral to treatment (RTT)

The organisation set ambitious milestones in the continued recovery of waiting times in regards to Referral to Treatment (RTT) post-pandemic. The 78-week waiting list of patients waiting for treatment were eradicated by August 2024 following small volumes of breaches from the beginning of the financial year.

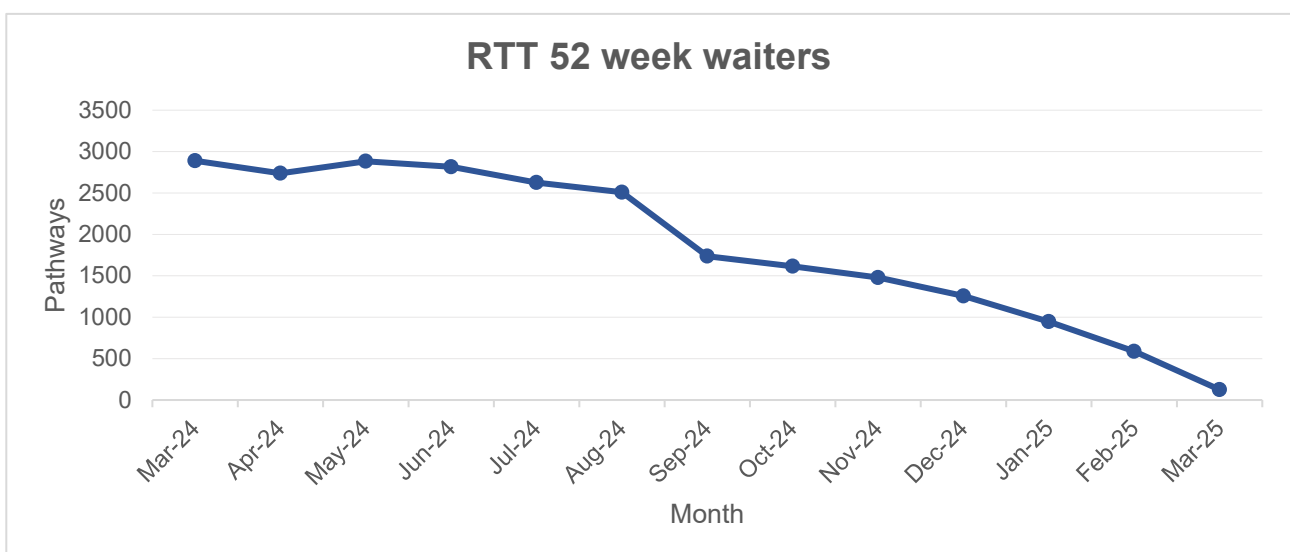
Elective Recovery Funding (ERF) took effect September 2024 leading to large-scale reductions in waits over 65 weeks leading to eradication of month-end reportable breaches as of December 2024. The only exception has been patients awaiting treatment for corneal repairs and patellofemoral joint replacements. Due to national supply shortages of materials, NHS England have allocated material according to longest wait time and clinical priority. As a result, some patients have waited in excess of 65 weeks, however these have been manually excluded from the nationally reported performance position for all trusts.

Divisions have continued to work hard in reducing waiting times over 52 weeks; the March 2025 year end 52 weeks performance forecast predicted 250 patients would be waiting for treatment – GHFT ended March with 113 patients still awaiting treatment (this figure excludes patients awaiting treatment currently unavailable for reasons outside the control of the Trust). Continued recovery throughout 2025-26 will eradicate 52-week breaches and facilitate specialties to return to constitutional standards (18 weeks maximum wait RTT) by March 2029 with positive impact on our patients

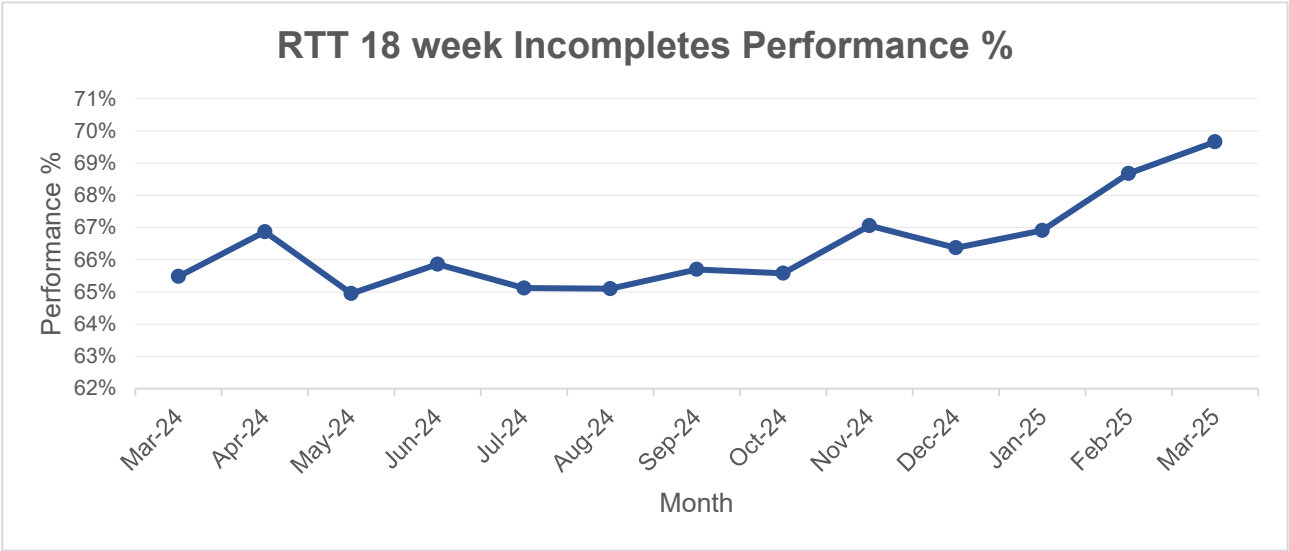
For RTT total incompletes (these are patients who we are still waiting to start their treatment), we have been on a downward trajectory since late 2024, and will continue to fall with our April 2025 position falling below 68,000.



There has been considerable progress made in the reduction of 52-week waiters (patients waiting) across 2024/25, starting with 2,889, and finishing with 125 patients as per graph below (this figure includes a number of patients awaiting treatment outside the control of the Trust). Certain specialties were targeted throughout the year to reduce backlog, such as ENT and oral surgery.



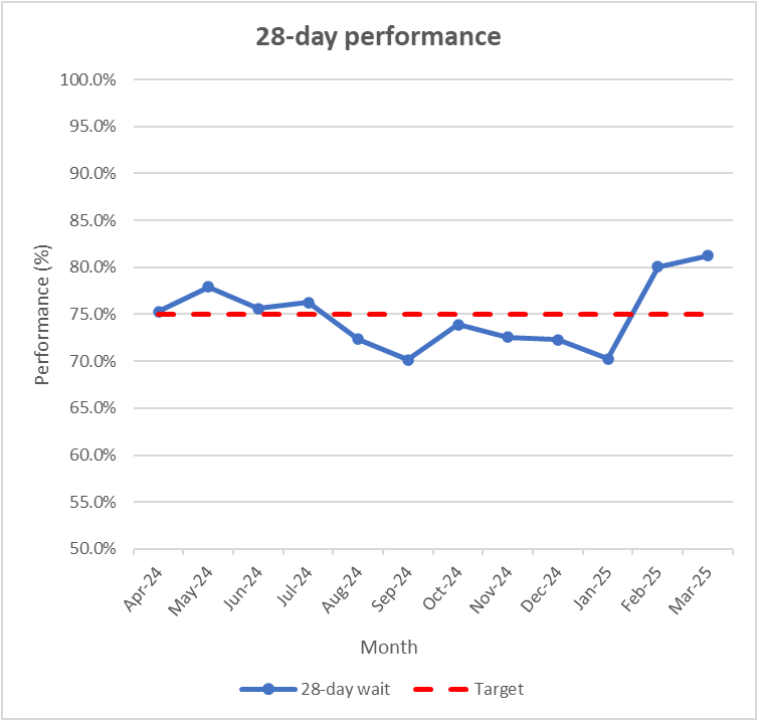
We continue to work towards the national target of 92% of patients seen before 18 weeks, as per graph below. Although there is still some considerable work to be done to achieve this target, our performance is continuing to improve, partly due to the work undertaken to reduce our number of patients waiting for an extended period.



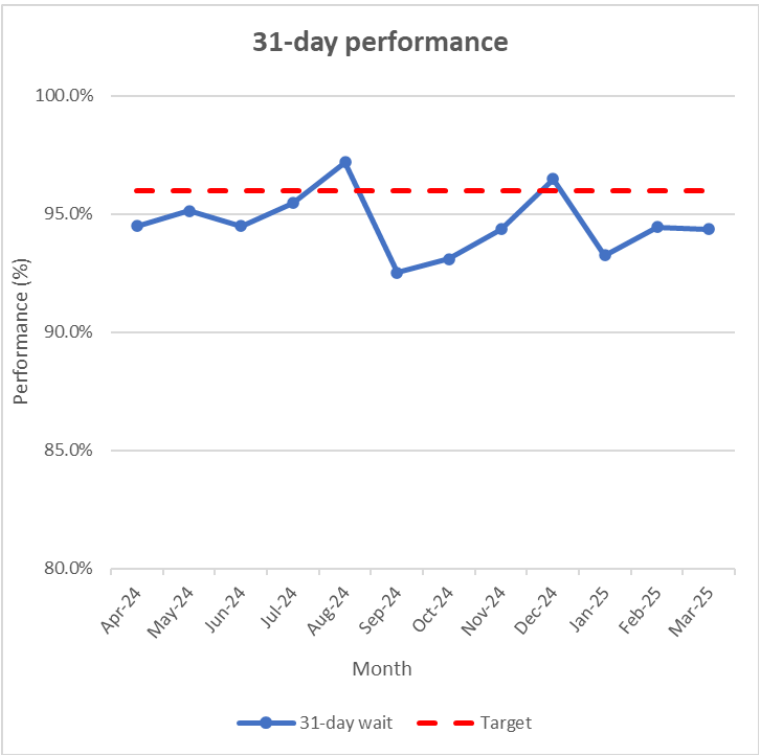
Cancer performance

Cancer performance has struggled to consistently improve comparatively to the NHS England agreed trajectory for 28 days, 31 days and 62 days national performance standards.

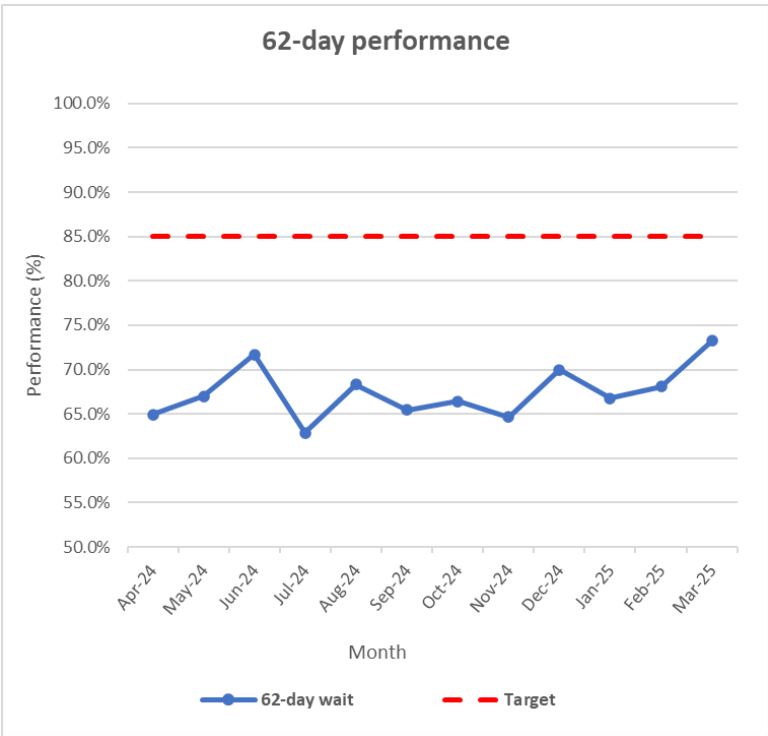
Cancer performance 2024/25 graphs shown below, please note these are current figures rather than submitted. The trust has been above target for the 28-day faster diagnosis standard in the last 2 months of the 24/25 financial year, as shown in graph, right.



The 31-day standard was met twice in the financial year and has been below target in the last 3 months of 24/25, as shown in graph, right.



62-day standard has been below target throughout the financial year with improvements seen since January 2025 and stood at 73.2% in March, as shown in graph, right.



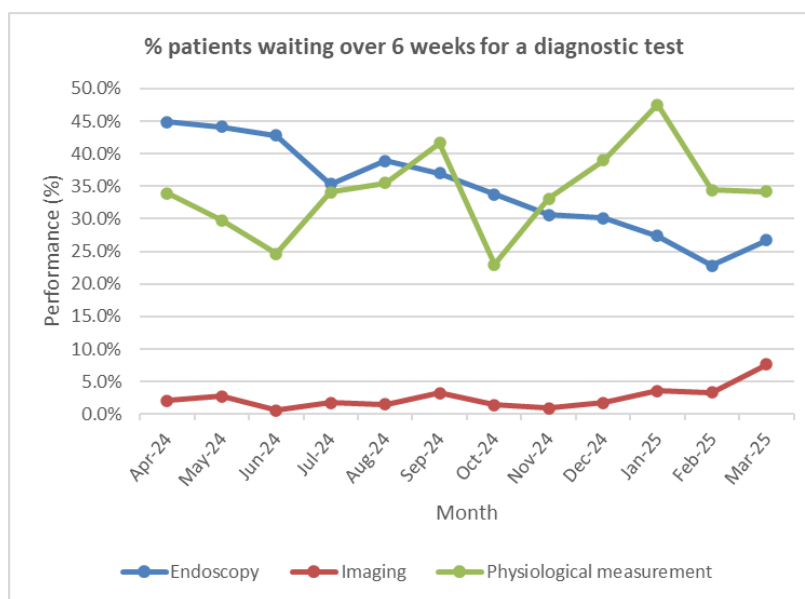
Note these are current figures and are slightly different from submitted (national submission) due to retrospective updates in the clinical system. Submission audits take place every 6 months to update national portal.

In quarters 2 and 3 of 2024-25 Breast and Skin cancer service were challenged in delivering to the 28-day pathway, leading to an overall underperformance in all tumour sites. Urology has been the most challenged specialty in reaching 28 days and 62 days target performance throughout the year. Histopathology reporting turnaround have highlighted the variable in-house capacity that has led to further outsourcing of reports. All four specialties have been subject to formal “mandated support”

This is part of the Trust’s internal performance management support process, where services are provided with targeted support which includes weekly governance oversight meetings in line with the Performance Accountability Framework (PAF). The increased frequency of conversations and supervision has supported challenged services in making sustainable improvements. 2025-26 improvement focus will be in delivering 28-day as standard across the majority of tumour sites with specific focus on Urology, Histopathology and Colorectal.

Diagnostics

Overall, for DM01 Diagnostic performance for patients waiting over 6 weeks for a diagnostic test shows improvements in Endoscopy but the percentage of over 6 weeks waiters stood at 26.7% at the end of March 2025. DM01 Diagnostic performance 2024/25, shown in image, right, as percentage of patients waiting over 6 weeks for a diagnostic test – less than 1% of patients should wait 6 weeks or more for a diagnostic test.



Imaging performance indicates an upward trend in patients waiting over 6 weeks for a diagnostic test since February due to a combination of increased demand and reduced capacity due to staffing and equipment issues. Performance stood at 7.6% at the end of March 2025. New MRI scanners to be available at CGH and GRH by the end of the first quarter of 25/26 financial year.

Physiological Measurement performance stood at 34.2% of patients waiting above 6 weeks for their diagnostic test at the end of March.

Throughout 2023-24 and for the majority of 2024-25 the MRI modality held a compliant performance position in regards to DM01. In 2024 one of the two MRI scanners based on Cheltenham General Hospital broke and has been out of action for the majority of the financial year. Recovery is anticipated to align with the commissioning of a replacement scanner in July 2025; until this time the remaining MRI capacity will be used according to clinical priority (serving emergency services first, then cancer and urgent elective patients and finally remaining capacity is used for routine DM01 patients). Neurophysiology and Cardiac echocardiogram (echo) have experienced volatile performance throughout the year, including 20% swings in improvement and deterioration from one month to the next. Endoscopy governance has embedded a methodical improvement approach to stabilise wait times whilst recovering long waits for planned surveillance.

Urgent and Emergency Care

Overall, the Trust has made progress and improvements in number of key areas relating to our Urgent and Emergency care provision.

Key highlights have included the change of provider of the Integrated Urgent Care Service offer (pre hospital services, Minor Injuries and Illness units and GP Out of Hours services) in November 2024. The Integrated Urgent Care Service is provided by our partners at Gloucestershire Health and Care. The Trust and Integrated Care Board partners had a challenging Christmas Period where the whole of Gloucestershire declared a Critical Incident in respect of demand for services, the impact of Norovirus and influenza; the Trust were not unique in this, but it did offer the opportunity to reflect on what changes will be required in preparation for the winter to come.

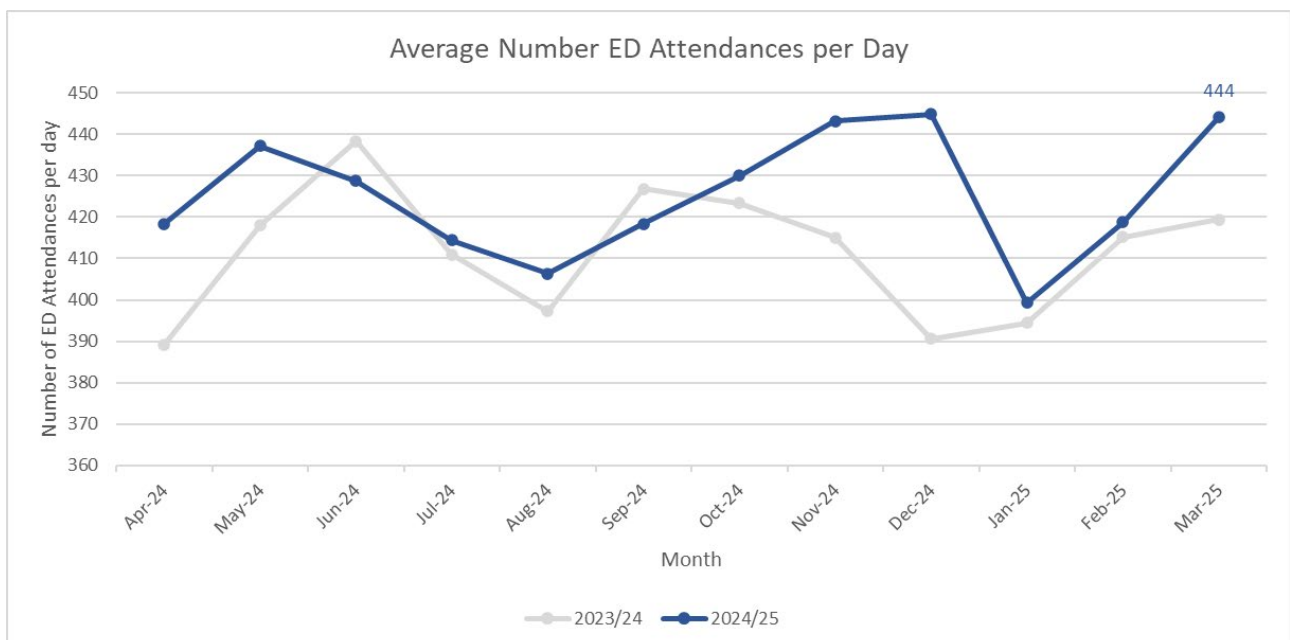
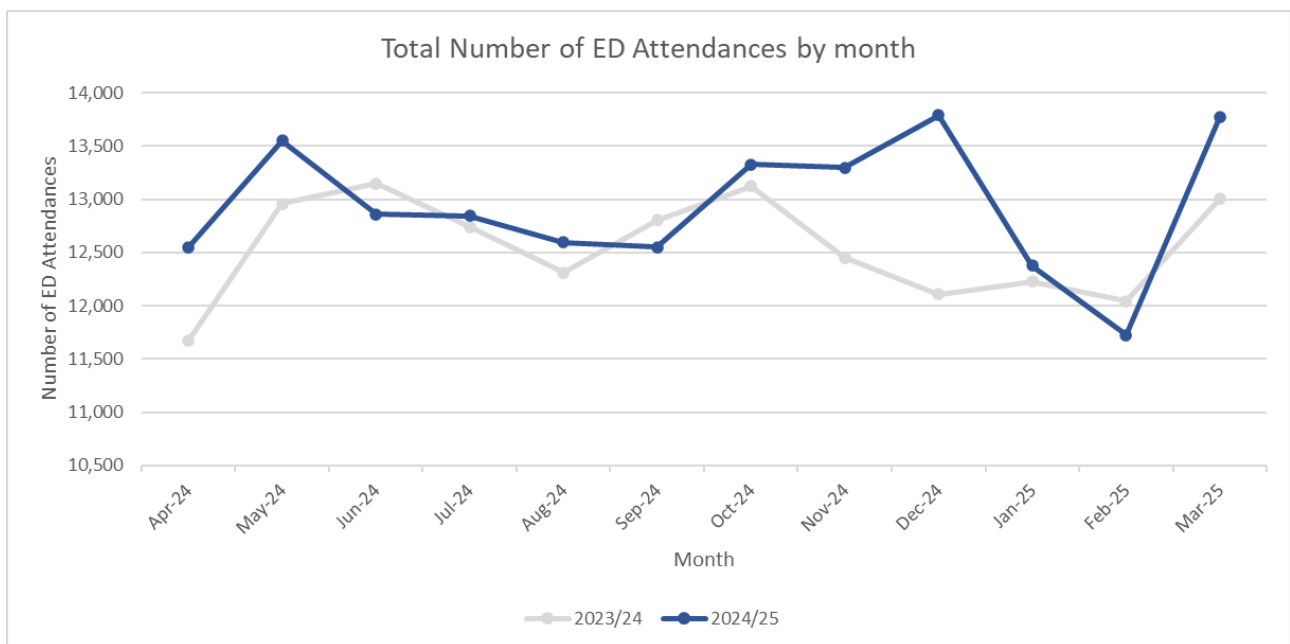
The Trust worked with colleagues from South West Ambulance NHS Foundation Trust (SWAST) in implementing a Timely Handover Process which sought to ensure that no patient waits over 90 minutes outside the Emergency Department in an ambulance. Gloucestershire was previously noted to be one of the worst performing hospitals in the country for these delays. This process was implemented during the course of the year and following implementation the Trust's Emergency Departments have seen an overall improvement.

Since November 2024 the Trust has halved the number of lost hours compared to the same period 2023/24 and increased the number of ambulances offloaded in the Emergency Department within 15 minutes (slides below). The numbers of patients conveyed by ambulance who have been delayed by more than an hour has continued to reduce month on month. We continue to work with our colleagues at South West Ambulance NHS Foundation Trust and continue to improve as we move into 2025-2026 and are pleased that the work we have done on the Timely Handover Protocol has been shared more widely across the South West.

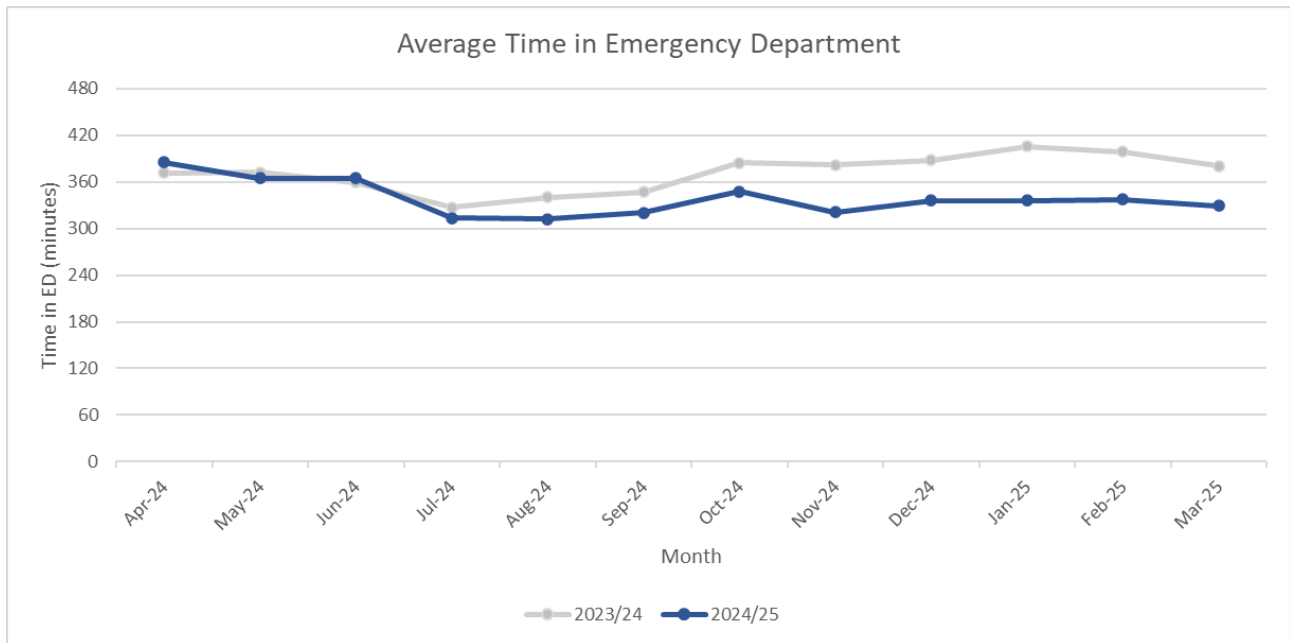
It was the first real test year for the changes in the Trust's approach to Acute Medical Take, moving to a single site model with centralisation of acute medicine at the Gloucester

site in July 2024. This has seen a supportive impact on performance, particularly in reducing the wait to see a clinician, with patients being referred to Same Day Emergency Care (SDEC) and Medical Assessment Unit (MAU) directly and not having to wait in ED first. The Surgical Assessment Unit, Trauma Assessment Unit, Gynaecology Emergency Unit, Head and Neck Assessment Unit and Urology Assessment Unit all came on line in early 2025 to support the early intervention of specialist care and treatment with surgical colleagues earlier in the pathway.

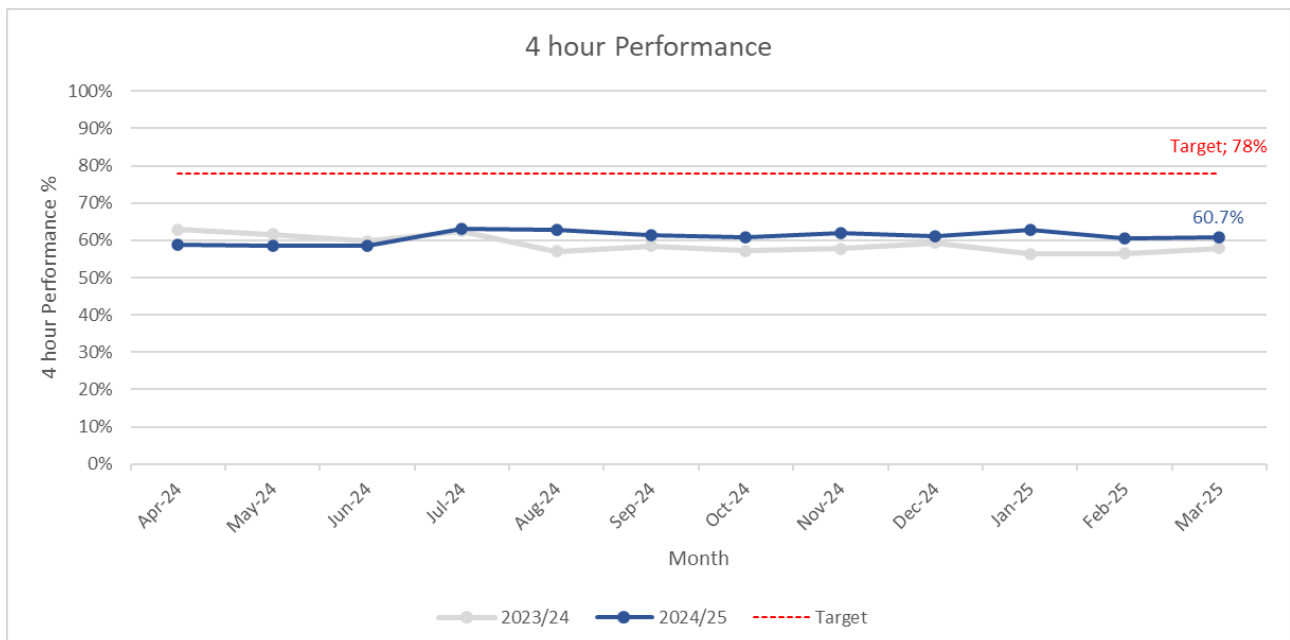
Emergency Department attendances increased overall, with the Trust seeing on average 13,000 attendances per month; making a daily average of 425 attendances compared to 413 in 2023/24;



Average time spent in the department remained high, but saw an improvement in year from 380 minutes in 2023/24 to 329 minutes overall in 2024/25, further work is planned to continue to reduce this further in 2025/26.

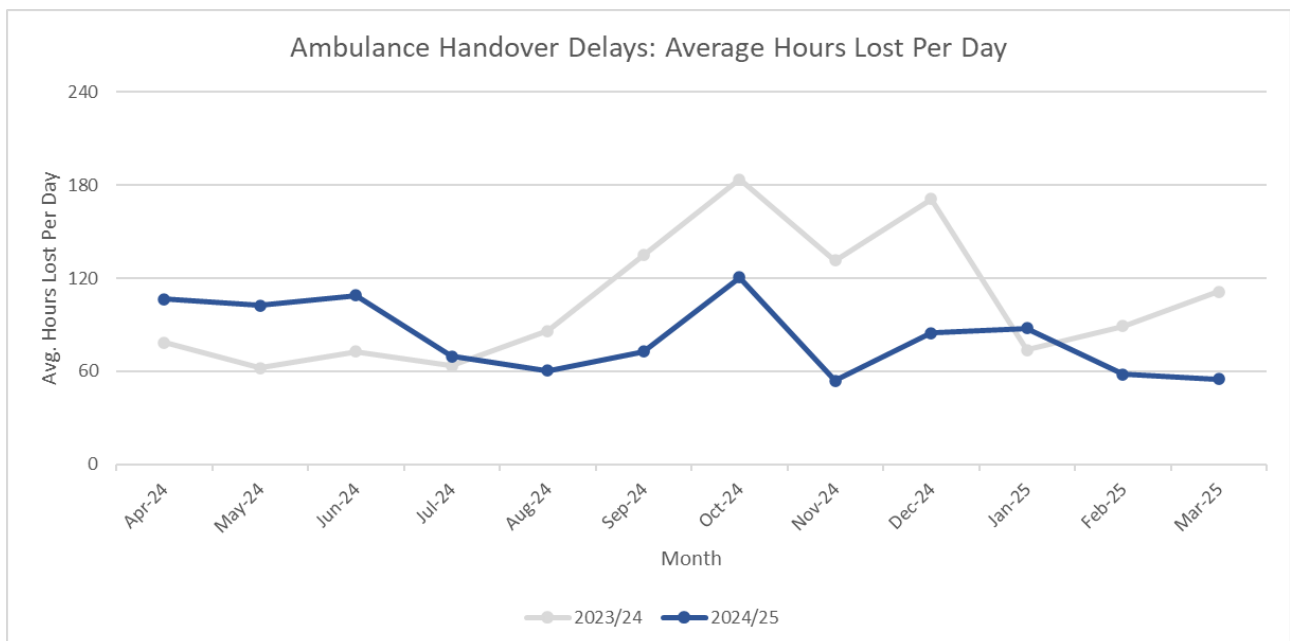
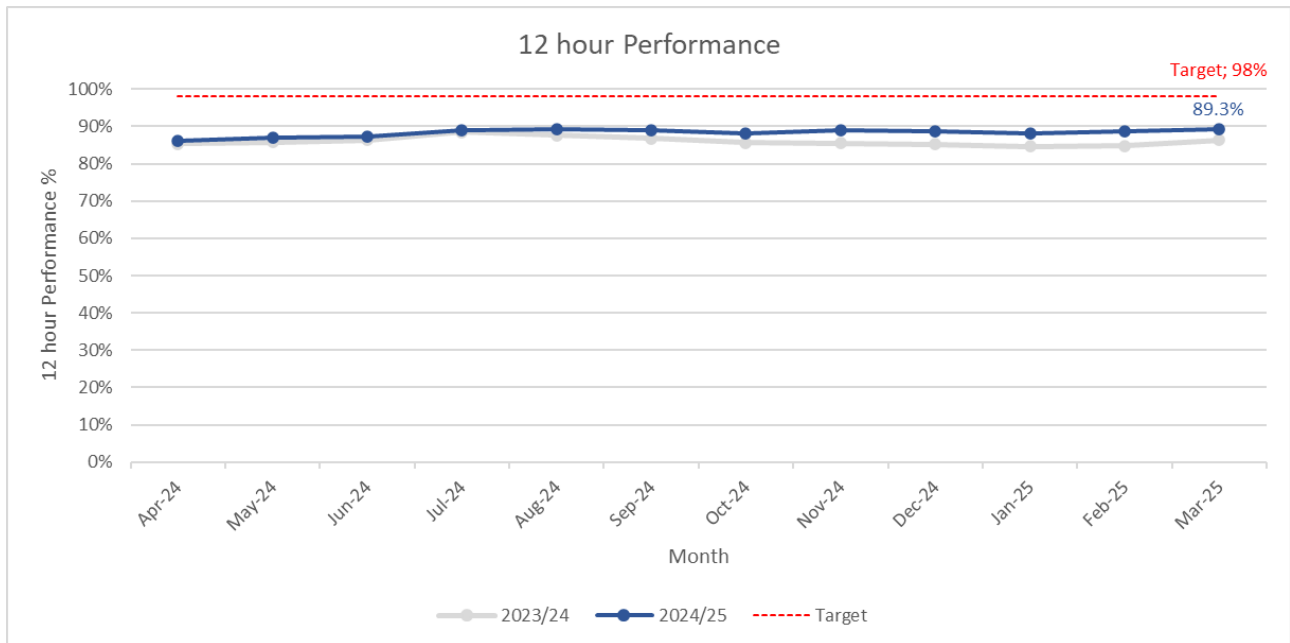


Performance against the 4-hour national target remained stubborn and below our target of 78%, ending the year at 60.7%.



Performance against the 12-hour standard (98%) was also not achieved, remaining at 89% patients admitted, transferred or discharged within 12 hours of arrival at the Emergency Department. However, there was a consistent and sustained reduction in the length of time patients waited on a trolley before being admitted. This was consistently recorded as half of the previous year's performance. There continues to be work needed

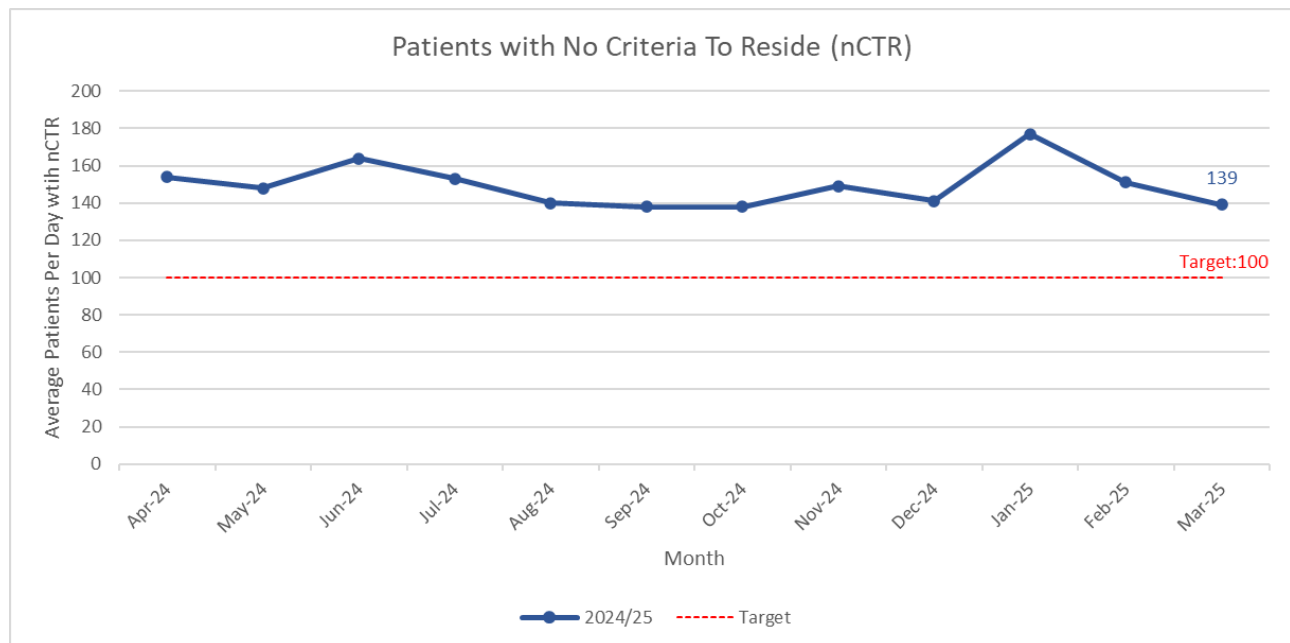
to reduce this even further and this remains a primary focus of the Trust as we enter 2025/2026 with the aim of returning to compliance with national standards. We recognise the importance of this work, in terms of both our patient experience and staff morale.



A greater proportion of ambulances are being offloaded by the 15-minute standard and improvements have been demonstrated in all other offload indicators showing a real improvement in all areas.

Patients without the need to stay in hospital has remained a key focus for the Trust and its partners across the One Gloucestershire system; with the exception of the Christmas and

New year period there was a steady reduction in the average number of patients with no criteria to reside per day from 154 to 139. The shared system target is to maintain a figure below under 87 consistently with the Trust's initial target set at 100.



Incident management

During 2024-25, the Trust entered several periods of Incident Management, ranging from a pre-emptive approach which anticipated challenges, to business continuity, to responding to an Integrated Care Board initiated system-wide Critical Incident. These saw the Trust enter a state of heightened escalation and response, when a decision is taken to redistribute staff and resources in order to maintain safe and effective clinical and operational services. These incidents were due to operational pressures on urgent and emergency care; industrial action; infection control challenges and IT system downtime.

The Trust has incorporated an incident review process that strives to learn from each of these incidents and put in place measures to ensure more effective processes for future. Such improvements include an increase in training for Strategic and Tactical On-Call personnel, in particular focusing on 'Chemical Biological Radiological Nuclear' (CBRNe); the development of a Business Continuity platform that is due to go live in early June 25, and the increased use of MS Teams and its associated functionality to streamline planning, response and governance when responding to incidents.

Quality priorities achievement

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

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
	outcome for mother or baby.	
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 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.

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
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. Patients/ or their families/carers are being asked, at least daily, about how they are feeling. All staff are able to refer to clinicians if they are concerned a patient is deteriorating. There is an escalation route available to patients, their families and carers advertised across the specialties.

In the Trust's annual Quality Account for 2024/2025 we have provided information about how we have improved patient experience within our quality priority areas.

Risk profile of the Trust

The Trust and GMS (the Group) operates three levels of risk register (speciality, divisional and Trust) in addition to the strategic risks set out within the Board Assurance Framework (see Annual Governance Statement below). The appropriate register for a risk is determined by the Trust Risk Appetite as shown below and risks are reviewed at prescribed periods as defined in the Risk Management Strategy.

Risk Appetite

Category/ Domain	Speciality	Escalate to Division	Escalate to Trust
Workforce	1-6	8	10 or above
Safety	1-6	8-10	12 or above
Environment	1-6	8-10	12 or above
Quality	1-6	8-12	15 or above
Finance	1-6	8-12	15 or above
Business	1-6	8-12	15 or above
Statutory	1-6	8-12	15 or above
Reputational	1-6	8-12	15 or above
Any domain		Consequence of 5 and likelihood of 1	Consequences of 5 and likelihood of 2

The Group combined have over 500 active risks on the risk register. 61% of risks are scored with a high risk retain between 8 and 12, with a further 10% of risks rated extreme with a score between 15 and 20. The remaining 29% or risk are either low or moderate.

Risk Matrix

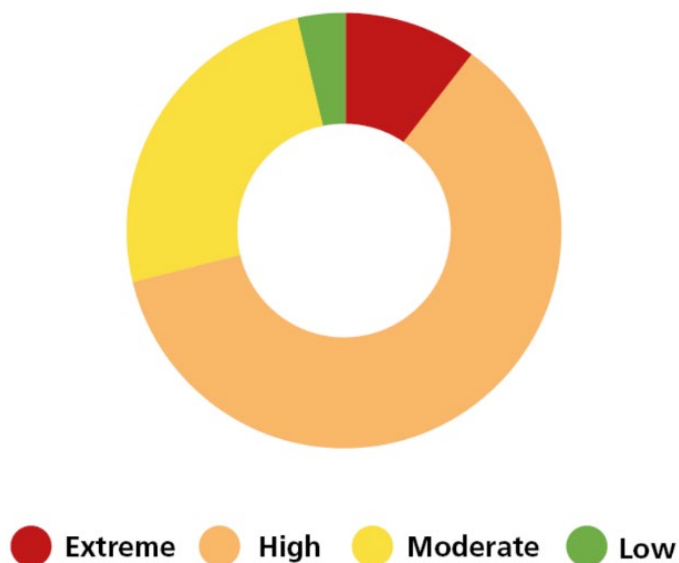
This chart show the number of risks by likelihood and consequence

Likelihood

	Consequence				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain	0	20	19	6	0
Likely	2	34	69	25	3
Possible	3	46	151	40	4
Unlikely	2	22	61	29	4
Rare	2	1	10	12	3

Risk level

This chart shows the number of risks by level

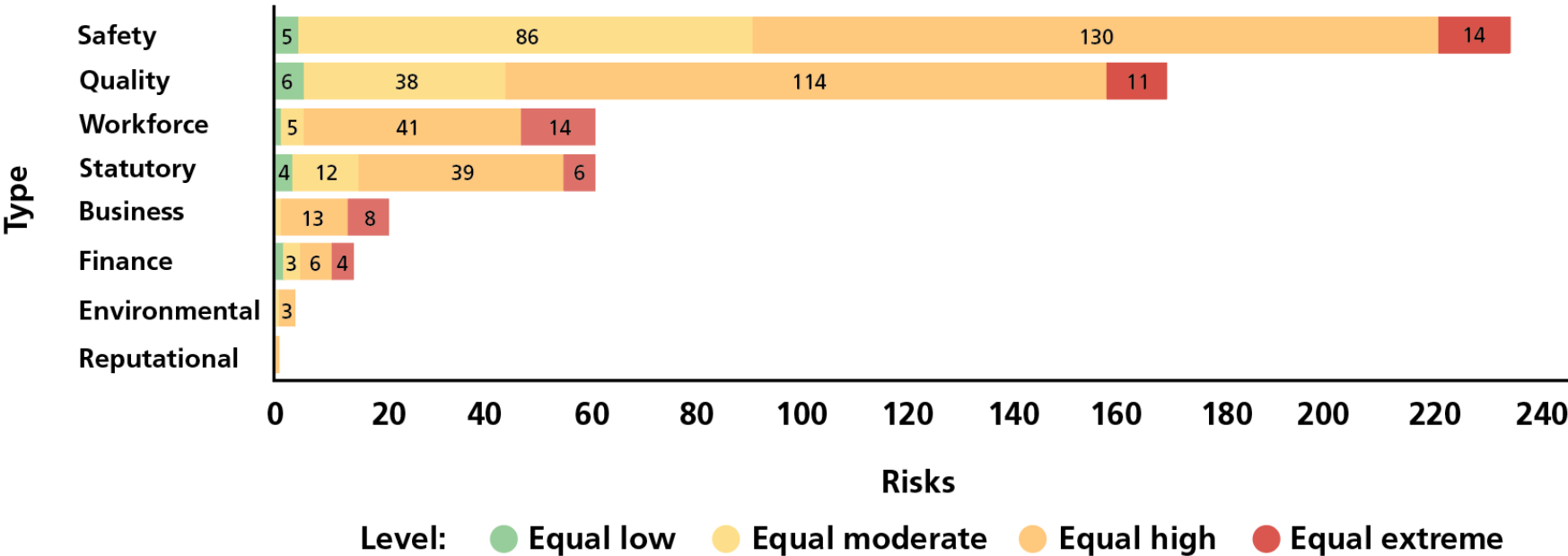


Risks are recorded by a type (domain), with majority of risks within the Group profile falling under safety and quality. However, as shown below, workforce and safety risks account for the largest number of extreme scoring risks on the register.

Number of risks by Type, sub-type and level

This chart shows the number of risks by type and sub-type broken down by level

Risk types

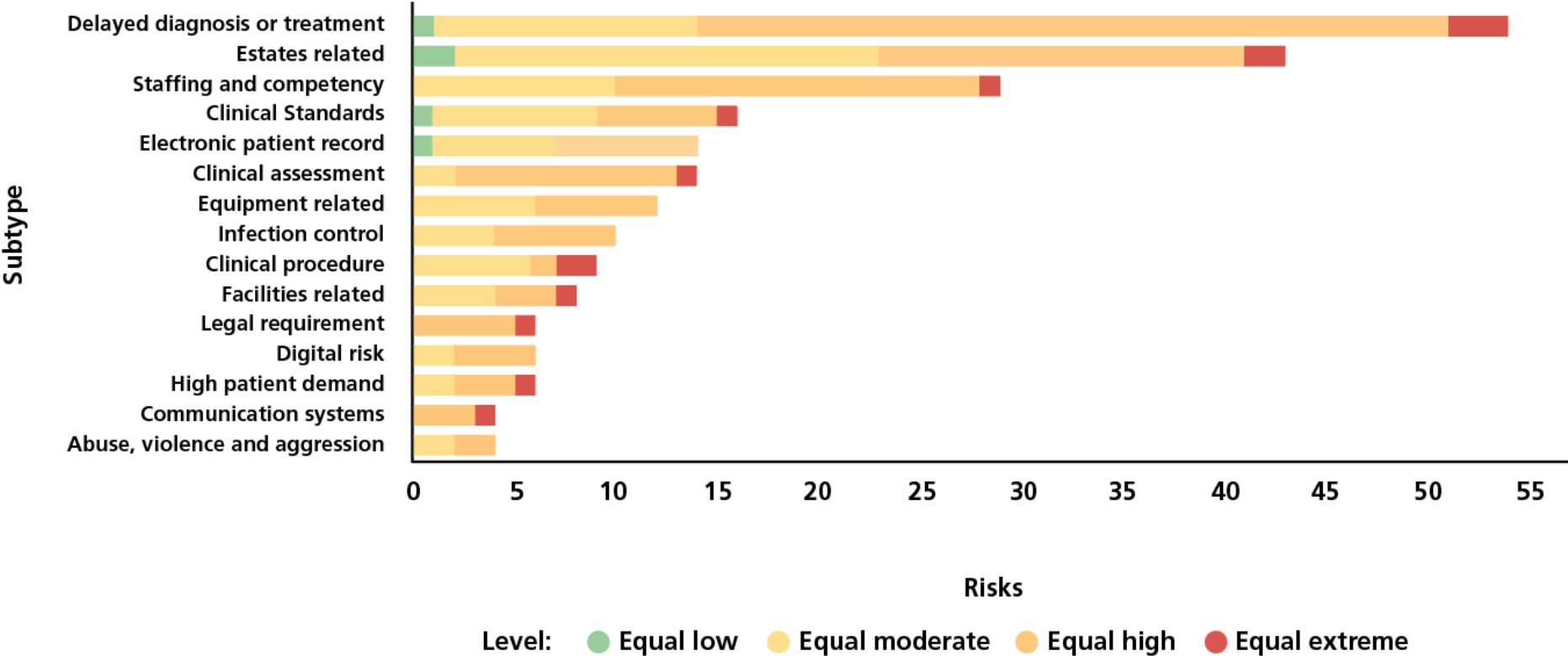


The risk profile under the safety domain, indicates that safety risks are predominantly related to delayed diagnosis (patient safety), estates related risks and staffing and competency concerns. This is also reflected in quality risks which are focussed on delayed diagnosis, and estates but also highlight equipment related risks, clinical standards and digital risks.

Number of risks by Type, sub-type and level

This chart shows the number of risks by type and sub-type broken down by level

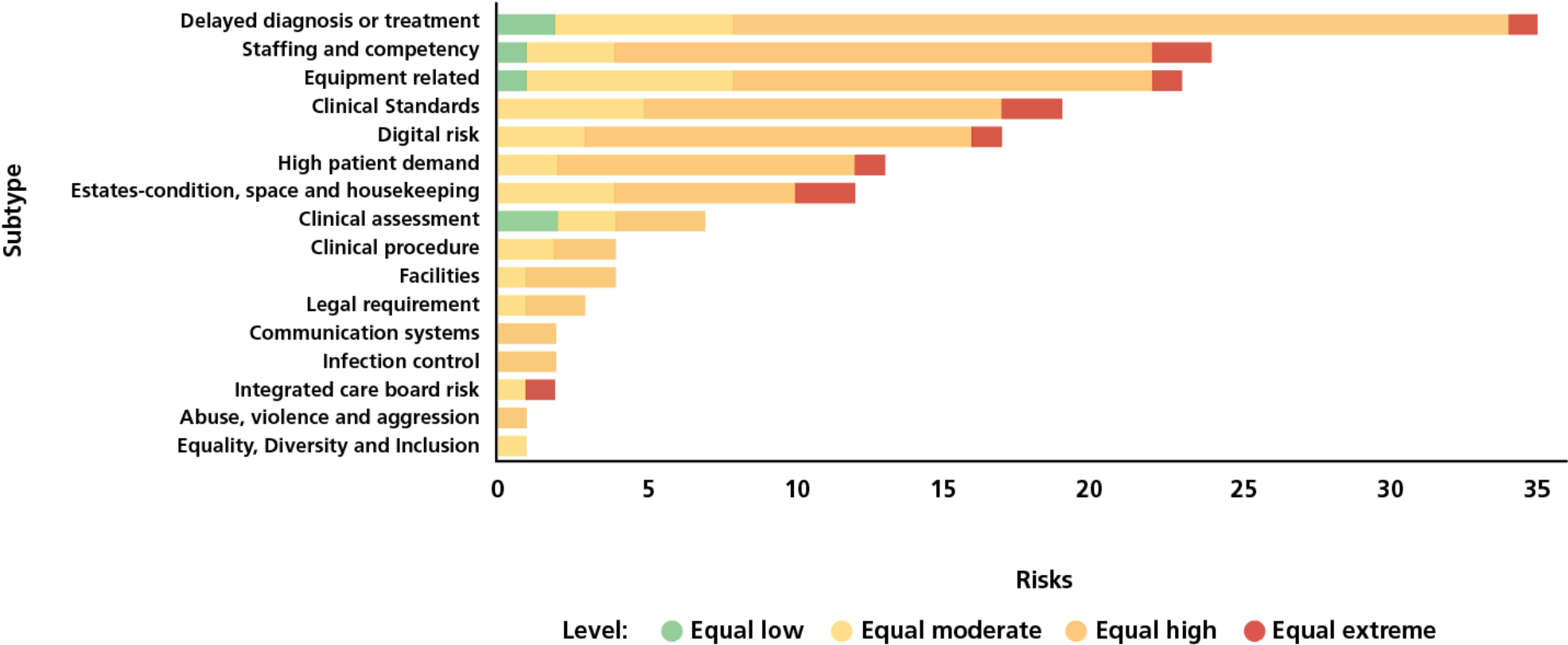
Safety risk sub-types



Number of risks by Type, sub-type and level

This chart shows the number of risks by type and sub-type broken down by level

Quality risk sub-types

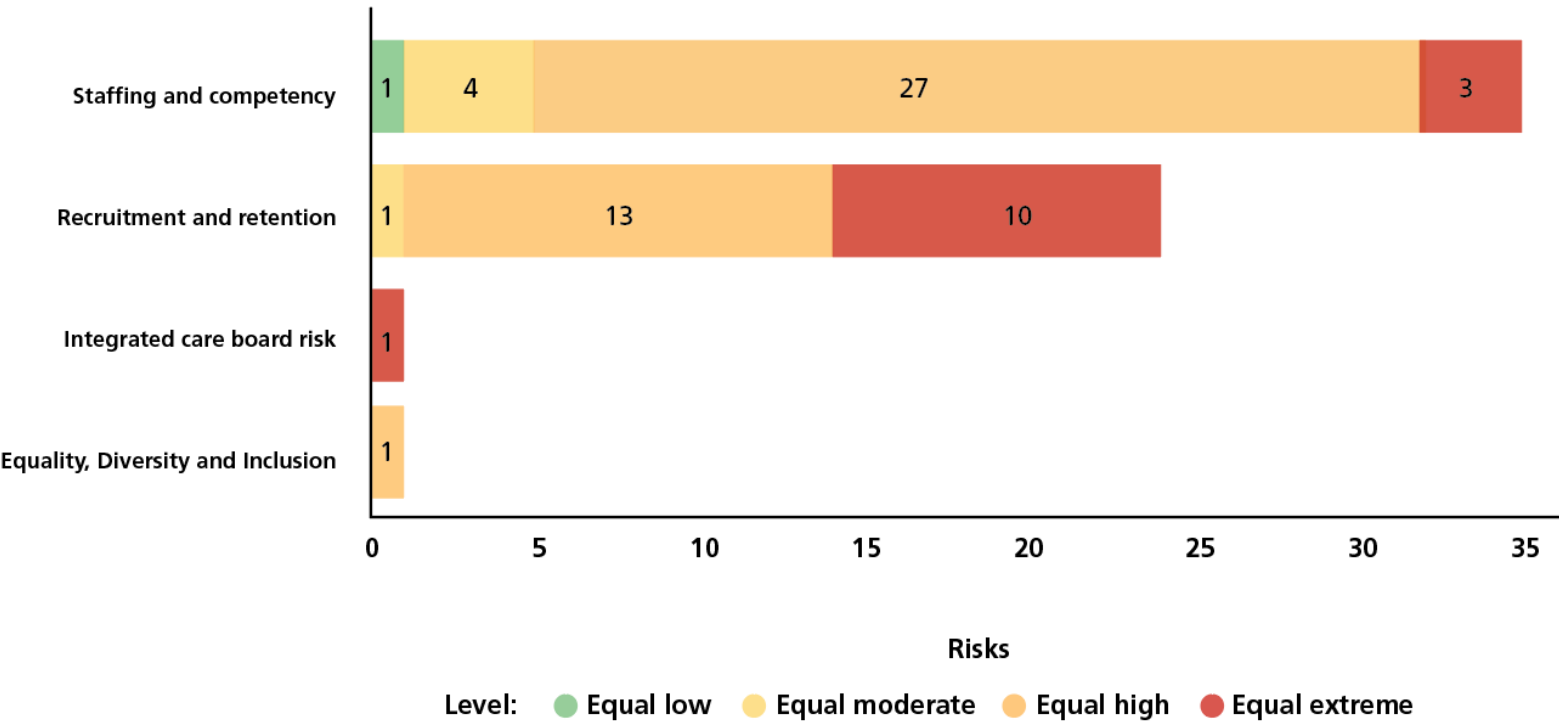


Workforce risks are dominated by staffing and competency concerns but also relate to the wider recruitment and retention elements of our workforce.

Number of risks by Type, sub-type and level

This chart shows the number of risks by type and sub-type broken down by level

Workforce risk sub-types



With the introduction of DATIX Cloud in January 2024, changes in risk scores can now be monitored via the reporting function and risk escalation is managed through the new online escalation feature. Risk score changes, escalation and de-escalation is reported through the Risk Management Group and the divisions.

High Scoring Operational Risks

There are three risks on the Trust Risk Register scoring 20. These include overcrowding in minors, a shortage of Interventional Radiologists and an insufficient Consultant Radiologists.

There are a further 12 risks on the Trust Risk Register that score 16, which include, but are not limited to, the hospital flow risk, maternity ultrasound services, Critical Care Consultant shortages and inadequate bed base, discharging dying patients to a place of choice, a capital risk, IT infrastructure and staff retention. Other risks rated 16 include the fractured neck of femur pathway, ventilation in theatres, follow up delays on ophthalmology and medical capacity in haematology outpatients.

These risks are distinct from the Strategic Risks (or principal risks) which are managed within the Board Assurance Framework and monitored by both Board Committee and the Board of Directors. These are set out within the Annual Governance Statement and referenced above.

Risk Mitigation

Between April 2024 and March 2025, twelve significant risks on the Trust Risk Register were mitigated and de-escalated to a lower register. These included key risks relating to maternity services in response to the Care Quality Commission intervention, improvements in the care and admission of young people with mental health needs, the cessation of boarding (corridor care) and improved patient flow.

A further thirteen risks which met the threshold but were managed by the division, were also mitigated and de-escalated within the year. These included active measures to reduce risks relating to children's safeguarding, a successful programme designed to improve staff retention, and improvements in the quality of care for stroke patients, endoscopy services and 62-day wait for treatment times.

Across all registers a total of sixty-one risks have been mitigated during the course of 2024/2025. As risks are mitigated and new risks emerge this impacts on and provides insight into the potential barriers to the Trust achieving its strategic objectives. The Trust remains dynamic in relation to its response to risks, formulating new plans and re-prioritising resources and funding as appropriate.

Key Performance Indicators

The Key Performance Indicators (KPIs) apply to the Group and are monitored on a monthly basis for risk and incidents by Risk Management Group (RMG) and at the divisional risk meetings. A suite of KPIs approved by RMG, Board and the Audit and Assurance Committee are in place to support the monitoring process. The new Patient Safety incident KPIs were agreed in April 2025.

The current KPIs and end of year performance (March 2024) are as follows:

KPI	Data evidence	RAG rating	Performance at year end 2024/25
All risks must have relevant controls identified	Risks without identified controls as % of all live risks in division / Trust	5% or less 6–25% 26% or more	0%
All risks must have actions	Risks without identified actions as % of all live risks in division / Trust	5% or less 6–25% 26% or more	2%
All risks must be reviewed by the specified review date	Risks not reviewed by due date as % of all live risks in division / Trust	5% or less 6–25% 26% or more	31%

Investigation KPIs and end of year performance (March 2025) are as follows:

KPI	Data evidence	RAG rating	Performance at year end 2023/24
All no and minor harm incidents with a high or extreme risk rating should be reviewed within 7 days	No and low harm incidents with high or extreme risk not reviewed within 7 days as % of those reported in a 7-day reference period	10% or less 11-25% 26% or more	222% Patient safety incidents
			3% Health and Safety Incidents
All no and minor harm incidents under investigation with a	No and minor harm incidents with a risk rating of high or extreme	10% or less 11-25% 26% or more	16%

high or extreme risk rating should be completed within 30 days	not investigated as % of number reported in rolling 12 months period		
All declared DOCs should be have a notification letter	The number of declared DoCs where an initial notification letter has not been sent to the patient / family as a percentage of the number of DoCs declared in the last 12 months.	10% or less 11–25% 26% or more	88%
All incidents declared a Serious incident (PSII) should be investigated within 6 months	The number of PSII not completed within a 6-month timescale closed in the preceding month as a percentage of the total number closed in that same month.	10% or less 11–25% 26% or more	50%
After Action Reviews Completion	the number of AERs not completed within a 3-month timescale closed within the preceding month as a percentage of the total number closed within the same month.	10% or less 11–25% 26% or more	0%
All health and safety harm incidents affecting staff should have contributory factors identified on the incident in DATIX	Health and safety harm incidents closed with no contributory factors identified as % of total closed in last month	10% or less 11–25% 26% or more	0%
Multiple Professional Review Completion	The number of MPRs not completed within a 3-month timescale closed within the preceding month as a percentage	10% or less 11–25% 26% or more	100%

	of the total number closed within the preceding month.		
All health and safety harm incidents affecting staff should have contributory factors identified on the incident in DATIX	Health and safety harm incidents closed with no contributory factors identified as % of total closed in last month	10% or less 11–25% 26% or more	5%
All actions must be in date	Actions overdue	10% or less 11–25% 26% or more	60%

Financial performance

Trust's Financial performance overview

In 2024/25 the Trust, like others across the NHS, has continued to work with significant pressures across emergency and elective services. At the same time the Trust has been managing a high level of patients who are medically fit for discharge who have remained in our hospitals due to a lack of suitable support for them in the community. As a consequence, this has led to the need for escalation areas and the loss of beds for elective activity in order to care and accommodate medically sick patients. Despite this the Trust has worked hard to deliver against a number of performance targets.

The Trust has also put in place a number of workforce controls with the aim of limiting growth and reducing the use of higher cost agency and bank staff to cover operational areas. Combined with support for recruitment to key posts the Group has been able to reduce its use of temporary staffing to 2.5% of the total pay bill (3.7% in 2023/24).

Payments to the Trust from commissioners for patient care activity were made using Aligned Payment Incentive (API) contracts. In simple terms these comprise a fixed payment element (approx. 70%) to cover non elective services and a variable element (approx. 30%) for elective services.

In addition, Integrated Care Systems (ICS) were able to earn additional funding from the Elective Recovery Fund by achieving a set of nationally identified targets for elective activity (including outpatients, day cases and inpatients). In Gloucestershire the Integrated Care System was able to earn additional funding which the Trust received a share of and used this to support unplanned pressures, escalation areas and to implement plans to support elective recovery (£3m), in addition to this value a further £7.5m supported baseline costs from the ICB.

During the year the Group has faced material financial challenges:

- Recruitment issues leading to continued temporary staffing costs.
- A challenging financial sustainability programme, in particular in its ability to deliver recurrent schemes.
- Escalation capacity issues due to no criteria to reside levels.
- Non pay inflation costs

Upon identification of pressures to the Group position support arrangements were put in place to focus on the drivers and available actions to address these – with actions being undertaken both by the Trust and by system partners, which include the ICS, Gloucester Health and Care (community and mental health provider) and the Council. Actions included:

- Operational expenditure reviews with divisions.
- System level expenditure reviews to identify opportunities.
- Impact of workforce plans and temporary staffing arrangements.
- Review of balance sheet and one-off opportunities.

Through the use of non-recurrent measures (including one-off savings, slippage on investments and one-off income, the Group position has been able to deliver a £67k surplus position for 2024/25 (£535k deficit 2023/24) – this is in comparison against the adjusted financial position which NHS England monitor against. When compared against the statutory reported position there is an operational deficit of c£29m for the Group, taking account of asset revaluations and impairments (prior year £13.3m deficit).

A summary of the adjusted financial performance of the Group (excluding Charity) is shown below:

All £'000s	2024/25	2023/24
Income	869,561	807,200
Expenditure	898,560	820,517
Operating surplus / (deficit) for the year from the SOCI	-28,999	-13,317
Adjustments for impairments	29,041	18,106
IFRIC 12 adjustments	365	1,783
Removal of capital grants and donations	-340	-7,107
Adjusted financial performance surplus / (deficit)	67	-535

Planning for 2024/25 has continued to be undertaken on the basis of a system approach. The ICS in Gloucestershire continues to look at sharing resources across its ICS partners on the basis of supporting costs after taking out of area and non-patient care income into consideration.

The collective plan for the Gloucestershire Integrated Care System (ICS) in 2025/26 sees a significant financial, and operational challenge. As a system there is a material underlying deficit from 2024/25 of c£129m. For 2025/26 the ICS has submitted a financial

plan with a break-even position which requires the system to deliver c£89m of sustainability solutions. This is a significant increase on the level that has been delivered in previous years and represents c5.9% of the ICS funding allocation. If the recurrent solutions are delivered this would leave an underlying exit deficit position from 2025/26 of c£109m. As part of this the Trust has submitted a breakeven plan for 2025/26 with a savings requirement of c£41.8m (of which 65% is recurrent). If sustainability solutions are delivered recurrently, there is an underlying deficit of c£69.8m.

Operationally colleagues continue to face the challenge of capacity in relation to workforce availability, urgent care demand and bed capacity due to a lack of onward care capacity for patients. The Trust continues to work with its partners to seek to address these challenges.

Financial sustainability schemes

Supported by our Programme Management Office divisional colleagues developed plans which have drawn upon a variety of locally identified opportunities and nationally informed opportunities (utilising benchmarking from Model Hospital, Getting it Right First Time etc.).

At the end of 2024/25 the Programme Management Office have reported full delivery of our 2024/25 target, c£37.4m, of which c£10.8m of schemes have been delivered on a recurrent basis.

The need to deliver recurrent sustainability opportunities remains a significant challenge for the Trust, and wider NHS, moving into future years. Our plan for 2025/26 looks to improve upon the recurrent delivery levels from 2024/25 (65% from c30%).

Financial governance

Throughout the year strong financial governance has been maintained. This is demonstrated on a day-to-day basis through the use of the scheme of delegation to approve expenditure for requisitions and invoices, obtain quotes for non-pay items etc. Financial reporting processes have continued through monthly reporting at various levels in the organisation – at divisional Executive reviews, at Finance and Resources Committee, at Trust Leadership Team and at Trust Board. Financial training also continued albeit on a virtual and in person basis which proved to be very successful and welcomed by the managers who attended.

The Trust also implemented the Accountability Framework which provides measurable targets for each division spanning operational, quality, workforce and finance. This has resulted in escalation of support for those divisions that need it.

To further support our financial governance arrangements both internal and external auditors have undertaken reviews. In relation to external audit there were some control recommendations highlighted which, once implemented, will further strengthen the year-end assurance process.

Income disclosures required by section 43(2a) of the NHS Act 2006.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2024/25 financial year.

Information on the impact that other income it has received has had on its provision of goods and services for the purposes of health services in England

Other income received has had no impact on the provision of goods and services for the purposes of the health service in England.

Financial Risk Management

The Trust continued to embed its risk management arrangements with good levels of engagement from risk owners and divisional strategic leaders. The assurance arrangements had been strengthened and a robust process put in place to monitor risks for potential threats to the achievement of the Trust's strategic objectives.

The profile of Trust risks still remains heavily safety-orientated as clinical services continue to work through the constraints of industrial action, winter pressures, service recovery and increased patient demand. The wider ICS risk of patient flow and timely discharge dominated the risk horizon and are reflected in the number internal incidents focused on patient flow. Workforce or skill shortage and ageing technology or equipment are also pre-dominate risks which impact on progress against our objectives. However, risk management remains a key focus at all levels, with appropriate escalation of critical risks. Our risk management culture continued to mature, supported by an active leadership in risk management.

Historical financial performance

Across the last five years the Trust has seen an improvement and stabilisation in its financial position although the underlying position is showing a deterioration which will be the focus of future years. Shown below is the position reported against the NHS England (NHSE) control total calculation:

	£'000s				
	2024/25	2023/24	2022/23	2021/22	2020/21
Surplus / (deficit)	67	-535	51	520	2,067

Future financial plans

Looking ahead to 2025/26 the Trust has now submitted a balanced plan along with our ICS partners. This plan was submitted to NHS England on 27th March 2025

The ICS has confirmed a plan of financial breakeven which was submitted on 12th June 24. This plan includes a significant level of savings in order to achieve this position, totalling £93m which will compromise of individual organisational targets as well as system targets. The ICS are committed to working in an integrated way to maximise our resources and to continue to provide safe care to our patients.

Financial risk issues

Issue	Response
Net asset of net current liability position	Total forecast net assets employed as at 31st March 2025 are c£267.2m, compared with £293.3m for 2023/24 – the net change reflects the additions from the capital programme, the impact of market equivalent asset valuations and the timing of the utilisation of cash balances held.
Cash position	Total cash position as at 31st March 2025 is £41,996k, a decrease of c£13m from March 2024 due to the timing of capital cash payments.
Debt repayment	All Public Dividend Capital payments made by due dates with no suspensions or arrears
PFI payments and impact	No issues to report
ICS Financial support arrangements	No issues to report. The ICS work on a collaborative basis to support the oversight framework requirements.
Inability to pay creditors on due dates	At the end of March 2025, the Trust paid 98.6% of invoices by volume and 96.1% of invoices by value within the target outlined in the Better Payment Practice code.
Reduction in normal terms of trade credit by suppliers	No issues to report
Loss of key management without replacement	Key colleagues are replaced should vacancies arise. The Trust supports staff through a range of internal, regional and national programmes and has shared leadership programmes at an ICS level. Key staff are replaced should vacancies arise
Loss of key staff without replacement	
Staffing difficulties or shortages of important supplies	Recruitment remains a risk to all providers and is an area of focus for the Trust. Overall, Trust vacancy levels (excluding GMS) in March 2025 were 7.21% (the latest available period) (6.59% in March 2024). Supplies are sourced without significant shortages.

Non-compliance with statutory requirements	No issues to report
Pending legal or regulatory proceedings against the trust, which if successful, would result in claims that are not capable of being satisfied	There is one pending legal issue which provision for is currently included in the Trust's forecast outturn position. No other issues to report
Changes in legislation or government policy expected to adversely affect the entity	None anticipated.

Other financial considerations

The local NHS commissioner has highlighted a number of key services provided by the Trust as designated services. In the event that the Trust was not able to operate these services would be required to be continued, potentially by a successor public sector body. This is important in the context of going concern as a key test is whether operations can continue and the designation of services supports this continuation.

Workforce performance

Overall, the Trust (including Gloucestershire Managed Services) vacancy rate has remained within the 8% target in 2024-2025. The number of substantive staff employed by the Trust was 8247.69 whole time equivalent (WTE) in March 2025, compared to 8169.23 in March 2024. The Trust's turnover (substantive employees) has reduced from 10.54% to 9.11% over the last 12 months.

The workforce has faced a number of challenges over the last year; supporting the elective recovery work, managing increased attendances through the Emergency Department, as well as significant focus on our maternity services. Our workforce meets these ongoing challenges with outstanding commitment, and continues to strive to provide outstanding care to our patients.

The improvements seen through our staff survey responses in key areas such as staffing levels, the rise in recommendations to work at the organisation, and a stronger perception that staff are not routinely working unpaid hours reflect the positive impact of our ongoing cultural work. Furthermore, confidence in how we act on concerns shows growing trust in our leadership and responsiveness.

However, the declines in areas like team enjoyment, feeling trusted and clarity of role indicate where we must now concentrate; deepening trust, team cohesion, and role clarity to strengthen engagement and psychological safety. These are essential elements for a thriving culture. These insights guide our continued investment in our cultural programmes creating an inclusive, supportive environment where staff feel valued and empowered. Specific work on our Sexual Safety at work, Licence to Lead; leadership and managers development and safe learning environments show that our cultural work underpins the performance of our workforce.

Environmental Impact

The Trust and Gloucestershire Managed Services (GMS), as a group, have a Green Plan (sustainability strategy) which was launched in November 2021. Our Green Plan provides a comprehensive and structured framework to show how we will work to embed sustainability into the organisational culture and take action to reach net zero carbon by 2040 (on the emissions we directly control).

In the year (2024/2025) there have been a number of projects which have delivered sustainability benefits:

Clinical Services

- Endoscopy have demonstrated CO2 emissions are reduced by 87% with judicious CO2 use and adoption of the Olympus MAJ-2010 valve. Work has been shared with European and national colleagues.
- Trialled reusable tourniquets in areas such as Phlebotomy and Theatres. Reduction in single use items and reduction in waste etc.

Medical Gas

- Central Destruction Unit installed in GRH Birth Unit to capture exhaled Entonox gas from birthing mothers. Savings of 500tCO2e and removes health risk to clinical staff from long term exposure to nitrous oxide.
- CGH Entonox manifold decommissioned in September 2024, reducing volume of gas used.

Waste

- Warp It (equipment reuse) now established, saved 30tCO2e and £44,171.
- £28,000 from sustainability fund for additional offensive waste bins which have replaced orange hazardous waste bins. Further offensive waste bins are required in 25-26.
- Food waste recycling in all GMS catering outlets and introduced for patient meals.

Green Space and Biodiversity

- GMS Grounds Team have taken on the Grounds maintenance contract for Apleona (PFI at GRH). This allows for continuity of approach and better management.
- Trees planted, including in large planters made by Men In Sheds – a group to make and repair, supporting local projects, whilst improving wellbeing and reducing loneliness.
- Installation of the Forget-Me-Not Garden (Baby Loss) at GRH.
- Additional compost facilities.

These actions encourage wildlife, help with adaptation and promotes engagement with local community groups.

Travel

- 5 bikes, abandoned in the bike sheds, were donated to the Glos Bike Project, supporting the local community.
- Increase of 2.6% (on previous year) of passengers using the shuttle bus – service 99.
- Staff travel claims for mileage conducted in electric vehicles increased by 13% on 23-24.

Active travel measures contribute to less traffic congestion, better air quality and reduced pressure on car parks.

Telemedicine

- There were 180,292 telephone and telemedicine appointments, an increase of 22.5% from 2023-24.

This flexible approach saves patients travelling to hospital sites, saves them travel and parking costs, time etc with wider benefits to the environment from avoided travel.

Working with the Integrated Care System

- Electric vehicles and EV chargers - feasibility study to review fleet requirements, EV options, and the provision and installation of EV charging facilities. Includes how the Trust can work with Integrated Care System partners on EV charging across the county.
- County-wide Climate Risk and Vulnerability Assessment being conducted via the Integrated Care System (to report in October 2025). This will inform Trust adaptation and mitigation strategy development in 25-26.

Task Force on Climate-related financial Disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, and will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1,2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below with appropriate cross-referencing to relevant information elsewhere in the annual report and in other external publications.

The Board's oversight of climate-related issues:

- The Director of Improvement and Delivery is the board lead for climate-related issues.
- The Finance and Resources Committee is a formal committee of the board and receives assurance of the Trusts delivery of its sustainability plan through regular reports and briefings.
- The Chair of the Climate Emergency Response Leadership (CERL) Group can also draw the attention of the Finance and Resources Committee to any sustainability related issues that require disclosure to the full Board, or require executive action.
- The Board receives an annual sustainability report as part of Trust reporting. This report includes progress against goals and targets, highlights achievements and notes actions for the following year.
- The Board also has an established Sustainability Group with cross organisation representation which hold responsibilities for developing and actioning the sustainability work plan.
- The Trust works in partnership and collaboration as part of One Gloucestershire and is a formal member of the Climate Action Group across Gloucestershire working with other NHS organisations including the ICB, other NHS Trusts and the County Council.

Trust processes for assessing and managing climate-related issues:

- As part of the Green Plan, the Trust has established the Climate Emergency Response Leadership Group with specific responsibilities to:
 - Understand the impact of climate emergency on the Trust
 - Lead and develop Trust strategy and policies on climate and carbon
 - Monitor progress on the Green Action Plan and all projects contributing to carbon reduction
 - Ensure national and local reporting requirements are met and produce an annual sustainability report
 - Embed sustainability culture throughout the Trust
 - Develop and deliver sustainability cost improvement programme
 - CERL reports to Finance and Resources Committee
- Six monthly energy reports to Gloucestershire Managed Services Board
- An annual energy report to Trust Board
- The Trust has established a £50k sustainability fund held by the Director of Improvement and Delivery and managed through the Climate Emergency Response Leadership Group.
- The Trust is also considering how it can strengthen this through addition sustainability to the focus and delivery of its well-established Quality Improvement Approach via the QI Academy and Equality, Health Inequality Assessment.
- An annual Sustainability Report is provided to the Board and includes details of progress on delivery within the year and details of future actions and timescales.

- Some, but not all, of our projects currently have carbon emission reduction targets associated with them which align with national legislation/targets. Some examples:
 - Water management – installation of additional water meters;
 - Building Management System – continuation of works to improve operational resilience and improve energy efficiency;
 - Feasibility study (in conjunction with Integrated Care System to review fleet arrangements, electric vehicle (EV) options and the provision and installation of EV charging facilities;
 - Food waste recycling to be introduced at ward level at Cheltenham General Hospital. Extend to non-Gloucestershire Managed Services run catering establishments within the Trust. Links to Trust target to recycle 100% non-clinical waste by 2025 and national requirements for Simpler Recycling (introduced March 2025).
 - Procurement developing Social Value questions and exploring how we can ask contractors to contribute to this. Project in-conjunction with Integrated Care Board and system partners.
 - County-wide Climate Risk and Vulnerability Assessment being conducted via ICS. To report October 2025. Will inform adaptation planning and identify mitigation actions

Trust process for identifying, assessing and managing climate-related risks:

- The Trust declared a climate emergency in November 2019.
- The Trust has three climate-related risks on the Corporate Speciality Risk Register
 - Risk 121 = The risk that extreme weather events (heat, cold, flooding, fire) and poor air quality, lead to increased demand on urgent and emergency care without corresponding increase in Gloucestershire Integrated Care System health resources. This is noted as a Business risk.
 - Risk 127 = The risk that the Trust does not meet net zero carbon emissions by 2040. This is noted as an Environmental risk.
 - Risk 130 = The risk that the Trust does not progress actions defined in the Green Plan due to a reliance on goodwill and out of hours working from colleagues in order to progress actions at local level. This is noted as an Environmental risk.
- The Board Assurance Framework includes a strategic risk related to “Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon footprint organisation by 2040”. This is rated 12. This is reported to the Board at every meeting as part of the Board Assurance Framework. This risk is also considered and reviewed by the Finance and Resources Committee ahead of the update to the Board. The risk and actions are reviewed and updated on a monthly basis.
- The three climate-related risks, and the BAF risk SR11 Sustainable Healthcare, are reviewed regularly by Climate Emergency Response Leadership group. This group

is responsible for many of the actions outlined and for monitoring reporting of sustainability / climate related issues.

- Climate Emergency Response Leadership group members are able to propose new risks or changes to existing risks.
- Risks are discussed by the Trust at regular intervals and are reported to the Risk Management Group, divisional Boards and the Audit and Assurance Committee.
- Work is continuing to enshrine climate control monitoring within the Board Committee structure.

Trust processes for identifying, assessing and managing climate-related risks are integrated into the organisation's overall risk management approach:

- The BAF risk SR11 Sustainable Healthcare is linked to BAF risk SR09 Failure to Deliver Recurrent Financial Sustainability and BAF risk SR10 Condition of the Estate.
- Climate related risks are evaluated, managed and monitored in the same way as all other Trust risks, following the Trust Risk Management Framework.
- Climate-related risks are considered under KIER at Finance and Resources Committee

Material metrics and targets used to assess and manage relevant climate-related issues:

- The Trust has adopted NHS national targets for the reduction of carbon emissions
 - For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach 80% reduction by 2028 to 2033
 - For the emissions we can influence (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach 80% reduction by 2036 to 2039.
- Carbon emissions for scope 1 and 2, and part of scope 3 (waste, water and business travel), are calculated annually and included in the sustainability annual report. These have been reported annually since 2017-18 and are reported in tonnes Co2e.
- Data used for energy, water and waste is also reported within the annual ERIC (Estates Return Information Collection) submission.
- The Green Action Plan details projects which aim to reduce carbon emissions and enable the Trust to achieve net zero targets.
- Target baseline 2019/2020.

Calculation of our climate risks has considered a number of factors including:

- Finance e.g. increased revenue costs from running inefficient estates and fleet
- Finance e.g. issues around our ability to secure or prioritise investment required for new infrastructure, retro-fit existing buildings and/or construct new buildings to EPC standard
- Reputational impact on the organisation
- Potential impact on recruitment and retention of staff

- Failure to unlock potential funding opportunities
- Availability of staff resources to deliver Green Plan and reliance on goodwill to develop and progress sustainability initiatives
- Scale of estate challenge with aging estate including the £86m backlog maintenance (as declared in ERIC 23-24)
- Impact of extreme weather events – including Trust ability to deliver services (staff availability, supply chain disruption, loss of building availability etc.), increase in number of patients needing urgent and emergency care and negative impact on mental health.

Climate risks based on discussion by members of Climate Emergency Response Leadership group. This group's membership includes experienced and specialist staff from Procurement, Communications, Estates and Facilities, Strategy and Transformation, Emergency Planning and Clinical input.

Risks are RAG rated following Trust policy on risk assessment. Risks are held on Trust Risk Registers and monitored by the Trust Risk Team and associated risk committees.

Targets

The Trust has adopted the NHS targets with interim targets including:

- NHS Carbon Footprint 11,366 tCO₂e by 2031/32
- NHS Carbon Footprint Plus 23,612 tCO₂e by 2037/38
- Interim targets are based on 2019/20 emissions footprint data provided by Greener NHS. Equivalent to:
- Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028-32.
- Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-38.
- We use the Greener NHS data for the Net Zero Carbon Footprint Plus, as this provided the data for Supply Chain (Medicines, medical equipment and supply chain), Commissioned Health Services outside the NHS and Personal Travel. At the moment we do have any other means of calculating this data so choose to use that supplied by Greener NHS. This helps ensure standardisation with other trusts.
- We calculate our own Carbon Footprint data based on our own usage data e.g. kWh for building energy, volume of water, waste tonnage, litres of anaesthetic gas, miles travelled for fleet and grey fleet.
- Interim targets based on 2019/20 emissions footprint data provided by Greener NHS. Equivalent to:
- Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028-32. Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-38.
- 2019/20 baseline for targets for 2040 and 2045.
- We use the Greener NHS data for the Net Zero Carbon Footprint Plus, as this provided the data for Supply Chain (Medicines, medical equipment and supply

chain), Commissioned Health Services outside the NHS and Personal Travel. At the moment we do have any other means of calculating this data so choose to use that supplied by Greener NHS. This helps ensure standardisation with other trusts.

- We calculate our own Carbon Footprint data based on our own usage data.

The Green Plan will be reviewed during Summer 2025. Interim targets for Carbon Footprint and Carbon Footprint Plus will be reviewed and updated as appropriate, together with the Trust's commitment and goals.

Estates

The Trust is regarded as a medium sized acute Trust delivering services across two main freehold sites and a number of off-site buildings. The building stock on both sites is of varied age, some dating back to the early 19th century, design, configuration and condition which the Board recognise presents a risk to our achievement of our quality of care goals as well as having a potentially negative impact on our patients, relatives and visitors and staff, taking into account the age and condition of the Trust.

Gloucestershire Royal

The Gloucestershire Royal Hospital (GRH) site was developed at different times with the main Tower Block building first occupied in 1975. Part of the site is PFI, which houses the Emergency Department, Acute and Coronary Care, as well as a large Outpatient Centre for general, specialist and therapy services. Recent developments have included extensions to both the Emergency Department and Acute Medical Unit, as well as complete refurbishment of a Care of the Elderly Ward to provide a dementia-friendly environment.

In the last year, the site has undergone further changes with the refurbishment of the Diagnostic Imaging Department to create a state-of-the-art Image Guided Interventional Suite consisting of three new cardiac catheter laboratories, new X-ray rooms, new Nuclear Medicine Suite and two new Interventional Radiology (IR) labs. This has been linked to the refurbishment of two theatres to create an IR theatre, complementing the range of services offered to patients. This state-of-the-art facility has enabled the repatriation of some patients back to Gloucestershire who were travelling outside the county for treatment, as well as future-proofing the service with new equipment and technologies.

Cheltenham General

Similarly to the GRH site, Cheltenham General Hospital has been developed at different times, with the oldest parts of the site being Grade II listed buildings dating back to the early 19th century. The site delivers a range of planned care, including elective orthopaedics and urology, as well as being the centre for stroke care. The site also houses the Oncology Centre, treating patients from four counties. Recent developments included the completion of the new Day Surgery Unit and two brand new operating theatres with laminar flow. As services have moved sites in line with the clinical Fit for the Future programme, upgrade works have been done to several areas creating a new dedicated Stroke Unit and a new Medical Day Unit.

2025–2026 forward look

Areas of our hospitals have very poor estate due to age and backlog maintenance. Our focus over the next few years will be to focus and increase spending on upgrading our estate and reducing the risk profile; improving statutory compliance for fire, electrical and water safety and our backlog maintenance. Particular focus will be on works to the Tower

Block on the GRH site and in particular to improve fire safety in the tower. The Trust is also investing in new infrastructure to support improved electrical capacity and resilience over the next four years. In terms of new developments, work is progressing on the Gloucestershire Cancer Institute which will extend and enhance our oncology provision. We are also working in partnership with health and care organisations across Gloucestershire to delivery better value for more and use of our total estates such as looking at working across each other's buildings to reduce costs and improve partnership working. Our focus over the next year will be on space utilisation and disposals.

Subsidiary operations

Gloucestershire Managed Services (GMS) is an integral part of the Trust, providing and managing the estate and facilities functions on behalf of the Trust, providing a substantial contribution to the Trust's delivery of both clinical and non-clinical operations, adapting its provision of service to meet the needs of the Trust and its patients.

It provides the following services for the Trust:

- Catering
- Material Management
- Sterile Services
- Estates Management
- Medical Engineering
- Domestic Services
- Capital Development
- Portering and Transport Management
- Linen and Uniform Services
- Transport and Post
- Grounds
- Sustainability
- Switchboard

GMS has its own board of directors in charge of the management of the company's business to ensure the company's prosperity by collectively directing the company's affairs, while meeting the appropriate interests of its shareholders and relevant stakeholders. They support the senior leadership team in making the strategic and operational decisions of the company and for ensuring that the company meets its statutory obligations.

The GMS Chair is accountable to the Trust Group Chair and a member of the Trust Board as an Associate Non-Executive Director. In addition, the GMS Managing Director is a member of the Trust Leadership Team forum.

During 2024-2025 the business employed approximately 880 people with an annual turnover of £98,410,000. At an operational level, its financial performance both ongoing and annually is consolidated in the Trust's accounts. We also work with local NHS partners, to provide crucial non-clinical services for their business.

GMS regularly reviewed its risk profile during the course of the year and identified within its corporate risk register and identified nine risks with a score of 15+ covering issues of performance, finance and workforce.

In 2024 the Trust and Gloucestershire Managed Services Boards undertook a Strategic Review of the interaction of the Trust and its wholly owned subsidiary and this was reported to both Boards in July 2024. It made a number of recommendations as to future investment, structure of the relationship and assurance/governance processes which are being implemented on an ongoing basis by both the Trust and GMS.

Tackling 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.

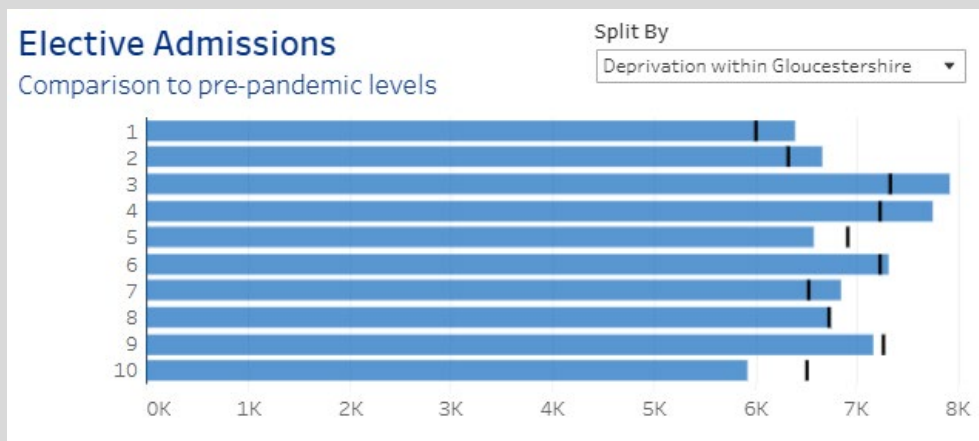
Gloucestershire is characterised by a comparatively small population of ethnic minorities (excluding white minorities). The 2021 Census showed the population of ethnic minorities (excluding white minorities) accounted for 44,765 people or 6.9% of the population; this was much lower than the England percentage 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

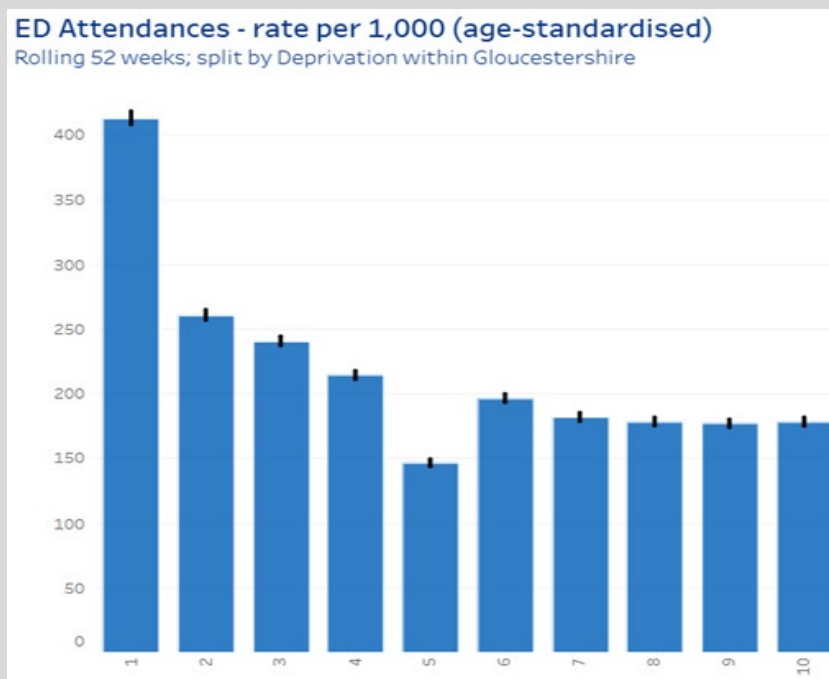
- Elective activity for children's services is in-line with pre-pandemic levels
- Adult activity is below pre-pandemic levels by 7.4%
- No differences noted by gender or ethnicity
- However, we are carrying out more activity for patients living in the most deprived parts of the county, where we are delivering in excess of pre-pandemic levels



Urgent and Emergency Care

There are consistent inequalities identified in urgent care. The 10% most deprived patients are significantly more likely to attend ED

- IMD 1 (10% most deprived): 414 attendances per 1,000 population
- IMD 10 (10% least deprived): 178 attendances per 1,000 population

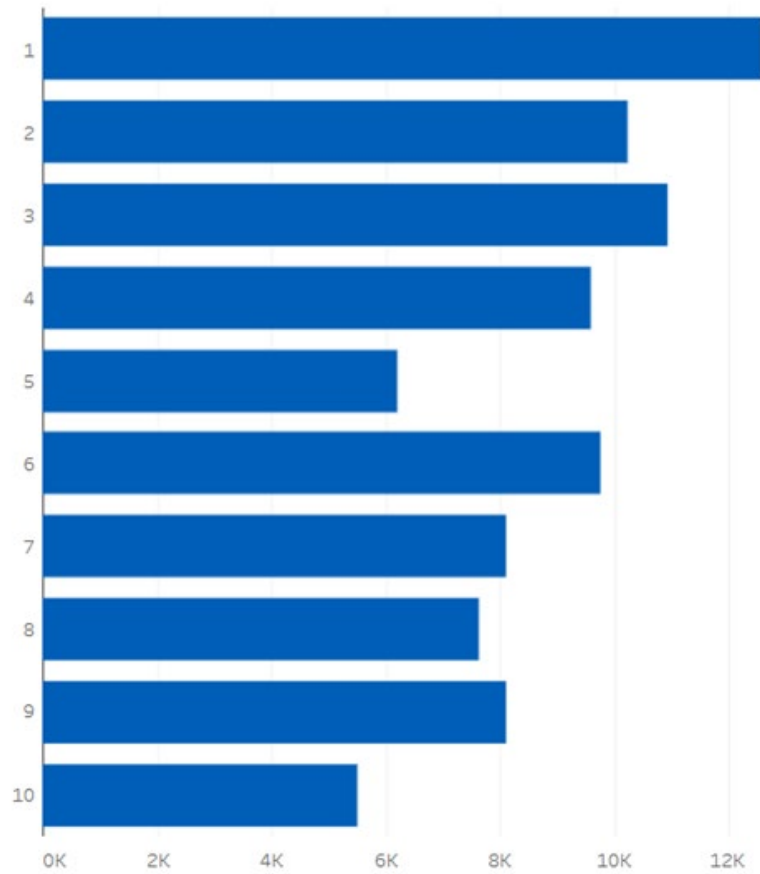


- Similar pattern of attendances by deprivation for children, although the difference between the most and least deprived is less stark.

Emergency Admissions for under 18s

Split By

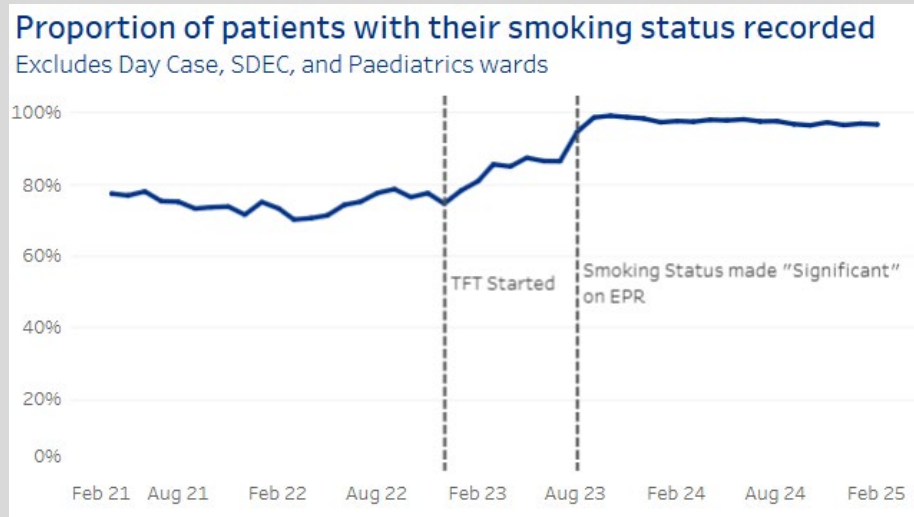
Deprivation within Gloucestershire ▼



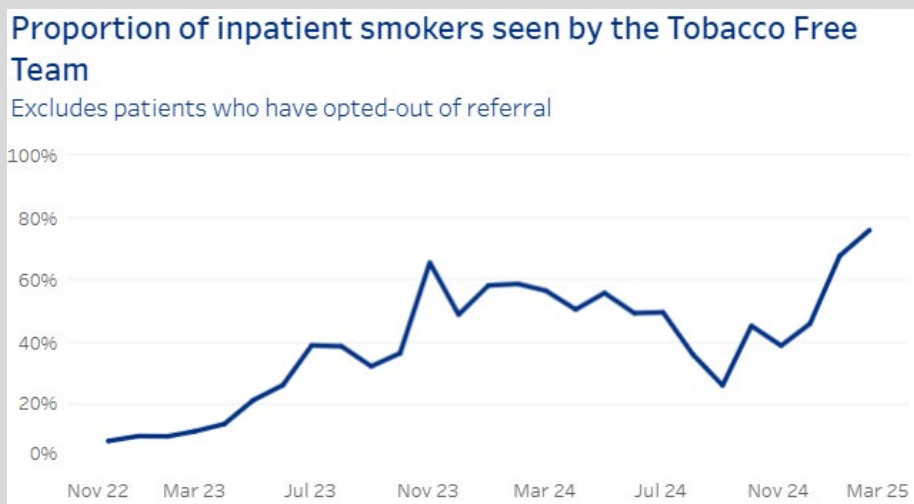
- No differences noted by gender or ethnicity

Smoking Cessation

- 97% of inpatients have their smoking status recorded on admission, compared to 74% prior to the introduction of the Tobacco Free Team

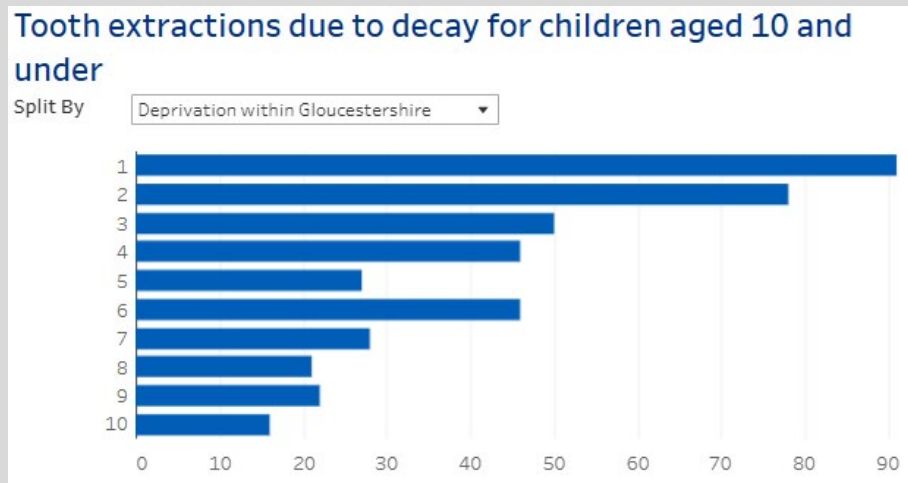


- Last month we saw a record number of patients. As of Feb 2025, 75% of inpatient smokers were offered support from the Tobacco Free Team



Children's Oral Health

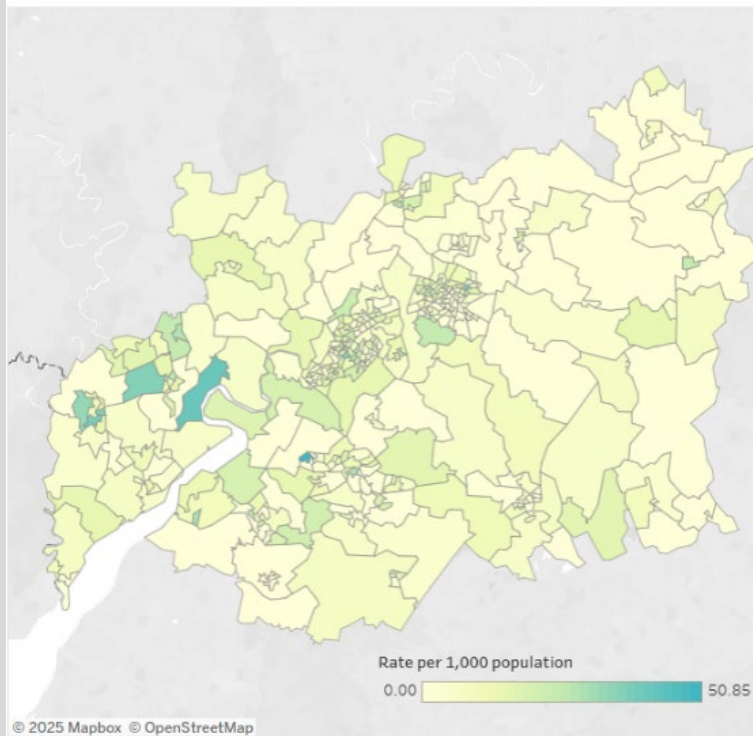
- There is a stark difference in the rate of tooth extractions (due to tooth decay) being carried out between the most and least deprived parts of the county



- 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 and 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 and Robinswood (Gloucester)
 - Oakley (Cheltenham)
 - Parts of Stonehouse (Stroud)

Extractions per 1,000 population

April 2019 to date; Population is the no. of children aged 10 and under



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.

Further information on specific work programmes can be found in the Quality Account.

Social, community, human rights, and anti-bribery

Our Highlights of the Year, earlier in this Report (Page 16-21) demonstrate our commitment to our community through a wide range of projects and events, attended by Board members, colleagues from all departments, governors and our community members.

Human rights, the dignity of our patients, and welfare of our people are central to who we are as a Trust. We continue to work closely in partnership with the Integrated Care Board, our neighbouring Trusts, primary healthcare providers and voluntary sector organisations, to tackle the challenges that face our community. Staff are trained in adult and child safeguarding at a level appropriate to their role,

The Trust has its own internal Counter Fraud Service which ensures a robust counter fraud, bribery and corruption risk and control framework. Our Counter Fraud, Bribery and Corruption Policy was updated in 2023-24 and remains compliant with the NHS Counter Fraud Authority 3-Year Strategy 2023-26. In 2024-25, the Trust benchmarked itself against other NHS organisations in the South West and ranked highest for number of referrals, identified loss, recoveries, prevented fraud and sanctions. This demonstrates a robust and effective counter fraud framework and a strong commitment to combatting fraud and maintaining high standards of governance and accountability. The Head of Gloucestershire NHS Counter Fraud Service presents a detailed progress report to each Audit and Assurance Committee meeting and the annual Cabinet Office Government Functional Standard 013: Counter Fraud return confirmed the Trust rating green in 11 of the 12 standards (one amber).

Ensuring equality of service delivery

Public Sector Equality Duty

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. This is overseen by the Trust Board with regular reporting on access and diversity led by the Director for People and Organisational Development.

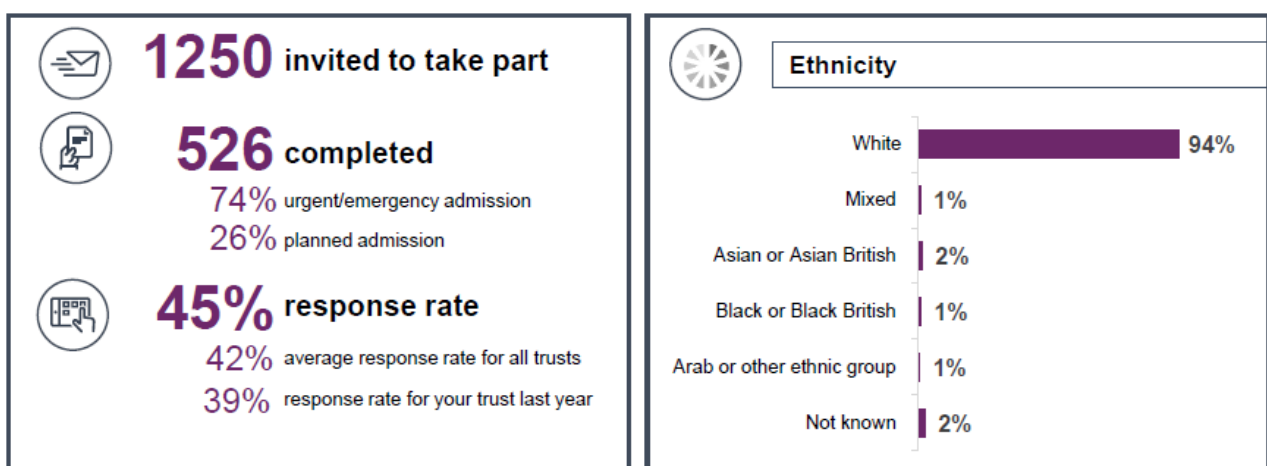
The general duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

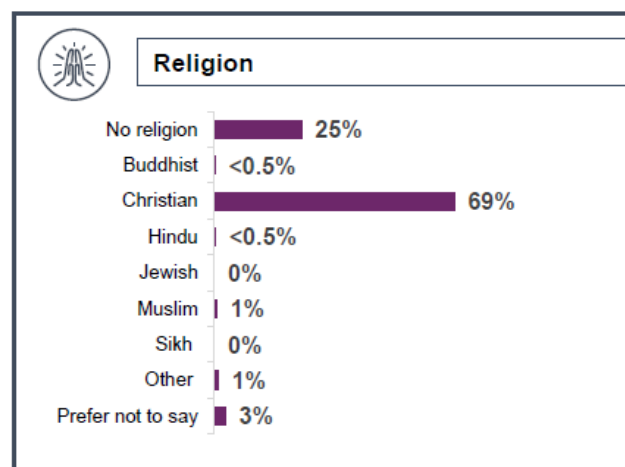
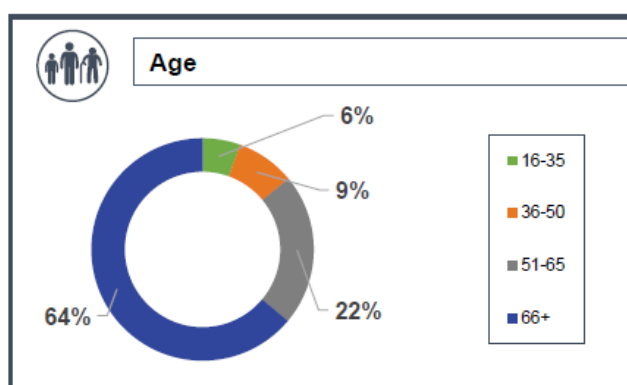
- Eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share and people who do not share relevant protected characteristic
- Foster good relations between people who share and people who do not share a relevant protected characteristic

Customer satisfaction

CQC National Survey Programme provides patient and staff satisfaction scores broken down by protected characteristic, additionally we have been able to work with our business intelligence team to better understand the wider determinants of health, particularly deprivation. This has helped us to begin to identify and foster good relations with people with protected characteristics where we are receiving less feedback.

The below results were received in 2024:



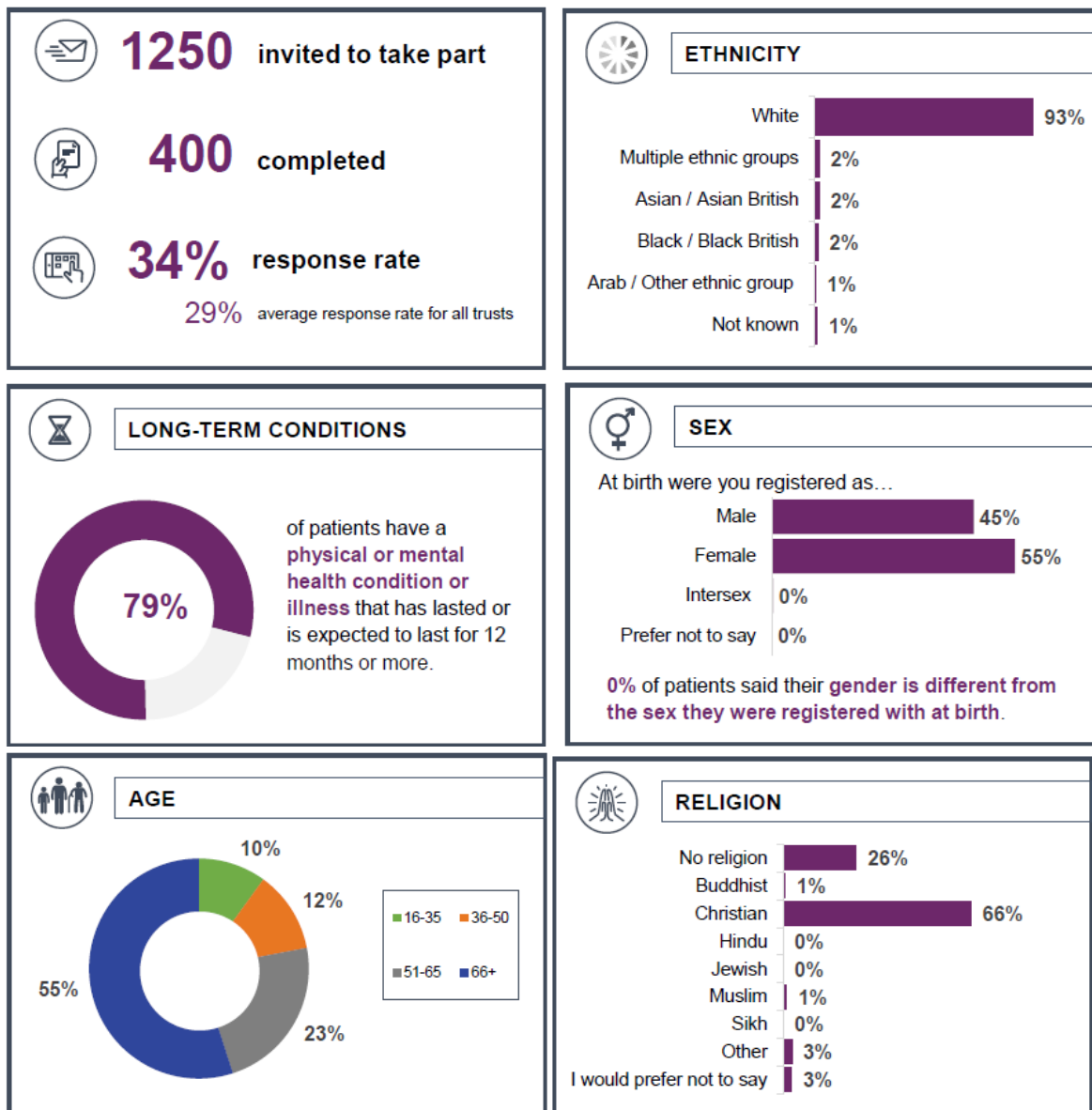


When looking at our results against protected characteristic, in some cases the number of responses is not high enough and therefore the results are suppressed. We can see, however, that have certain disabilities and long-term health conditions report a poorer experience to those with no long-term health condition. We can also see from the data that the majority of patients responding to the survey, report having a long-term health condition.

Further work with our Business Intelligence team has also reviewed the responses against deprivation deciles and we have identified that those patients living in areas with high deprivation are not responding to the survey. We therefore, need to ensure we have other options for patients in these areas to provide feedback should they wish.

National Urgent and Emergency Care Survey 2024, results published 2024

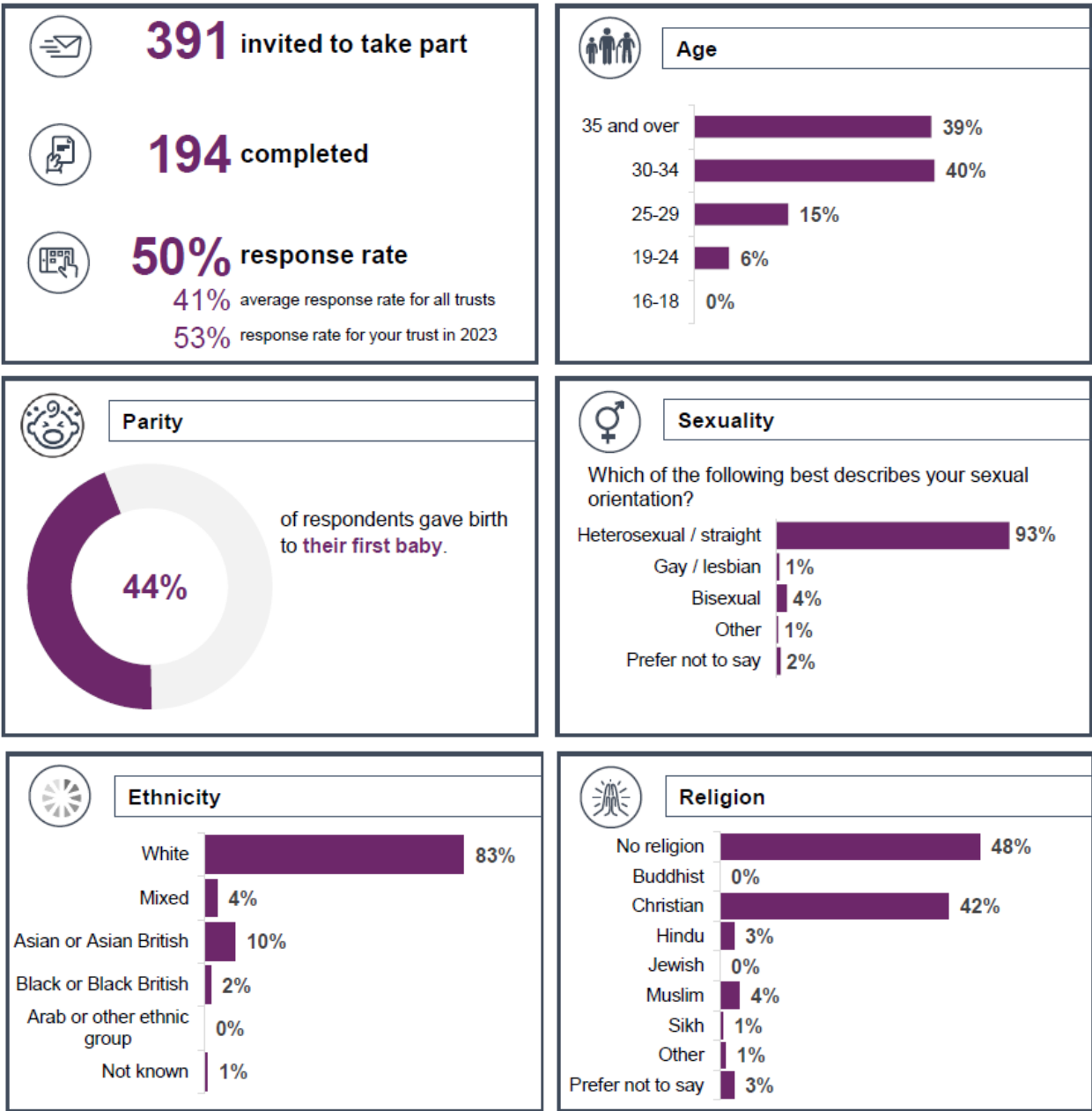
The following charts show the patient demographic of those that completed the survey:

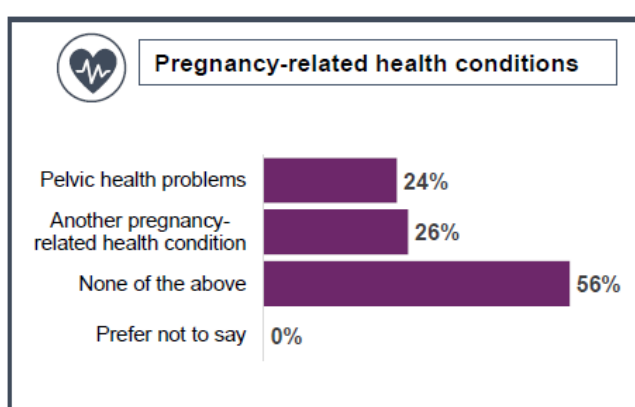
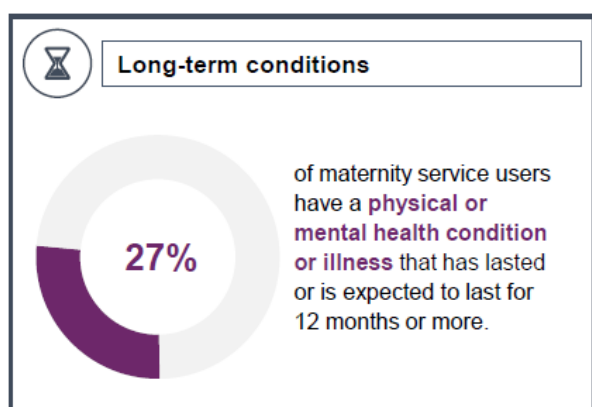
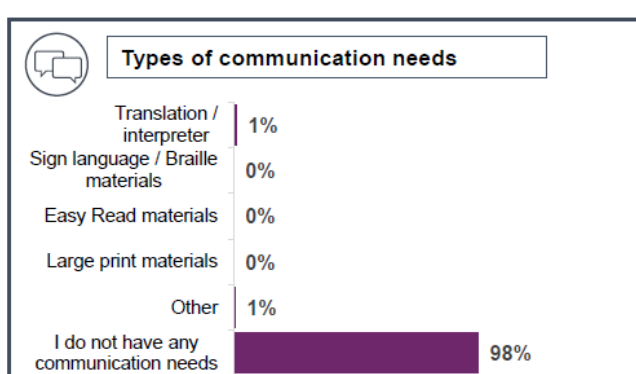
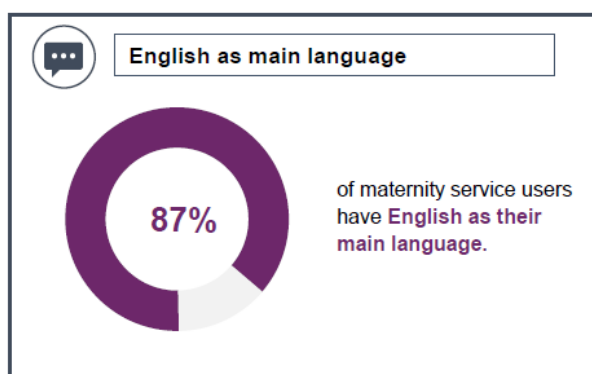


Much of the data for this survey is suppressed, however, we can see that similarly to the adult inpatient survey, we are not hearing from those patients that live in more deprived areas of the county.

National Maternity Survey 2024, results published 2024

The following charts show the patient demographic of those that completed the survey:





Unfortunately, due to the numbers of responses against some of the protected characteristic groups being lower than the threshold for the data to be published, the data has been suppressed. This means we cannot compare and draw conclusions about the experiences of women within some of the protected characteristic groups, e.g. ethnicity. We can see that women who state that their ethnicity is other than White report a slightly above average experience. We can also see that women that report that they have a long-term health condition report a below average experience.

By identifying where experiences are less positive, we can begin to work with women to improve experiences.

Activities being undertaken

As an organisation we complete the Equality Delivery System Framework which has been designed by NHS England. It is designed to enable NHS organisations to review their current performance and improve services for individuals with characteristics protected by the Equality Act 2010.

Translation and interpreting services are essential for ensuring patients who have language barriers can access healthcare information and services in a way that they can understand. By facilitating understanding, we are able to improve the quality of care, improved safety, experience and support reduction of health inequalities. To support our patients where English is not their first language, including British Sign Language (BSL) we have tendered a new contract for both spoken language and sign languages including BSL. Further work with our providers is planned in order to broaden the scope of offer to our patients and staff to support use and quality of service.

Under the Equality Act 2010, and latterly the Accessible Information Standard, organisations have a responsibility for providing information in a format that meets their communication needs. We have worked with 'Experts by Experience' to translate specific patient information into Easy Read to support patients' communication needs. Next steps are to work with clinical teams and experts by experience through our Accessibility Panel to improve the data collection required to support patients' communication needs.

Overseas operations

There were no overseas operations during 2024–2025.

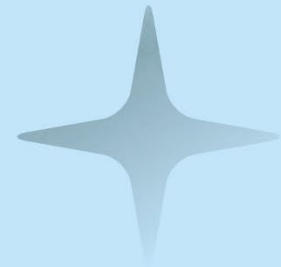
Significant events post year end

There have been no significant events since year-end 2024-2025 affecting the Foundation Trust's financial statements.

Accountability report

In this section:

- ▶ Directors' report
- ▶ Remuneration report
- ▶ Staff report
- ▶ Code of governance
- ▶ Statement of Accounting Officer's responsibilities
- ▶ NHS oversight framework
- ▶ Annual governance statement
- ▶ Accountability report conclusion
- ▶ Independent auditor's report



Accountability report:

Directors' report



The Directors are responsible for preparing the annual report and accounts. We consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model, and strategy.

The Board of Directors

Biographies for individuals who served as Directors on the Board at any time during the year 2024-25 are detailed on the following pages. The Board of Directors composition, balance of skills, and depth of experience is detailed through this report, and is considered by the Governance and Nominations Committee to be reasonable to lead the Trust.

Independent Non-Executive Directors are identified in this report. Where these individuals have served more than six years in post, their independence is considered and agreed by the Nominations Committee and Council of Governors annually prior to re-appointment. There are currently no other circumstances that may impair any Non-Executive Director's independence.

Deborah Evans, Chair

Appointed May 2022

Deborah is an experienced Chair with 25 years Board-level involvement in health and social care. Notable appointments from her executive career include Chief Executive of NHS Bristol; Chief Executive of Bristol, North Somerset, and South Gloucestershire PCT cluster; and latterly Managing Director of West of England Academic Health Science Network, which convened 21 NHS Trusts/CCGs, 3 universities and other stakeholders to promote innovation and spread improvement in the NHS. Since 2017, Deborah has been Trustee and Chair of Brunelcare, a housing and social care charity providing nursing homes, re-enablement, home care, and supported living.



Mike Napier, Vice Chair

Appointed May 2018

Mike Napier is an experienced senior executive with a background covering a range of corporate services. He spent 31 years with Shell plc, during which time he headed their global Procurement, Real Estate, Shared Services and Corporate Communications divisions. He has lived and worked in a number of countries across five continents. He also has more than fifteen years' experience as a non-executive director in the UK.



Mike is a resident of Cheltenham and is also Chair of the Cheltenham Trust, a local charity providing cultural and leisure services in the town. Mike is also a keen sportsman; he runs,

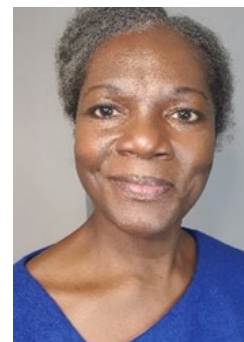
plays golf and club cricket and also follows Gloucester County Cricket Club and Gloucester Rugby Club.

Vareta Bryan, independent Non-Executive Director

Appointed February 2023

Vareta is a proven and commitment leader in the health and care sector. Her experience spans over 25 years' director and senior management roles in local government, Social Care, the NHS and the voluntary sector.

Her expertise spans health and social care service provision, leading partnership working across the health and social care system to deliver service transformation that improves services and outcomes for patients, service users and staff. She also has a strong background in and commitment to equality, diversity and inclusion in service provision, employment practice and organisational development.



Prior to joining the Trust, she held a similar role with Gloucestershire NHS Clinical Commissioning Group and was a Trustee with North and West Gloucester Advice Bureau. Vareta has a longstanding commitment to the voluntary and community sectors having both worked and held voluntary positions on a range of boards in the sector. Vareta's interests are travelling, gardening, healthy lifestyle coaching, teaching plant-based cooking, and enjoying her grandchildren.

John Cappock, independent Non-Executive Director

Appointed July 2023

John Cappock lives in Bristol. He is a Chartered Accountant and is originally from Dublin. A graduate of University College, Dublin, John undertook his professional accountancy qualification at the University of the West of England, Bristol. John has spent the bulk of his career within Higher Education and has served as University Secretary and Chief Operating Officer at a number of universities.



He was a Non-Executive Member, deputy Board Chair and Chair of Finance of Bristol, North Somerset and South Gloucestershire (BNSSG) NHS Clinical Commissioning Group. He is an Independent Non-Executive Member and Chair of Audit and Risk for the BNSSG NHS Integrated Care Board. John also serves as an independent member of the Audit and Risk Committee of the General Optical Council, which is the regulator for the Optical profession.

He has previously served as a Non-Executive in Higher and Further Education and on the Board of a Housing Association.

Sam Foster, independent Non-Executive Director

Sam is the Executive Nurse Director for Professional Practice at the Nursing and Midwifery Council, where she has been leading a comprehensive review of advanced nursing and midwifery practice and quality assurance of education programmes.

Sam previously worked at Oxford University Hospitals NHSFT, where she was Chief Nursing Officer for five years. Sam's portfolio included the professional leadership and education of over 5,000 Nurses, Midwives and AHPs. In addition to the executive leadership of the Trust Estates and Facilities services, delivery of the capital programme and leading the Urgent Care programme across the Oxfordshire system.

Sam has a particular interest in education, research and advancing practice and has a MSc in Advancing Critical Care Practice. Sam also has a drive to influence maternity and neonatal safety and held the role of Board Maternity and Neonatal safety champion in her role at Oxford.



Marie-Annick Gournet, independent Non-Executive Director

Appointed December 2020

Dr Gournet is Associate Professor of Lifelong Learning and Inclusive Pedagogy at the University of Bristol. She has over 20 years' experience of working in senior leadership roles both in higher education and the voluntary sector. She joined the University of Bristol as Director of Part-Time Programmes in August 2019 and in February 2024 was seconded as Programme Lead for the University of Bristol Reparative Futures Mobilisation phase. Prior to joining the University of Bristol, she worked at UWE, Bristol where she occupied a range of leadership roles. In September 2017, Marie-Annick set up MAG Consulting which offered a variety of consultancy, research, training and coaching services with a focus on diversity and inclusion. In June 2019, she set up the Global Majority Teachers Network, a community of practice bringing together qualified global majority teachers with focus on staff support, global curriculum, access, retention and progression of global majority people in the education sector.



Throughout her professional career Marie-Annick worked with a range of organisations in diverse Non-Executive Director roles. She is currently F2SU NED Champion, has chaired the Charitable Funds Committee, and now chairs the People and OD committee in the Trust.

Balvinder Heran, independent Non-Executive Director

Appointed May 2019

Balvinder was appointed Deputy Chief Executive of Dudley Council on 29 March 2021 and since October 2024 has been the interim Chief Executive. Prior to this she was Joint Strategic Director Information Assets and Digital Development for Buckinghamshire NHS Healthcare Trust, Clinical Commissioning Group, and County Council and Chief Information Officer (CIO) for the Buckinghamshire Integrated Care System (ICS).



Balvinder specialises in turning around and transforming services shaped around individual needs through the effective use of ICT, business intelligence, performance improvement and service re-design.

Jaki Meekings-Davis, independent Non-Executive Director and Senior Independent Director (SID)

Appointed February 2023

Jaki has more than thirty years' experience in the NHS in both commissioning and finance roles including Director of Specialist Commissioning for the South of England and Director of Finance of the South West Regional Health Authority.



Prior to joining the NHS, she had a successful career as an accountant in local government and the water industry. She has lived in Gloucestershire since 1998. Jaki is a former president of the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Healthcare Financial Management Association and is currently a member of CIPFA's Practice Oversight Panel and Nomination Committee. Jaki is also a Co-opted member of University of Gloucestershire Finance and General Purposes Committee.

An experienced Non-Executive Director and Trustee, her recent roles include Non-Executive Director and Chair of the Audit and Charitable Funds Committees at North Bristol NHS Trust and Trustee of The Cheltenham Trust and Friends of the Wilson charities.

Sally Moyle, Associate Non-Executive Director

Appointed May 2022

As a Professor in Health and Care Education Sally has over 25 years' academic experience of developing and leading innovation and change within Higher Education. She is currently the Pro Vice Chancellor for Health and Science at the University of Worcester and is a member of the University Executive Board. She provides academic leadership to the Academic Schools of Nursing and Midwifery, Allied Health and Community, Medicine, Sports and Exercise, Science and the Environment and Psychology with a focus on delivering an outstanding academic experience for all students, enhancing research and enterprise, and developing the University's educational offer.



She previously worked in a range of senior leadership roles at the University of West of England, Bristol. She is passionate about ensuring that health and care programmes develop practitioners for the future who will have a positive impact in their chosen field. Sally's professional background is in nursing and her area of expertise is within the field of Emergency Care and Advanced Clinical Practice, with a focus of developing and supporting new roles within the health and care sector. She has extensive experience of working in partnership with external organisations to develop innovative programmes to support workforce need.

Kaye Law Fox, Associate Non-Executive Director, Chair: Gloucestershire Managed Services

Appointed January 2023

Kaye Law Fox has 25 years' public sector executive and senior leadership experience. She is non-executive director Chair of Gloucestershire Managed Services (GMS) the Trust's wholly owned subsidiary estates and facilities company, and associate non-executive director on the Trust Board.



Prior to focusing on non-executive board roles, Kaye directed and delivered complex national and regional change programmes in regulated sectors, notably for the Serious Organised Crime Agency and Security Industry Authority (both agencies of the Home Office), and the London Ambulance Service NHS Trust. Kaye specialises in aligning strategic governance frameworks to business needs and regulatory requirements, including corporate systems of internal control and risk management. Her business governance experience includes work in the not for profit, charity and private sectors.

Kaye has extensive board level experience and has been an independent board member since 2003. She is currently senior independent director of a registered social housing provider in Wales and has previously chaired boards and committees of a registered

housing association, commercial asset management and development subsidiary company, operations, audit and risk, remuneration and professional standards, and led many executive and non-executive director appointment panels.

Kevin McNamara, Chief Executive

Appointed January 2024

Kevin joined the Trust as Chief Executive Officer (CEO) in January 2024 from Great Western Hospital NHS Foundation Trust, an integrated Acute and Community provider based in Swindon, where he was the CEO from 2019, leading over 5,500 staff and local communities through the COVID-19 pandemic.



Kevin has worked for the NHS since 2003, having worked for the South-Central Strategic Health Authority, before joining Great Western Hospital in 2009 where he was the Director of Strategy and Community Service before becoming CEO in 2019.

As CEO, Kevin is ultimately responsible for the day-to-day leadership of the organisation through the executive team and for ensuring the implementation of the Board's strategic objectives.

Prof Mark Pietroni, Deputy Chief Executive, Director for Safety and Medical Director

Appointed March 2019

Mark has had a varied career path starting in London in Infectious Diseases, then 15 years in Bangladesh, and returning in 2012 to a role as Director of Public Health for South Gloucestershire. He was appointed to a part-time role as a consultant in Acute Medicine at this Trust in 2016 and then as Specialty Director for Unscheduled Care in 2017.



A year into his role as Medical Director his overseas experience proved invaluable to the Trust's response to the Covid pandemic. He was appointed Deputy Chief Executive in November 2020. He continues to work as an acute physician one day a week alongside his executive role.

Matt Holdaway, Director of Quality and Chief Nurse

Appointed February 2022

With a background in Critical Care nursing, Matt has extensive experience in nursing management, having previously held senior positions at Oxford University Hospitals NHS Foundation Trust where he was Divisional Director of Nursing before joining our Trust in 2021 as Deputy Director of Quality and Deputy Chief Nurse.



Matt was appointed to the Chief Nurse and Director of Quality position initially as an interim appointment and has held the substantive role since 2022. He continues to make a significant impact on our nursing workforce and the wider Trust.

Karen Johnson, Director of Finance

Appointed January 2020

Karen Johnson is responsible for ensuring good stewardship of the public finances. She has worked in the public sector over 30 years, which includes workings in the NHS for 16 years. She prides herself on helping to make a difference to individuals and the community. She is fully committed to ensuring the Trust provides good value for money while maintaining good quality services.



Her key focus is to move the Trust to a financially sustainable position and will work closely with divisions and individuals to achieve this. Karen joined the Trust in January 2020 from Great Western Hospitals NHS Foundation Trust, where she was Director of Finance from 2015.

Will Cleary-Gray, Director of Improvement and Delivery

Appointed September 2024

Will joined the Trust in September 2024 as our Executive Director of Improvement and Delivery. He brings over 25 years of experience working within the NHS and partner organisations at a local, regional and national level in board-level, clinical and research roles. He started his NHS career as a critical care nurse and has diverse experience from working in acute, community and primary care and roles with NICE, the RCN, the University of York, Greater Manchester System and the Department of Health, before joining South Yorkshire.



His most recent role was Executive Director of Strategy and Partnerships at South Yorkshire Integrated Care Board leading for the board and system on strategy, planning, improvement, transformation and partnerships. Will was instrumental in establishing one of

the first large and complex Integrated Care Systems in England and shaping the NHS's contribution to the wider social and economic development of the region as anchor organisation, working with NHS organisations, VCSE sector, local government and South Yorkshire Combined Mayoral Authority.

Will is passionate about improving quality, outcomes and experience for patients, families and working with local communities. He is a champion for improving population health and addressing health inequalities and harnessing the power of collaboration to tackle some of our most complex challenges. He has experience of leading change in large, complex systems to give measurable improvements for patients, families and staff. Will is the Trusts executive lead for Improvement and has a range of executive portfolio responsibilities including strategy and transformation, health inequalities, sustainability and our role as an anchor organisation and partner.

Dr Claire Radley, Director for People and Organisational Development

Appointed February 2022

Claire joined the Trust in February 2022 having previously been the Director for People at the Royal United Hospital Bath NHS Foundation Trust and Assistant Director of Organisational Development at Cardiff and Vale Health Board. Before that Claire worked in policing in roles spanning research, performance, culture change, and organisational development.

She has worked for a local police force and in national roles, including as the advisor to the Chair of the College of Policing. She has a Ph.D. in organisational culture and is a Fellow of the CIPD.



Claire has experience in leading large-scale culture change work that has improved both staff and patient experience.

Al Sheward, Chief Operating Officer

Appointed December 2023

Al joined the Trust in December 2023 from Great Western Hospitals where he had held the position of Deputy Chief Operating Officer since May 2020. Prior to his time at Great Western, Al was Winter Director for the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System.



Al played a key role in establishing the Swindon Integrated Care Alliance Coordination Centre building on experience from his time on the Isle of Wight and West Yorkshire, where he led a team using video-based technology to support residents in over 750 care homes across the UK.

Kerry Rogers, Director of Integrated Governance

Appointed April 2024

Kerry joined the Board of Directors as a non-voting executive director in April 2024, having previously been Director of Corporate Affairs and Company Secretary at Oxford Health for over eight years.



Kerry has more than 30 years board level experience including director roles in the NHS; in acute, mental health and community services. Kerry was previously a lay member for the Nursing and Midwifery Council and on the Business Planning and Governance Committee. She was, for 6 years, a trustee for Age UK Oxfordshire and has been a Board member of The Hill, an organisation which works with NHS trusts, universities, digital developers, innovators and investors to promote and encourage commercial and impactful technological solutions to problems in health and care.

With over 30 years' experience in business and finance in both public and private sectors, Kerry champions good governance, and in her role provides the essential interface between the Board and all stakeholders. Prior to joining the NHS in 2005, her early public sector career was as an Inspector of Taxes for Her Majesty's Inspector of Taxes. She then went on to be a Finance Director and Company Secretary in the private sector for an IT professional services company contributing to the strategic direction and operational excellence of the business.

Lee Pester, Chief Digital and Information Governance

Appointed March 2025

Lee joined the Trust as Chief Digital Information Officer (non-voting) in February 2025 from University Hospitals Plymouth NHS Trust. where he had led on all aspects of digital strategy, transformation, delivery, and operations. Lee has worked in the NHS since 2013 and has a background in NHS Procurement.



Before his time in the NHS, Lee has a varied career including time spent in the armed forces and commercial sector.

Lee's current role includes driving forward the digital strategy within the Trust with the aim of empowering staff in their roles and patients in their healthcare. He has and continues to champion digital inclusion, ensuring the delivery of technology does not create barriers to healthcare across the population.

Interim directors who relinquished their Board role during 2024/2025 included Ian Quinnell, Interim Director of Strategy and Transformation (August 2024) and Helen Ainsbury, Interim

Chief Digital and Information Officer (March 2025). The Trust extends its grateful thanks for their contribution throughout the year.

GatenbySanderson (recruitment consultants) were instructed under a framework agreement during 2024/25 to support recruitment of executive and non-executive recruitment. GatenbySanderson has no connections to the Trust or individual directors.

Directors' and Governors' interests

The Trust's public registers of interests, are maintained at:

<https://intranet.gloshospitals.nhs.uk/departments/corporate-division/corporate-governance/>

With recruitment to the Corporate Governance team we are undertaking a substantive review of the registers and updating the same for 2025.

Political donations

No political donations were made during the course of the year nor the previous year.

HM Treasury compliance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Better payment practice code

The aim of the better payment practice code is to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed. Please see compliance tables below

For the financial year 2024/25 the Better Payment Practice Code (BPPC) performance was 96.1% by value and 99% by number as detailed below. 95% of bills paid within 30 days of receiving an invoice is the best practice benchmark.

	Cumulative for the financial year	
	Number	£000s
Total bills paid within period	116,219	284006
Total bills paid within target	114,565	273022
Percentage of bills paid within target	99%	96%

The split between NHS and Non-NHS payables are shown below.

	Cumulative for the financial year			
	NHS Payables		Non-NHS payables	
	Number	£000s	Number	£000s
Total bills paid within period	2,592	52,007	113,627	231,999
Total bills paid within target	2,419	47,561	112,146	225,461
Percentage of bills paid within target	93%	91%	99%	97%

The Trust has not paid any interest under the Late Payment of Commercial Debts (Interest) Act. The notional interest under the terms of the Act for 2024/25 would be £72.8k.

Income generation and disclosures

This information is incorporated in the annual accounts.

Well-Led Framework

The Council of Governors, Board, committees and services are reviewed to assess whether they are well-led under NHS England's well-led framework. In 2022-23, Good Governance Institute was commissioned to undertake an external well-led review, and found that overall, a number of governance processes were working effectively, and identified four main areas for improvement relating to executive oversight, administration, prospective agendas and alignment of organisational development activity.

With the appointment of the Director of Integrated Governance on 29 April 2024, and the work of the Director of Nursing and Medical Director during the year regarding the quality governance restructure, we have responded positively to the recommendations which will only be enhanced further following finalisation of the next phase of the Trust's strategy.

Furthermore, in January 2025 we appointed a substantive Trust Secretary to support the continued strengthening of the Board and Committee secretariat and corporate governance support to the wider Trust, including an enhanced focus on the role of the Council of Governors.

The Audit and Assurance Committee has delegated responsibility to monitor the Trust's system of internal control, aided by our internal audit partners, BDO. This is discussed further in the annual governance statement.

Well led in the context of patient services

As a Foundation Trust we are accountable to local people through our Council of Governors, which represents local residents, key stakeholders and staff. Our governors play a role in both the governance of the Trust and also our delivery of quality patient services. This includes site and service inspections, receipt of quality and service updates as well as engagement in identifying the Trust's quality priorities. The Trust works closely with local communities to develop services that best meet local needs.

The Trust ensures delivery of patient services via a number of vehicles; patient and staff feedback including complaints and the measurement of performance. Key performance indicators (KPIs) and metrics are used to monitor and improve the quality and safety of care. These metrics, and their targets, have been integrated into one report called our Integrated Performance Report (IPR) and this includes metrics for patient wait times, patient safety, operational efficiency, finance and people. Our Trust Board reviews the IPR at every public Board meeting. Our Quality Account for 2024/2025 provides detailed information on how we have performed against our quality targets.

To monitor healthcare quality improvements and progress towards targets, the Trust utilises a multifaceted approach including clinical audits, data collection, and patient

feedback mechanisms. These tools are used to identify areas for improvement and track progress against established standards and targets, both nationally and locally.

There was only one inspection by the Care Quality Commission in 2024/25 and this was to Oncology and Medical Services at the Cheltenham General Site in July 2024. The report was published in May 2025 and confirmed a rating of 'good'.

Whilst the Commissioning for Quality and Innovation (CQUINS) programme for 2024/2025 was paused by the NHS England national team the Trust has continued to focus on the quality improvement agenda. The Gloucestershire Safety and Quality Improvement Academy was established at Gloucestershire Hospitals NHS Foundation Trust in June 2015 and supports services and staff to carry out quality improvement training. In 2024/25, many quality improvement projects and programmes were delivered. A list of projects can be found on the Trust's website here - <https://www.gloshospitals.nhs.uk/work-for-us/training-staff/gsqia/gsqia-graduation/>.

During 2024/2025 we have continued to strive to both improve and develop new patient services as set out below:

The Acute Medical Take is the process of coordinating medical assessments for patients to determine if they need hospital admission, can be seen by a specialist service or can return home after treatment in one of the walk-in units. The Acute Medical Take was centralised at Gloucestershire Royal Hospital on 23 July 2024.

By centralising the Acute Medical Take at Gloucestershire Royal Hospital (GRH) there were several benefits, including:

- Patients are seen more quickly by the most appropriate specialist teams
- Patients experience more rapid diagnoses and shorter hospital stays
- Improved patient flow, shorter patient waiting times, and faster ambulance handover times
- Health outcomes and the overall patient experience are improved.

At Cheltenham Hospital, this led to further improvements for patients, including:

- Becoming a regional centre of excellence for cancer and oncology;
- A larger specialist Hyper Acute Stroke Unit (HASU);
- Centre for Urology services, including new Urology Assessment Unit later in 2024;
- An improved Consultant-led Same Day Emergency Care (SDEC) service – which provides care for emergency patients who would otherwise be admitted;
- Recent opening of Chedworth Surgical Unit and two new theatres.

These benefits align with our 'Centres of Excellence' vision, where there is more planned care at CGH and a greater focus on urgent and emergency care at GRH.

Other significant innovations in patient services include the partnership work of our eye health team whose work has been recognised for their excellent partnership working and creative use of technology for a project which is supporting joined up care closer to home and saving the NHS money. The team's digital project, the first of its kind in the country when it was launched three years ago, won the Most Impactful Use of Technology on Clinical Practice category at the Health Service Journal Partnership Awards 2025. The system, OphthalSuite Community Ophthalmic Link, developed by BlueWorks OIMS alongside NHS Gloucestershire, Gloucestershire Hospitals NHS Foundation Trust, and Gloucestershire Local Optical Committee, enables community optometrists to access patient's eye health records quickly and securely.

Christmas 2024 marked a fresh chapter for Cheltenham General Hospital's Medical Day Unit (MDU), as it opens in its new home on Oakley Ward, Centre Block, after relocating from its previous site near A&E. The MDU provides vital intravenous (IV) therapies for conditions such as multiple sclerosis, rheumatoid arthritis, inflammatory bowel disease, osteoporosis, iron deficiency anaemia, asthma and renal issues and this development has supported patients receiving treatment both as in-patients and on discharge.

Stakeholder engagement

Gloucestershire Hospitals NHS Foundation Trust remains committed to engaging with our communities, ensuring their voices shape our services. This year, we have continued to expand our outreach, strengthened partnerships, and delivered impactful projects to improve accessibility and inclusivity in healthcare.

We work closely with our partner NHS and Local Authority organisations with the Trust being a formal member of both the statutory Integrated Care Partnership in Gloucestershire, represented by both the Director of Improvement and Delivery and Deputy Chief Executive. The Trust is also a number of formal sub-committees of the ICB including the One Gloucestershire strategic executive and finance of committees' groups and forums which support and enhance partnership working on patient safety, quality issues and delivery. These include the system safety committee and system quality group with representation from GHFT Chief Nursing Officer and Director of Quality.

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. Much of this is evidenced within the Performance Report.

Accountability report:

Remuneration report



The Remuneration Report summarises the Trust's Remuneration Policy and particularly, its application in connection with the Executive and Non-Executive Directors.

It describes how the Trust applies the principles of good corporate governance in relation to Directors' remuneration as defined in the NHS FT Code of Governance, in Section 420 to 422 of the Companies Act 2006 in so far as they apply to Foundation Trusts; and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS Foundation Trusts; Parts 2 and 4 of Schedule 8 of the Regulations and elements of the NHS Foundation Trust Code of Governance.

Details of Executive Directors' remuneration and pension benefits; and non-Executives' remuneration are set out in tables later in this report. They have been subject to audit.

Appointments and Remuneration Committee

The Board appoints the committee that considers remuneration, which is the single committee considering both nominations and remuneration called the Appointments and Remuneration Committee and its membership comprises only Non-Executive Directors.

The Committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation including the framework of executive and senior manager remuneration. Its remit includes determining the remuneration and terms and conditions of the executive and approving senior manager severance payments where relevant.

The Committee approved the policy for compliance with the Fit and Proper Persons Regulations and were apprised of application of the process when presented with the outcome of the appraisals of each of the executive directors.

All voting Non-Executive Directors are members of the Committee. The Committee has met on 4 occasions during 2024-2025. During the year, the following Non-Executive Directors have served on the Committee as voting core members:

Committee Member	Attendance
Mike Napier (Chair of committee)	4/4
Deborah Evans	4/4
Jaki Meekings Davis	3/4
Marie-Annick Gournet	4/4
John Cappock	4/4
Vareta Bryan	2/4
Balvinder Heran	4/4
Sam Foster	1/2

The Committee also invited the assistance of the Chief Executive, the Director for People and OD and the Director of Integrated Governance. The Trust Secretary serviced the meetings. None of these individuals or any other Executive or senior manager participated in any decision relating to their own remuneration.

Senior Managers' Remuneration Policy

The Trust is committed to the governing objective of maximising value over time. To achieve its goals, the Trust must attract and retain a high calibre senior management team to ensure it is best positioned to deliver its business plans.

The Trust defines its senior managers as those managers who have the authority or responsibility for directing or controlling the major activity of the Trust - those who influence the Trust as a whole. For the purposes of this report, 'senior managers' are defined as the voting and non-voting members of the Board of Directors.

During the year the Trust adhered to the principles of the agreed pay framework that remunerated the performance of the Executive Directors based on the delivery of objectives as defined within the Trust's plans.

There are no contractual provisions for performance related pay for executive and direct reports and as such no payments were made in 2024-2025. The approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility needed to adapt to the dynamics of an ever-changing NHS. It is fundamental to business success and is modelled upon the guidance in The NHS Foundation Trust; Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health). The key principles of the approach are that pay and reward are assessed relative to the performance of the whole Trust and in line with available benchmarks.

The remuneration policy for 2024-2025 did not include any performance related pay elements, and all directors' performance will continue to be assessed against delivery of objectives and kept in line with recognised benchmarks (e.g. NHS Providers and the wider pay policies of the NHS).

Executive Directors who had been at the Trust during the year received an annual consolidated inflationary uplift of 5% of base pay rates in 2024-2025 reflecting the national guidance received and published by regulators including two discretionary executive director uplifts to account for contractually agreed incremental uplifts over a phased period for one and to close an executive team salary differential for the other.

Executive appointments to the Board of Directors continue under permanent contracts and during 2024-2025, no substantive director held a fixed term employment contract. The Chief Executive and all other executive directors (voting and non-voting) hold office under notice periods of six months except when related to conduct or capability.

There were no interim members of the Board of Directors during 2024-2025 with the exception of the Chief Digital Information Officer who ceased on the Board of Directors in February 2025 and the Director of Strategy who ceased to be a member in September 2024. Our subsidiary company, Gloucestershire Managed Services, as detailed below, appointed an interim Managing Director in 2022 who was succeeded in the period of this report.

The new non-voting role of Director of Integrated Governance was created in the previous period, and Kerry Rogers was appointed on 29 April 2024. The process to appoint a new Director of Improvement and Delivery (replacing the role of Director of Strategy and Transformation) concluded during the year, with William Cleary-Gray approved as successor to interim, Ian Quinnell, taking up his appointment in September 2024 following the end of Ian's interim role. The process to appoint a successor non-voting Chief Digital Information Officer also concluded in the period, with Lee Pester taking up his appointment in March 2025 following the end of Helen Ainsbury's interim appointment.

In accordance with reserved matters, the appointment of Mike Gregson on a fixed term of 2 years to the role of Managing Director of the Group subsidiary was approved during the year and he succeeded Simon Wadley who occupied the interim position until stepping back into his substantive position as subsidiary Finance and Commercial Director in August 2024. The remuneration of the subsidiary's directors is provided in the Company's own annual report as they do not have the authority or responsibility for directing or controlling the major activity of the Trust – and so who do not influence the Trust as a whole.

We are committed to making our services fair, inclusive and accessible for everyone. To help us do this, we use the NHS Equality Delivery System (EDS2), a national framework that supports organisations like ours to improve equality for patients, communities and staff.

The EDS2 helps us assess how well we are doing and where we need to improve. It has helped us set clear equality priorities and build on the progress we've already made through a wide range of partnerships, inclusive practices and collaborative initiatives.

We have a Trust-wide strategy for Equality, Diversity and Inclusion (EDI), which includes specific work streams and action plans to help us achieve our goals. Progress on this work is regularly reported to our Board of Directors through the Appointments and Remuneration Committee. These reports are also discussed as part of the Board's development programmes, ensuring that our leadership stays informed and accountable.

Further details about our EDI strategy and our objectives can be found in the Staff Report section of this Annual Report and on our Trust's website.

Annual Statement on Remuneration from the Chair of the Committee

There are no additional elements that constitute any senior managers' remuneration, including executive and non-executive directors, in addition to those specified in the table of salaries and allowances which feature later in the report. The amounts that are designated salary in the table represent a single contracted annual salary and there are no particular remuneration arrangements which are specific to any senior manager. There were no changes made in the period to existing components of the remuneration policy and no components were added.

The majority of staff employed by the Trust are contracted on Agenda for Change terms and conditions and the general policy on remuneration contained within these terms and conditions is applied to senior managers' remuneration (and all other staff employed on non-Agenda for Change contracts), with the exception of the Medical Director, to whom Medical and Dental terms and conditions apply.

The list of Board members who are each not on Agenda for Change contracts is available later in this report (their contracts are permanent, and there are no unexpired terms).

Remuneration for senior managers is set on appointment or following benchmark comparison or substantial change in responsibilities, with reference to reports on NHS senior manager pay and NHS benchmarking data collected by organisations such as NHS Providers. The main consideration for annual pay increases for senior managers has been the inflationary uplift award made under Agenda for Change and the Very Senior Manager guidance from regulators and against benchmark comparators.

The Code of Governance submits that the Board of Directors should not agree to a full-time Executive Director taking on more than one Non-Executive Directorship of an NHS Foundation Trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation. No Executive Director of the Trust served as a Non-Executive Director on organisations of comparable size elsewhere throughout the year.

Non-Executive Directors' Remuneration

The remuneration for Non-Executive Directors has been determined by the Council of Governors and is set at a level to recognise the significant responsibilities of Non-Executive Directors in Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs.

They each have terms of no more than three years and are able to serve two consecutive terms dependent on formal assessment, confirmation of satisfactory on-going performance and the needs of the organisation. Exceptionally, a third term of three years or less may be served, subject to on-going positive appraisals and a broader review considering the needs of the Board and the Trust and the ongoing independence of the individual under

consideration. The maximum period of office of any Non-Executive Director shall not exceed nine years.

The Non-Executive Directors' Remuneration, as agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2024-2025 has been consistent with that framework. From 1st April 2024, the governors awarded the Non-Executive Directors and Chair a 5% inflationary increase. The remuneration of the Non-Executive Directors had not until this period been reviewed since 2021.

All trusts also have local discretion to award limited supplementary payments depending on the organisations' size in recognition of designated extra responsibilities. Foundation trusts are expected to explain their rationale for divergence from the recommended structure. The responsibility allowance (for chairing Board committees/onerous responsibility) will not be increased during the tenure of existing Non-Executive Directors whilst the guidance sets the responsibility allowance at £2,000 given that currently the payment received by those who joined the Trust prior to 21/22 was agreed at £3,000.

The disparity between the current payment and that in the guidance (expected to be phased in over several years) is to ensure that no Director receives a reduction in their remuneration. Current Non-Executive Directors' total remuneration (regarding the £2,000 responsibility cap) will not reduce until their terms at the Trust expire. New appointments or new responsibilities attracting payments will be in accordance with the guidance and the responsibility allowance will not exceed £2,000.

None of the Non-Executive Directors are employees of the Trust; they receive no benefits or entitlements other than fees and are not entitled to any termination payments. The entire Council of Governors determine the Terms and Conditions of the Non-Executive Directors. The Trust does not make any contribution to the pension arrangements of Non-Executive Directors. Fees reflect individual responsibilities including higher rates for the Senior Independent Director and Deputy Chair, with all Non-Executive Directors otherwise subject to the same terms and conditions.

Annual Report on Remuneration

This section of the remuneration report includes some elements that are subject to audit.

Termination Payments

Notice periods under senior managers' contracts are determined and agreed taking into consideration the need to protect the Trust from extended vacancies on the one hand and the needs of the employee and financial risks to the Trust on the other. The maximum notice period is six months.

Payments to senior managers for loss of office are governed by and compliant with the NHS standard conditions and regulations; where relevant, payments are submitted to

NHSI for Treasury approval. Any payments made in the period to any senior manager for loss of office are outlined in the tables detailing Staff Exit Packages below.

Fair Pay Disclosures (audited)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024-25 was £270,000 to £275,000 (2023-24 £270,000 to £275,000).

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

For employees of the Trust as a whole (excluding the highest paid director), the range of remuneration in 2024-25 was from £1,000 to £428,000 (2023-24 £1,000 to £431,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 0.07%.

14 employees received remuneration in excess of the highest-paid director in 2024-25 (19 employees in 2023-24).

The relationship between the remuneration of the highest paid director against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce is set out below and also shows the pay ratio between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2024/25	25th percentile	Median	75th percentile
Salary Component of Pay	£26,576.36	£38,158.32	£53,081.50
Total pay and benefits excluding pension benefits	£26,576.36	£38,158.32 £34,320.30	£53,081.50 £47,247.01
Pay and benefits excluding pension: pay ratio for highest paid director	10.32	7.19	5.17

2023/24	25th percentile	Median	75th percentile
Salary Component of Pay	£24,336.00	£34,320.30	£47,247.01
Total pay and benefits excluding pension benefits	£24,336.00	£34,320.30	£47,247.01
Pay and benefits excluding pension: pay ration for highest paid director	11.15	7.90	5.74

In 2023/2024 the Trust, and the wider NHS, was significantly impacted by industrial action. Consequently, the highest paid director undertook a number of additional shifts to provide medical cover. This was not required during 2024/2035 which has led to a reduction in the ratio.

To achieve its goals, the Trust must attract and retain high calibre and experienced members of the Executive Team to ensure the Trust is best positioned to succeed. As referenced within this Remuneration Report, the Trust applies the principles of the Code of Governance and NHS guidance on remuneration, in addition to a regular review of available benchmark information, and consideration of pay and conditions across the wider Trust and the associated pay increases each year.

The Governors' Governance and Nominations Committee includes Staff Governor representation amongst the other constituency classes, and the Committee is consulted prior to recommendations to the Council with regard to any changes in Non-Executive Director remuneration.

The Non-Executive Directors' Appointments and Remuneration Committee is satisfied that it has taken appropriate steps to ensure where any senior manager is paid more than £150,000 that the level of remuneration is reasonable and proportionate, including benchmarking of job content, responsibility and salary across similar sized organisations.

Expenses

There were 8 non-executive directors who served in office during the financial year 2024-2025 and 2 Associate non-Executive directors (2023/24, 8 and 4), of which, 6 (2023/24, 5) received expenses with a total value of £3,390.29 (23/24 £6,766.57)).

During 2024-2025, the Trust had 25 governor seats available (2023/24, 25). Full details of the governors in post through the year can be found in the Council of Governors report of this Annual Report. Whilst the role is voluntary, governors are entitled to claim reasonable expenses. In 2024-2025, 4 governors' (2023/24, 6) expenses were reimbursed for £676.98 (total value of £1,165.80 2023/24).

Salaries and Allowances

Details of Executive Directors' remuneration and pension benefits and Non-Executive Directors' remuneration are set out in the tables available next. Remuneration, cash equivalent transfer values (CETV), exit packages, staff costs and staff numbers are all subject to audit. No exit packages made in the year relate to the Executive Directors or Non-Executive Directors.

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary	Expense payments (taxable) to nearest £100	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total Remuneration
Year ended 31 March 2025		(Bands of £5,000)	(£)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Kevin McNamara	Chief Executive Officer	245-250	0	N/A	N/A	185-187.5	430-435
Matt Holdaway	Director of Quality and Chief Nurse	160-165	0	N/A	N/A	162.5-165	320-325
Karen Johnson	Director of Finance	185-190	0	N/A	N/A	97.5-100	280-285
Mark Pietroni	Medical Director and Deputy Chief Executive	270-275	100	N/A	N/A	60-62.5	335-340
Claire Radley	Director for People and Organisational Development	155-160	200	N/A	N/A	40-42.5	195-200
Helen Ainsbury	Interim Executive Chief Digital and Information Officer (until 16th February 25)	165-170	0	N/A	N/A	0-2.5	165-170
Lee Pester	Executive Chief Digital and Information Officer (from 17th February 25)	15-20	0	N/A	N/A	27.5-30	45-50
Ian Quinnell	Interim Director of Strategy and Transformation (until 29th September 24)	75-80	100	N/A	N/A	27.5-30	105-110
William Cleary-Gray	Director of Strategy and Transformation (from 30th September 24)	75-80	0	N/A	N/A	0-2.5	75-80
Al Sheward	Chief Operating Officer	150-155	200	N/A	N/A	115-117.5	265-270
Kerry Rogers	Director of Integrated Governance (from 29th April 24)	145-150	200	N/A	N/A	85-87.5	230-235
Deborah Evans	Chair	55-60	900	N/A	N/A	0	55-60
Vareta Bryan	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Marie-Annick Gournet	Non-Executive Director	15-20	0	N/A	N/A	0	15-20

Balvinder Kaur Heran	Non-Executive Director	15-20	100	N/A	N/A	0	15-20
Kaye Law-Fox (ANED)	Associate Non-Executive Director	5-10	500	N/A	N/A	0	5-10
Jaki Meekings-Davis	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Alison Moon	Non-Executive Director (Left March 24)	0-5	100	N/A	N/A	0	0-5
Sally Moyle (ANED)	Associate Non-Executive Director	5-10	0	N/A	N/A	0	5-10
Mike Napier	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
John Cappock	Non-Executive Director	15-20	0	N/A	N/A	0	15-20
Sam Foster	Non-Executive Director (from 1st April 24)	15-20	0	N/A	N/A	0	15-20

Notes:

Salary for Mark Pietroni includes £75k for clinical role

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary	Expense payments (taxable) to nearest £100	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total Remuneration
Year ended 31 March 2024		(Bands of £5,000)	(£)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Deborah Evans	Chair	55-60	2000	N/A	N/A	0	55-60
Vareta Bryan	Non-Executive Director	10-15	0	N/A	N/A	0	10-15
Claire Feehily	Non-Executive Director (until 31st July 23)	5-10	0	N/A	N/A	0	5-10
Marie-Annick Gournet	Non-Executive Director	10-15	0	N/A	N/A	0	10-15
Balvinder Kaur Heran	Non-Executive Director	10-15	1000	N/A	N/A	0	15-20
Kaye Law-Fox (ANED)	Associate Non-Executive Director (from 1st Jan 23)	5-10	500	N/A	N/A	0	5-10
Jaki Meekings-Davis	Non-Executive Director	10-15	0	N/A	N/A	0	10-15
Alison Moon	Non-Executive Director (until 31st March 24)	15-20	1000	N/A	N/A	0	15-20

Sally Moyle (ANED)	Associate Non-Executive Director	5-10	0	N/A	N/A	0	5-10
Mike Napier	Non-Executive Director	10-15	0	N/A	N/A	0	10-15
John Cappock	Non-Executive Director (from 1st July 23)	10-15	0	N/A	N/A	0	10-15
Rebecca Pritchard	Associate Non-Executive Director (until 31st July 23)	0-5	0	N/A	N/A	0	0-5
Matt Holdaway	Director of Quality and Chief Nurse	150-155	0	N/A	N/A	0-2.5	150-155
Karen Johnson	Director of Finance	200-205	100	N/A	N/A	0-2.5	200-205
Simon Lanceley	Director of Strategy and Transformation (until 2nd July 23)	45-50	0	N/A	N/A	0-2.5	45-50
Deborah Lee	Chief Executive Officer (until 30th January 24)	260-265	100	N/A	N/A	0-2.5	260-265
Mark Pietroni	Medical Director and Deputy Chief Executive	270-275	100	N/A	N/A	45-47.5	315-320
Claire Radley	Director for People and Organisational Development	150-155	200	N/A	N/A	37.5-40	190-195

Qadar Zada	Chief Operating Officer (until 16th July 23)	50-55	0	N/A	N/A	0-2.5	50-55
Helen Ainsbury	Interim Executive Chief Digital and Information Officer (from 1st Oct 23)	90-95	0	N/A	N/A	480-482.5	570-575
Ian Quinnell	Interim Director of Strategy and Transformation (from 1st July 23)	140-145	0	N/A	N/A	375-377.5	515-520
Kevin McNamara	Chief Executive Officer (from 1st January 24)	60-65	0	N/A	N/A	55-57.5	115-120
David Coyle	Interim Chief Operating Officer (from 4th July 23 to 28th March 24)	135-140	0	N/A	N/A	0-2.5	135-140
Al Sheward	Chief Operating Officer (from 11 December 23)	40-45	0	N/A	N/A	60-62.5	100-105

Notes:

Deborah Lee chose not to be covered by the pension arrangements during the reporting year.

Matt Holdaway, Karen Johnson , Simon Lanceley, Deborah Lee and Quada Zada are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values in the Pension Benefit are not disclosed in this table but are substituted for a zero.

Salary for Mark Pietroni includes £80k for clinical role

Director Pensions 2024/25								
Pension benefits of Senior Managers		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at age pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value as at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value as at 31 March 2025
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£'000	£'000	£'000
Kevin McNamara	Chief Executive Officer	7.5 to 10	15 to 17.5	50 to 55	130 to 135	813	151	1,049
Matt Holdaway	Director of Quality and Chief Nurse	7.5 to 10	15 to 17.5	50 to 55	130 to 135	848	152	1,077
Karen Johnson	Director of Finance	5 to 7.5	0 to 2.5	40 to 45	0 to 5	563	76	695
Mark Pietroni	Medical Director and Deputy Chief Executive	2.5 to 5	0 to 2.5	40 to 45	5 to 10	630	55	752
Claire Radley	Director for People and Organisational Development	2.5 to 5	0 to 2.5	20 to 25	0 to 5	284	30	352
Helen Ainsbury	Interim Executive Chief Digital and Information Officer (until 16 February 25)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	491	0	0
Lee Pester	Executive Chief Digital and Information Officer (from 17th February 25)	3.5 to 6	1 to 3.5	21 to 26	1 to 6	161	0	194

Ian Quinnell	Interim Director of Strategy and Transformation (until 29th September 24)	4.5 to 7	2 to 4.5	22 to 27	2 to 7	284	19	338
William Cleary-Gray	Director of Strategy and Transformation (from 30 September 24)	0 to 2.5	0 to 2.5	20 to 25	20 to 25	0	510	465
Al Sheward	Chief Operating Officer	5 to 7.5	10 to 12.5	55 to 60	145 to 150	1,026	119	1,232
Kerry Rogers	Director of Integrated Governance (from 29th April 24)	2.5 to 5	5 to 7.5	35 to 40	90 to 95	919	0	758

Notes:

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

Negative values are not disclosed in this table but are substituted for a zero.

Cash Equivalent Transfer Value (CETV) are calculated using the guidance on discount rates for calculating unfunded public service Pension Contribution rates that was extant at 31 March 2025. HM Treasury published updated guidance in April 2025; this guidance will be used in the calculation of 2024-25 CETV figures.

On 10 March 2022 the Public Service Pensions and Judicial Offices Act 2022 gained Royal Assent. This act sets a deadline of 1 October 2023 to pass regulations enabling the necessary retrospective adjustments arising due to the McCloud judgement. This involves an initial roll back of all eligible members so their relevant service is switched to become Final salary and then offering members a choice on their actual retirement date between CARE and Final Salary benefits for their service between 2015 and 2022.

Salary for Mark Pietroni includes £75k for clinical role

Helen Ainsbury was opted in to pension for six months only 01/04/2024 – 31/12/2024 and opted out from 31/12/24 onwards.

Director Pensions 2023/24								
Pension benefits of Senior Managers		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2024	Lump sum at age pension age related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value as at 1 April 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value as at 31 March 2024
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£'000	£'000	£'000
Matt Holdaway	Director of Quality and Chief Nurse	0 to 2.5	5 to 7.5	40 to 45	105 to 110	736	19	848
Karen Johnson	Director of Finance	0 to 2.5	0 to 2.5	35 to 40	0 to 5	446	21	563
Simon Lanceley	Director of Strategy and Transformation (until 2nd July 23)	0 to 2.5	0 to 2.5	25 to 30	0 to 5	327	11	417
Deborah Lee	Chief Executive Officer (until 30th January 24)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	1,420	0	0
Mark Pietroni	Medical Director and Deputy Chief Executive	2.5 to 5	0 to 2.5	35 to 40	5 to 10	462	95	630
Claire Radley	Director for People and Organisational Development	2.5 to 5	0 to 2.5	15 to 20	0 to 5	186	60	284
Qadar Zada	Chief Operating Officer (until 16th July 23)	0 to 2.5	7.5 to 10	30 to 35	85 to 90	445	44	660
Helen Ainsbury	Interim Executive Chief Digital and Information Officer (from 1st Oct 23)	5 to 7.5	15 to 17.5	20 to 25	60 to 65	0	117	491
Ian Quinnell	Interim Director of Strategy and Transformation (from 1st July 23)	12.5 to 15	0 to 2.5	15 to 20	0 to 5	0	195	284
Kevin McNamara	Chief Executive Officer (from 1st January 24)	0 to 2.5	12.5 to 15	40 to 45	105 to 110	491	60	813
David Coyle	Interim Chief Operating Officer (from 4th July 23 to 28th March 24)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	0	0	0

Al Sheward	Chief Operating Officer (from 11 December 23)	0 to 2.5	0 to 2.5	45 to 50	125 to 130	871	14	1,026
Pension benefits of Past Senior Managers								
Mark Hutchinson	Executive Chief Digital and Information Officer (until 31st March 2023)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	824	0	0

Notes:

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

Cash Equivalent Transfer Value (CETV) are calculated using the guidance on discount rates for calculating unfunded public service Pension Contribution rates that was extant at 31 March 2024. HM Treasury published updated guidance in April 2024; this guidance will be used in the calculation of 2023-24 CETV figures.

On 10 March 2022 the Public Service Pensions and Judicial Offices Act 2022 gained Royal Assent. This act sets a deadline of 1 October 2023 to pass regulations enabling the necessary retrospective adjustments arising due to the McCloud judgement. This involves an initial roll back of all eligible members so their relevant service is switched to become Final salary and then offering members a choice on their actual retirement date between CARE and Final Salary benefits for their service between 2015 and 2022.

Mark Hutchinson is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.

Mark Hutchinson was not in post in 23-24 however received some remuneration in April 23 for Loss of Office.

Deborah Lee chose not to be covered by the pension arrangements during the reporting year.

Salary for Mark Pietroni includes £80k for clinical role

Karen Johnson was opted out 01/04/2023 – 31/05/2023. Opted in 01/06/2023 – 30/11/2023 and opted out 01/12/2023 – 31/03/2024.

Helen Ainsbury was opted in to pension for three months only 01/10/2023 – 31/12/2023 and opted out from 01/01/24 onwards.

Contract Type and Notice Period

Name	Start Date as Senior Manager	Contract Type	Notice Period by Employee	Notice Period by Employer
Kevin McNamara	01/01/2024	Permanent	6 months	6 months
Mark Pietroni	01/02/2019	Permanent	6 months	6 months
Karen Johnson	06/01/2020	Permanent	6 months	6 months
Matthew Holdaway	13/12/2021	Permanent	6 months	6 months
Claire Radley	07/02/2022	Permanent	6 months	6 months
Alan Sheward	11/12/2023	Permanent	6 months	6 months
Kerry Rogers	29/04/2024	Permanent	6 months	6 months
William Cleary Gray	30/09/2024	Permanent	6 months	6 months
Lee Pester	17/02/2025	Permanent	6 months	6 months
Helen Ainsbury	To 16/02/2025	Interim	6 months	6 months
Ian Quinnell	To 29/09/2024	Interim	6 months	6 months

Notes: No senior manager has a contract of employment with a notice period greater than six months.

Analysis of Staff Costs

			2024/25	2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	399,763	2,227	401,990	364,185
Social security costs	44,354	-	44,354	41,960
Apprenticeship levy	2,218	-	2,218	2,099
Employer's contributions to NHS pension scheme	84,558	-	84,558	67,095
Pension cost - other	-	-	-	-
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	13,479	13,479	18,479
NHS charitable funds staff	487	-	487	443
Total gross staff costs	531,380	15,706	547,086	494,261
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	531,380	15,706	547,086	494,261
Of which				
Costs capitalised as part of assets	723	-	723	917

Analysis of Average Staff Numbers (WTE Basis)

			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	483	661	1,144	1,117
Ambulance staff	9	1	10	8
Administration and estates	2,153	211	2,365	2,129
Healthcare assistants and other support staff	1,311	275	1,586	1,686
Nursing, midwifery and health visiting staff	2,439	327	2,766	2,667
Nursing, midwifery and health visiting learners	82	8	89	224
Scientific, therapeutic and technical staff	633	87	720	683
Healthcare science staff	258	17	275	275
Social care staff	-	-	-	-
Other	1	3	4	13
Total average numbers	7,368	1,590	8,957	8,802
Of which:				
Number of employees (WTE) engaged on capital projects	12	-	12	6

*WTE - Whole Time Equivalent. WTE shown is an average throughout the year

Exit Packages

Reporting of compensation schemes - exit packages 2024/25

[A narrative description of any exit packages agreed in the period should be provided]

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	1
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	1	1
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	2	2
Total cost (£)	£0	£37,000	£37,000

Reporting of compensation schemes - exit packages 2023/24

[A narrative description of any exit packages agreed in the comparative period should be provided]

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	£0	£0	£0

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	1	7	-	-
Non-contractual payments requiring HMT approval	1	30	-	-
Total	2	37	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above will not necessarily match the total number in the exit packages note which will be the number of individuals. No senior manager, as defined in the Remuneration Report, received an exit package in the year.

Service Contracts Obligations

There are no obligations contained within senior managers' service contracts that could give rise to or impact upon remuneration payments which are not disclosed elsewhere in the remuneration report.

A handwritten signature in dark ink, reading "K. McNamara." with a horizontal line underneath.

Kevin McNamara
Chief Executive

26 June 2025

Accountability report:

Staff report



Staff overview

We have over 11,254 staff inclusive of bank workers and Gloucestershire Managed Services (GMS), seeing the Gloucestershire Hospitals Group as the largest employer in the County. Everyone continues to make such a difference in delivering high quality care to our patients, their carers and families.

The majority of colleagues live in the local community and they and their families are also users of the services.

Staff analysis

Staff numbers

Average Number of Staff and Staff costs: 1 April 2024 to 31 March 2025 (subject to audit).

Using the most up to date available data, the following table reflects the average number of staff in Whole Time Equivalent (WTE) terms. Bank and Agency worked WTE is included within the figure entitled "Other" (header in the top column).

Average number of employees (WTE basis)

Group	2024/25			2023/24		
	Permanen t	Other	Total	Permanen t	Other	Total
	Number	Number	Number	Number	Number	Number
Medical and dental	483	661	1,144	462	655	1,117
Ambulance staff	9	1	10	8	0	8
Administration and estates	2,153	211	2,365	1,945	184	2,129
Healthcare assistants and other support staff	1,311	275	1,586	1,357	328	1,686
Nursing, midwifery and health visiting staff	2,439	327	2,766	2,243	425	2,667
Nursing, midwifery and health visiting learners	82	8	89	211	13	224
Scientific, therapeutic and technical staff	633	87	720	607	76	683
Healthcare science staff	258	17	275	260	15	275
Social care staff	-	-	-	-	-	-
Other	1	3	4	2	11	13
Total average numbers	7,368	1,590	8,957	7,094	1,708	8,802

Of which:

Number of employees (WTE) engaged on capital projects	12	-	12	6	-	6
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Staff costs

Group	2024/25			2023/24		
	Permanent	Other	Total	Permanent	Other	Total
	£000	£000	£000	£000	£000	£000
Salaries and wages	399,763	2,227	401,990	362,152	2,033	364,185
Social security costs	44,354	-	44,354	41,960	-	41,960
Apprenticeship levy	2,218	-	2,218	2,099	-	2,099
Employer's contributions to NHS pension scheme	84,558	-	84,558	67,095	-	67,095
Temporary staff	-	13,479	13,479	-	18,479	18,479
NHS charitable funds staff	487	-	487	443	-	443
Total gross staff costs	531,380	15,706	547,086	473,749	20,512	494,261
Recoveries in respect of seconded staff	-	-	-	-	-	-
Total staff costs	531,380	15,706	547,086	473,749	20,512	494,261
Of which						
Costs capitalised as part of assets	723	-	723	917	-	917

Gender distribution – Trust and GMS

The table below shows the gender breakdown of substantive staff (bank staff are not included). The data is reflected by headcount.

		March 2025	March 2024
Chairs and Directors*	Male	9	9
	Female	14	14
Senior Managers**	Male	136	137
	Female	342	322
Employees	Male	2,080	2,037
	Female	7,037	6,948
All Employees	Male	2,225	2,183
	Female	7,393	7,284

*Voting and non-voting Executive and Non-Executive Directors

**Band 8A and above

At Band 8A+, female representation increased by 1.4% (20 staff) in 2024/2025, following an increase of 56 staff in 2023/2024 when compared to 2022/2023.

Gender representation at Board and Chair / Non-Executive level is consistent with 2023/2024, still showing a higher female to male ratio.

Staff turnover

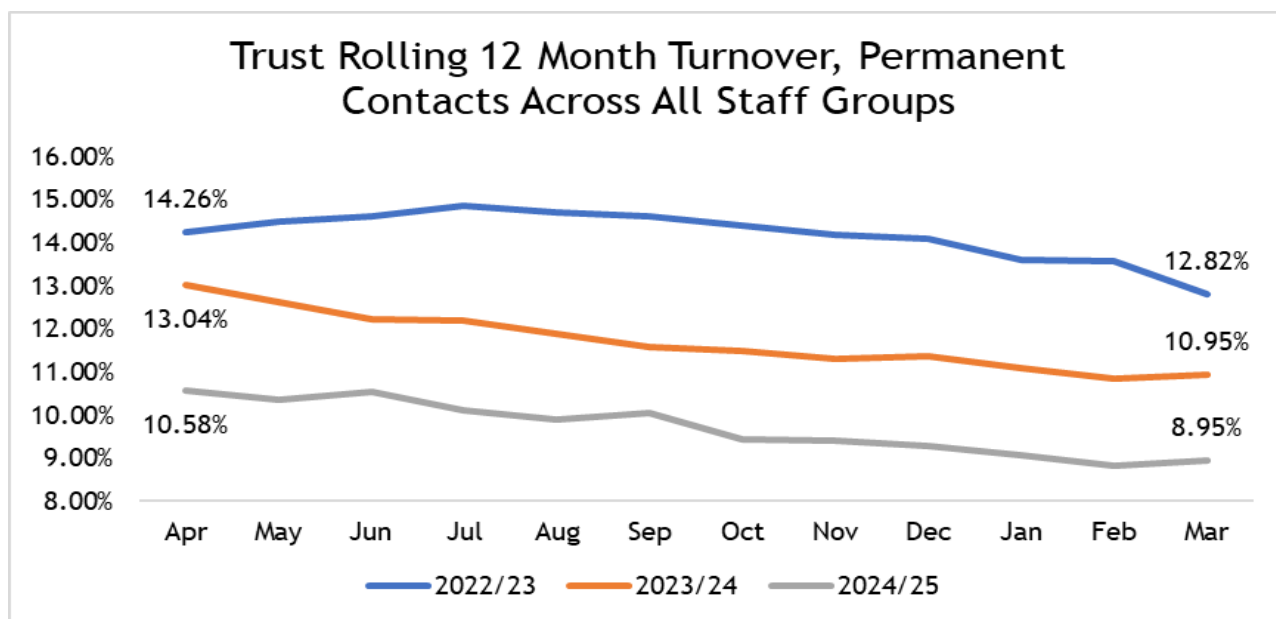
The Trust's turnover reduced from 10.95% to 8.95% over the last twelve months and we are performing favourably when benchmarked to other Trusts within the region. This staff turnover information does not include Gloucestershire Managed Services (GMS).

Historically Gloucester Managed Services (GMS) as a wholly owned subsidiary company have not consistently been included in national and regional data for Turnover. However, from 2025/2026 Financial Year GMS will be included.

Therefore, the following graphs show both reflect Trust only (i.e. without GMS) for comparison of data 2023/2024 compared to 2024/2025 and a graph that shows combined turnover data for both this Trust and GMS for 2024/2025.

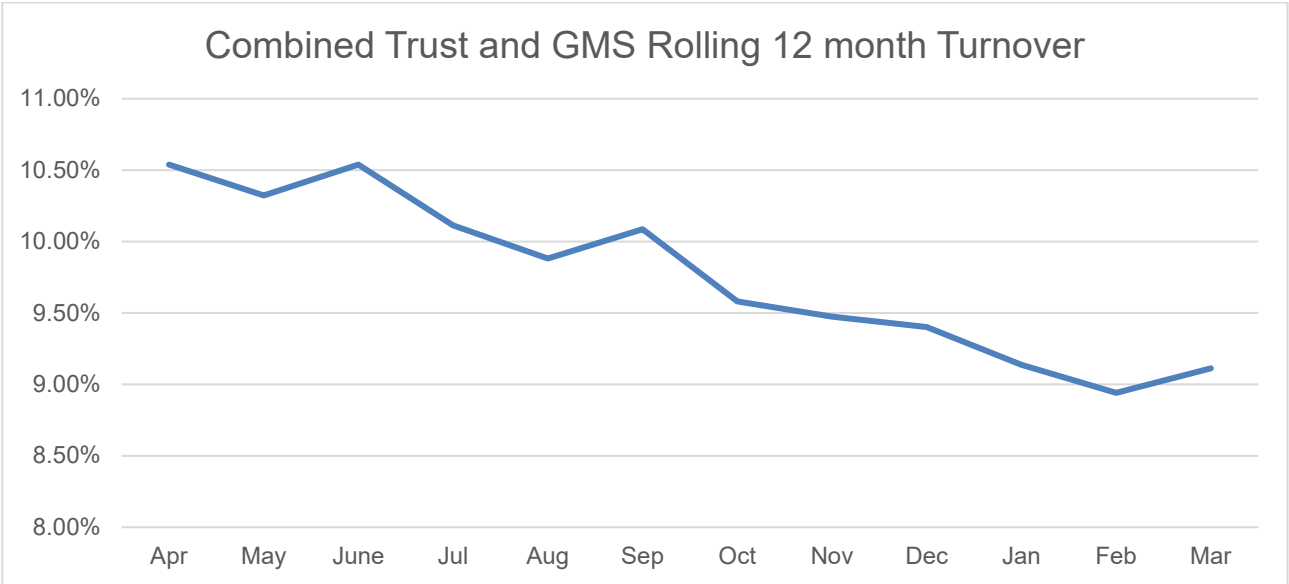
More detailed workforce statistics can be found at (<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>)

Note* This staff turnover information does not include Gloucestershire Managed Services (GMS).



Turnover for registered nurse and midwifery staff reduced from 8.67% to 6.2% during the year 2024/2025 with Medical and Dental staff turnover reduced from 4.39% to 3.97% during the same period.

The combined Trust and GMS turnover reduced from 10.54% to 9.11% over the last twelve months.



Sickness absence

The Trust sickness rate for 2024/25 of 4.35% is below the NHS England average of 5.4%*. This is a 0.06% increase compared to the previous financial year.

*source: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates> - November 2024 NB: latest available data

Short-term absence has seen slight increases in comparison to the previous year of 0.09% while long-term absence decreased by 0.03%.

The table below shows the sickness rate broken down:

		2024–2025	2023–2024
Sickness Absence	Long Term	2.15%	2.18%
	Short Term	2.20%	2.11%
Annual Sickness Absence	Total	4.35%	4.29%

Reducing agency

Over the past financial year, the Trust has implemented targeted measures to reduce agency staffing costs and usage, focusing on internal controls, rostering efficiency, and regional cost-saving initiatives. These efforts have improved workforce management and reduced expenditure.

The Trust has established 'Grip and Control Groups' for medical and non-medical staff, with divisional representation to scrutinize temporary staffing requests. This oversight ensures all requests are justified and aligned with service needs, reducing unnecessary agency use and embedding cost-consciousness across the organisation.

Optimised rostering systems for nursing staff and healthcare support workers have eliminated unjustified staffing requests, reducing reliance on agency staff. This approach enhances workforce planning and improves internal resource utilization.

The Trust has prioritised substantive recruitment in hard-to-fill roles, such as nursing specialties and medical positions with high agency usage. This strategy has strengthened the substantive workforce, reduced vacancies in critical areas, and minimized reliance on temporary staffing. Agency spending on nursing staff has been reduced to a quarter of its peak level in May 2024 (M2 24/25) due to robust controls and improved rostering practices, significantly lowering costs in one of the largest areas of agency expenditure.

In conjunction with other regional trusts the Trust has adopted regional rate cards to standardize pay rates for nursing and medical staff across the southwest region. This prevents inflationary pressures caused by competition among trusts while achieving substantial cost savings.

Recruitment: substantive and bank

Over the past year, The Trust has significantly improved recruitment processes for both substantive and bank staff, focusing on streamlining procedures, retaining experienced employees, and offering flexible career pathways. These efforts have reduced vacancies, improved workforce stability, and minimized reliance on agency staffing and are demonstrated as set out below:

Reduction in time to hire

A targeted improvement programme has reduced the time to hire from 79 days to 41 working days. This ensures quicker filling of vacancies, reducing the need for temporary staffing and maintaining continuity of care while lowering costs.

Retire and return initiatives

Retire and return schemes have helped retain experienced staff by allowing them to return in flexible roles. This has been particularly effective in retaining clinical staff with specialist expertise.

Bank-to-substantive pathways

Clear pathways have been introduced for bank staff to transition into substantive roles, particularly in hard-to-fill areas. This initiative strengthens the workforce while offering professional development for bank staff.

Substantive-to-bank flexibility

A substantive-to-bank route enables employees leaving substantive roles to remain on the bank, providing flexibility for those seeking reduced hours while retaining valuable skills within the organisation.

Hard-to-recruit forums

Hard-to-recruit forums offer tailored support to divisions facing staffing challenges in key areas such as emergency medicine and stroke services. These forums have successfully filled critical vacancies through targeted recruitment campaigns.

Enhanced recruitment attraction

The Trust has improved recruitment attraction by launching a dedicated website, developing a strong marketing brand, and engaging with the local community. These efforts have enhanced visibility and positioned the Trust as an employer of choice, strengthening recruitment pipelines across various roles.

Equality, Diversity and Inclusion

Equality, Diversity, and Inclusion (EDI) remain at the heart of the Trust's values, with a continued focus in 2024/25 on improving the experience of global majority and disabled colleagues, who report less positive workplace experiences. We have worked to strengthen our culture of inclusion and belonging, ensuring fairness and equity are embedded throughout our organisation. A key milestone was our 2024 Black History Month event, which featured honest, powerful stories from colleagues about racism and inequality.

These conversations have shaped ongoing staff engagement and helped inform future EDI priorities, with the group continuing to meet regularly to co-design events and guide our approach.

A specific Anti-Racism Campaign has commenced to raise awareness and amplify the lived experiences of staff affected by racism, addressing behaviours from microaggressions to overt discrimination and linking to our new *Report, Support and Learn* platform – a confidential tool for reporting discrimination, bullying, harassment, sexual misconduct, or incivility.

Our four active staff inclusion networks: Women's, Ethnic Minority, LGBTQ+, and Disability, have remained central to the staff voice and peer support, with leadership sponsorship ensuring strategic impact. In 2025/26, the Disability Network will expand to include a Neurodiversity Network, and plans are underway to launch a Veterans Network.

The Trusts EDI Development Plan, aligned with NHS England's High Impact Actions, focused on anti-discrimination, recruitment, and allyship through eight organisation-wide priorities. These priorities are currently under review to ensure our EDI work continues to be ambitious, inclusive, and responsive to the needs of our staff and communities.

To embed fairness in recruitment, we've introduced Inclusion Champions on interview panels for Band 8a roles and above, with further work underway to strengthen their impact. We are also continuing to use national frameworks such as WRES and WDES to identify and address disparities, ensuring our actions are data-driven and outcome-focused.

In May 2024, the Trust launched a new Reasonable Adjustments Policy, designed to provide comprehensive guidance to all staff and line managers. This policy is accompanied by the introduction of the *Purple Passport*, a practical tool that helps colleagues clearly communicate any existing adjustments and navigate the process with greater ease.

According to the 2024 NHS Staff Survey, 71.78% of respondents reported that their employer had made reasonable adjustments – previously referred to as "adequate adjustments" – to help them carry out their roles. While this figure is slightly below the national average for acute Trusts (by 2.14%), it reinforces the importance of continuing efforts to embed inclusive practices across the organisation.

The Trust has also undertaken a comprehensive review of its staff car parking scheme. New, needs-based criteria have been introduced for the review and allocation of parking permits, with specific provisions for staff who declare a temporary or permanent disability.

Neurodiversity has been identified as a key area of focus by the Education, Learning and Development Service. As a result, it will now be formally addressed within the Trust's Education, Learning and Development Policy, offering targeted support and guidance to both line managers and staff participating in training and development activities.

Freedom to Speak Up (FTSU)

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 needs to be spoken up about, whether it be an improvement or an issue that needs action and resolution.

The Freedom to Speak Up Guardian and team have been actively encouraging staff to speak up with another increase in cases this year. During 2024/2025 230 staff have accessed the support provided by the team, an increase on the previous year, 2023/24, when, 208 staff accessed the service as a vehicle to raise concerns.

Staff have raised a variety of concerns but inappropriate attitudes or behaviours remain the organisation's predominant reason for staff contacting the team. A variety of support mechanisms have been implemented within the Trust as a result of the triangulating this and other employee data, including Restorative Just and Learning Culture programmes.

HR Policy Development

We continue to work in partnership with our staff side and trade union colleagues to develop new and updated policies to reflect changes as required by law and legislation and best practice. We include our line managers in those conversations to ensure they reflect the real issues being discussed in the workplace.

Thirty-four policies, out of thirty-six, have been reviewed in 2024/25 through a focused work plan, leading to significant progress which has ensured our policies are up to date and are owned by the correct specialist team. This focus continues with early planning for each policy coming up for renewal.

There is an equality impact assessment completed as part of all policy reviews which enables us to keep improving the diversity and inclusiveness of the workforce.

All Trust policies are subject to an Equality Impact Assessment as part of the review process. This ensures that diversity and inclusion remain central to policy development, supported by ongoing work from the Quality and Equality Impact Assessment Review Group to drive continuous improvement in this area.

Gender Balance and Gender Pay Gap

All Trust policies are subject to an Equality Impact Assessment as part of the review process. This ensures that diversity and inclusion remain central to policy development, supported by ongoing work from the Quality and Equality Impact Assessment Review Group to drive continuous improvement in this area.

The Trusts seventh Gender Pay Gap report, based on data from 30 March 2024, shows women made up 78.1% of its 9,192 staff. The mean gender pay gap was 23.3% in favour of men (down from 25.7%), while the median gap was 17.2% in favour of women, largely due to senior male doctors' longer service and additional payments. Excluding medical staff, the gap narrows to a median of -5.3% (in favour of women) and a mean of 0.62% (in favour of men). In line with the Public Sector Equality Duty, these figures are published annually by 30 March 2025. For the first time, the Trust also analysed the Ethnicity Pay Gap: 22% of staff identified as being from an Ethnic Minority background, with a mean gap of 3.2% and a median of 5.25%, both in favour of EM staff. While 74% of bonuses went to White consultants, 23% were awarded to EM consultants, indicating progress in senior representation.

The report can be found both on the Trust website and the Cabinet office website. [Gender Pay Gap report: 2025](#)

Organisational development, staff wellbeing and recognition

Health and Wellbeing

The Trust continues to take a holistic approach to supporting staff wellbeing, focusing on colleague health, perceptions of the wellbeing culture, and how staff engage with available support. Data from sickness absence and the NHS Staff Survey highlight ongoing challenges, particularly with stress, mental health, and musculoskeletal issues, underscoring the need for sustained focus. In 2024, over 26,000 whole time equivalent days were lost due to mental health-related absences, and over 18,000 days lost due to Musculoskeletal related-absence.

It was noted by us that, despite a wide-ranging wellbeing offer, engagement remains lower than expected, with only 212 contacts made by 71 individuals with the Employee Assistance Programme during the year, which forms one element of the Trust wellbeing offer. The Trust made significant progress in the last year, guided by the Wellbeing Strategic Action Plan. This included forming a Wellbeing Steering Group, appointing Divisional Wellbeing Leads, and increasing the Wellbeing Champion network from 40 to 170 employees. Efforts also focused on engaging staff through a bespoke Wellbeing Survey, raising awareness of wellbeing resources through campaigns, training, and improved communication, while enhancing line manager capability to support staff. Key initiatives included the launch of manager wellbeing training, and self-care training; and new guidance around wellbeing conversations, suicide prevention, and menopause, and a redesigned wellbeing-focused intranet. Additional achievements include free weekly yoga, securing funding for provision of physical health checks by a dedicated Wellbeing Nurse in 2025/26, appointment of a Wellbeing Guardian, and collaboration across the ICS Health and Wellbeing Group.

Occupational Health

The Trust's occupational health services are provided by Working Well.

Working Well provides the Trust with a breadth of occupational health services for Trust staff which includes all pre-employment screening, immunisation checks, blood tests and vaccines. It supports staff with ill health retirement applications, health surveillance, contract tracing driven by disease outbreaks, clinical support across all management and staff self-referrals; supporting staff with a range of health conditions to help them return to the workplace.

Health and Safety

Our health and safety team are dedicated to providing support to all staff in a culture where health and safety management is important and the responsibility of all. Regular reports are provided to both our Health and Safety Committee and our People and Organisational Development Committee. During early 2025/2026 the Trust will be

introducing a Health and Safety Framework with renewed escalation routes to both the Trust Leadership Team and Board, via Audit and Assurance Committee.

Counter-Fraud

The Trust has its own internal Counter Fraud Service which ensures a robust counter fraud, bribery and corruption risk and control framework. Our Counter Fraud, Bribery and Corruption Policy was updated in 2023-24 and remains compliant with the NHS Counter Fraud Authority 3-Year Strategy 2023-26. Additional information can be seen throughout this Annual Report

Recognition of our workforce

Recognising our staff is vital to ensuring a positive and supportive workplace. Our 2023 staff survey highlighted the need for improvement, with only 49.92% of colleagues feeling satisfied or very satisfied with the recognition they receive. In response to this, we launched a review project to enhance our approach and work towards launching a revised offer of monthly awards, long service recognition, and everyday appreciation- ensuring inclusivity, fairness, and consistency across the Trust.

A highlight of the year was our largest-ever Staff Awards event in 2024, bringing together a record number of colleagues from across the Trust and our Trust subsidiary, Gloucestershire Managed Services. With over 820 outstanding nominations, our Executive Team, Staff Governors, and Lead Governor carefully selected finalists from an exceptional group of individuals and teams. This celebration would not be possible without the generous support of our hospitals' charity and their sponsorship efforts, enabling us to honour those who have made a remarkable impact on their peers, the patients we serve and the organisation.

Learning and Development

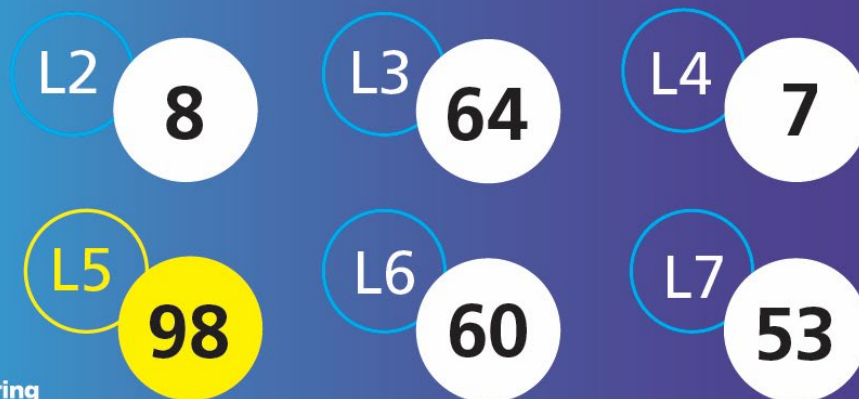
Education and People Development

The Education and People Development Service remains committed to equipping our workforce with the knowledge, values and skills needed for both individual and organisational growth.

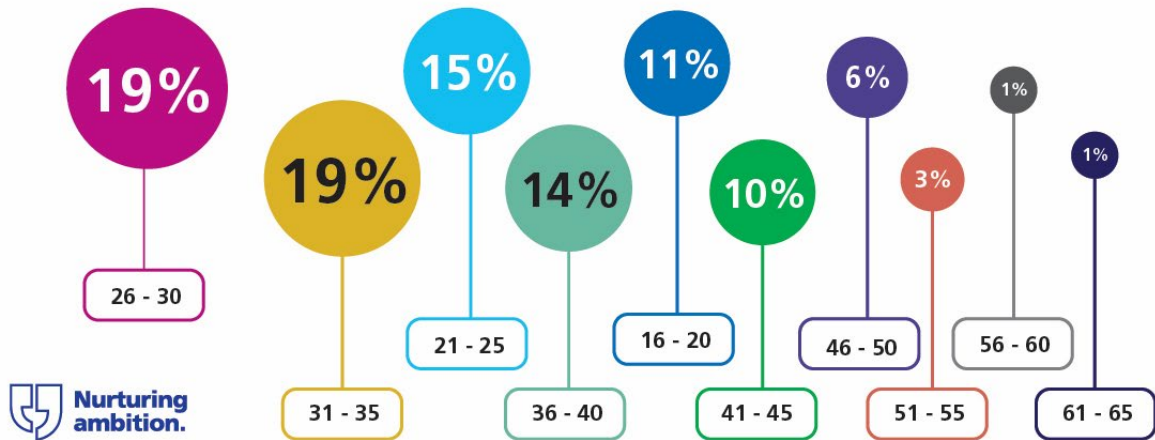
As an organisation we continue to commit to apprenticeships with a portfolio of 58 different standards varying from Level 2 to level 7. In the financial year or 2024/25 there were 69 staff that enrolled onto an apprenticeship bringing our total apprenticeship workforce up to 270 staff in progress at the end of the financial year.

The organisation and Gloucestershire Management Services (GMS) work collaboratively to support learners on programme and continue to diversify the areas in which apprenticeships are supported. During February's National Apprenticeship week, we celebrated the 290 staff on programme across our 5 divisions and GMS from a variety of ages and backgrounds.

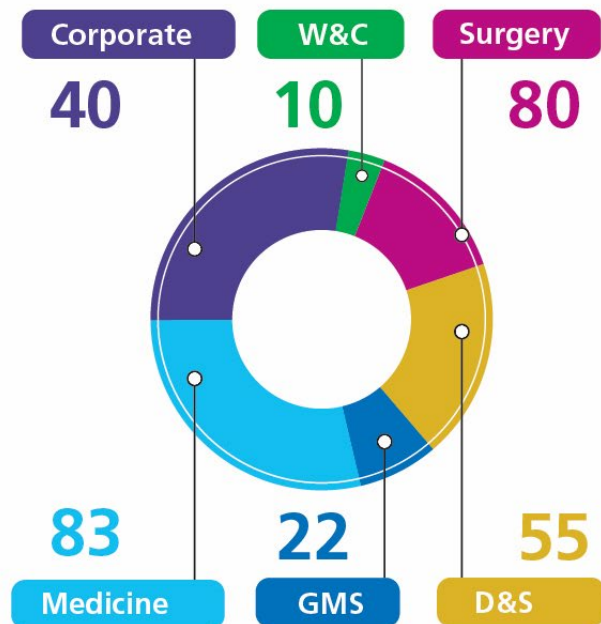
Access to 43 different apprenticeship standards



Age demographic of our apprentices



Number of apprenticeships in each division



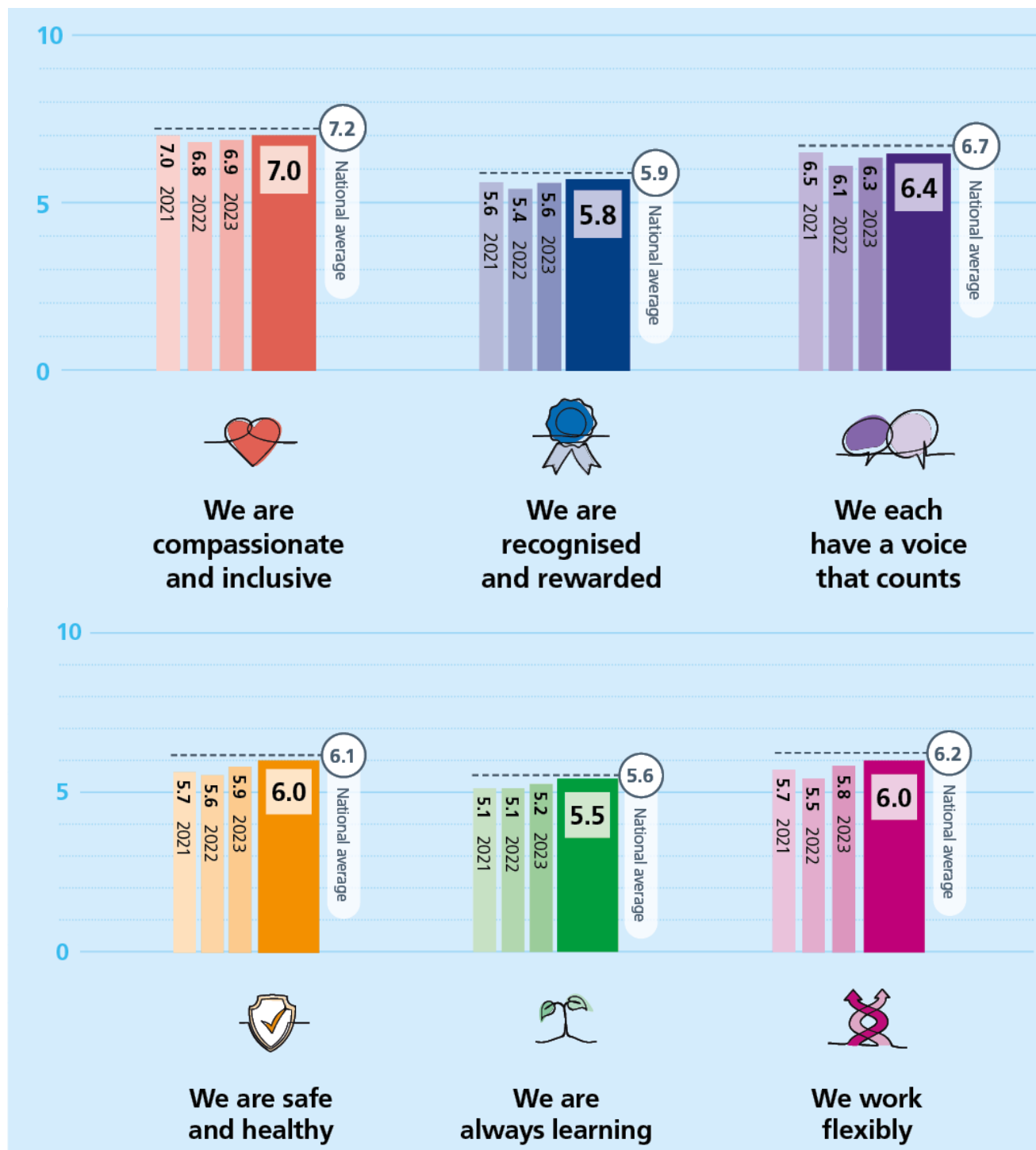
We continue to work with local colleges as a T-level industry placement provider, with 30 currently placed across the hospital, and were finalist for the Southwest T-level employer of the year.

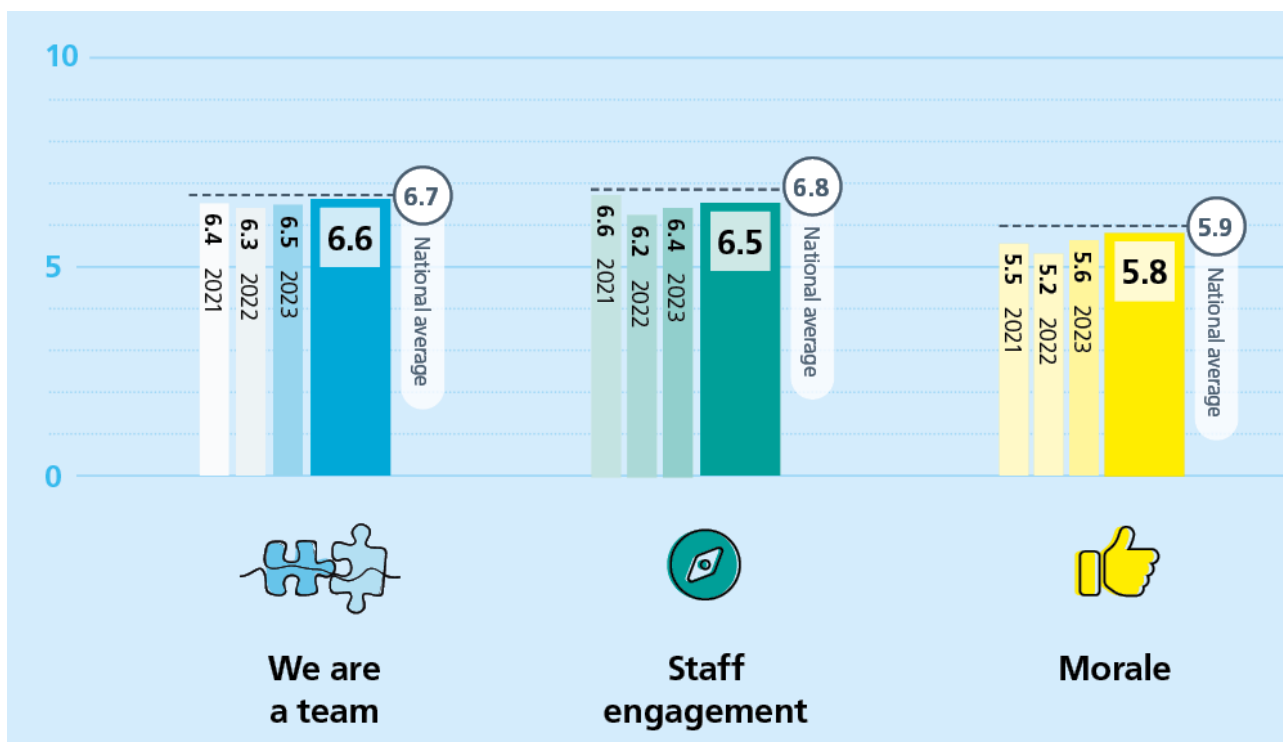
Supporting learners within the organisation remains a priority and this year we signed up to the NHS England Safe Learning Environment Charter and are committed to embedding its principles to strengthen the workforce by advancing high-quality learning environments, reducing learner attrition, and improving the retention of newly qualified staff. We have also met the terms of NHS England's Statutory and mandatory training programme, resulting in the trust having declared alignment to the core skills training framework, utilising the NHS England e-learning for healthcare (elfh) content, and establishing a local mandatory training oversight group.

National Staff Survey Results

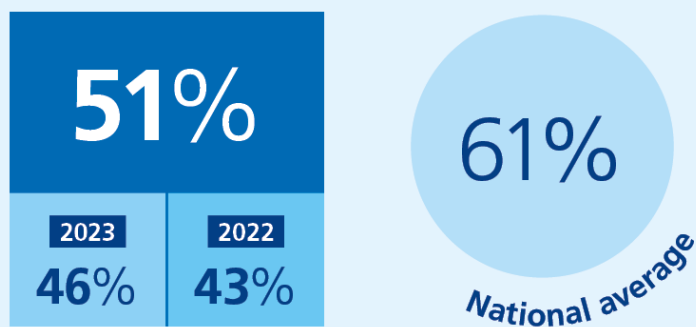
Response Rates

The response rate for the 2024 Staff Survey was 65% which is a positive outcome and can be attributed to the engagement programme which was implemented in 2023, resulting in a Trust record response rate of 68%. The national average for other NHS Acute Trusts is 49% response rate, which places us in the top 5 responding Acute and Acute Community Trusts.

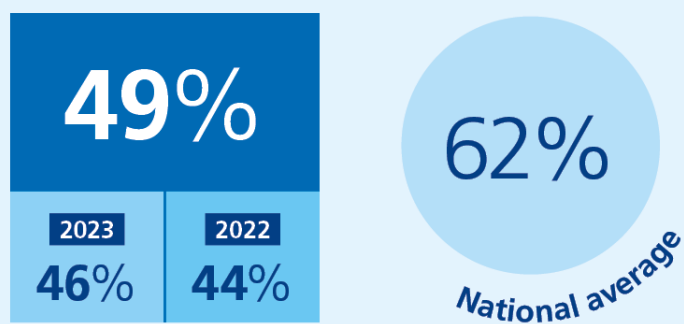




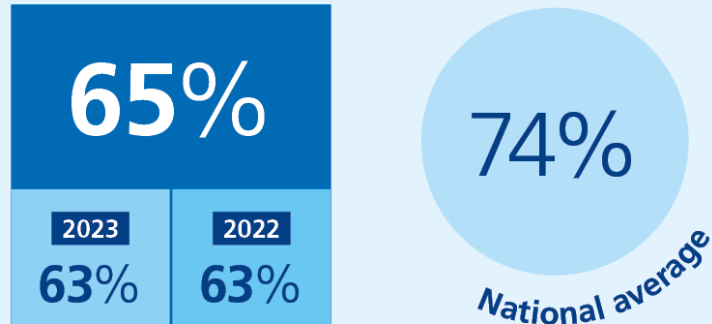
I would recommend my organisation as a place to work



If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



Care of patients/service users is
organisation's top priority



Summary of Performance

For the second year in a row the results show statistically significant improvement across all of the seven People Promises, Staff Engagement and Morale themes.

Appendix B: Significance testing – 2023 vs 2024

Survey
Coordination
Centre



Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the [technical document](#).

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	6.95	5462	7.02	5511	Significantly higher
We are recognised and rewarded	5.64	5458	5.76	5510	Significantly higher
We each have a voice that counts	6.30	5425	6.38	5487	Significantly higher
We are safe and healthy	5.92	4993	6.05	5487	Significantly higher
We are always learning	5.26	5145	5.45	5263	Significantly higher
We work flexibly	5.87	5438	5.99	5493	Significantly higher
We are a team	6.50	5454	6.59	5502	Significantly higher
Themes					
Staff Engagement	6.44	5468	6.53	5518	Significantly higher
Morale	5.61	5469	5.79	5519	Significantly higher

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

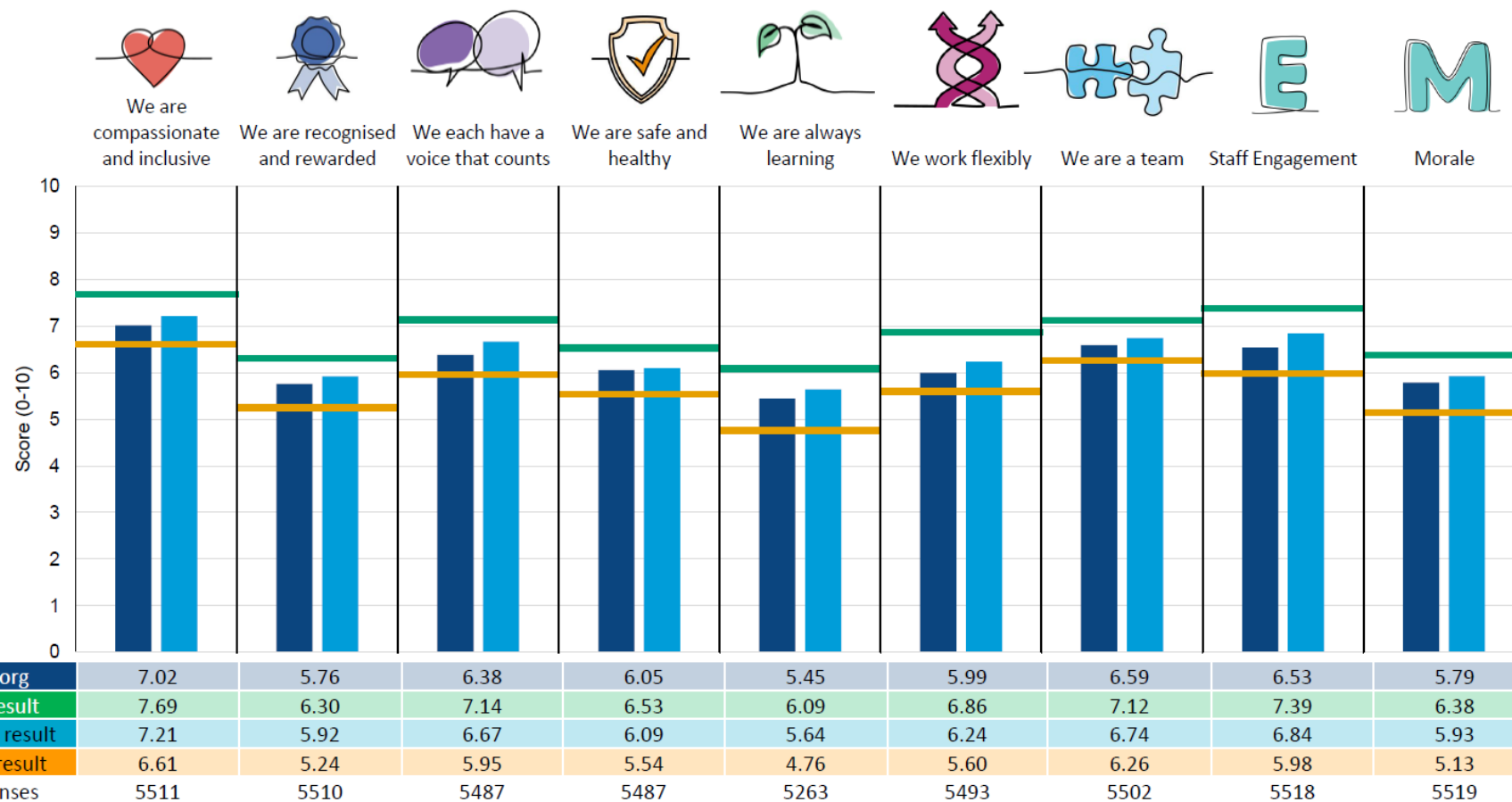
Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see <https://www.nhsstaffsurveys.com/survey-documents/> for more details.

Despite the positive progress, the Trust recognises that it still falls below the average for Acute and Acute Community Trusts across all elements and themes.

People Promise elements and themes: Overview

Survey
Coordination
Centre **NHS**

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



We recognise that there is still much to do as an organisation, despite the 'green shoots' that show we are beginning to move in the right direction. We must not be complacent, with the focus on staff experience, seen over the last two years, continuing. These results underline the need for the continuing priority and focus we are placing on our organisation's culture.

We continue to support this work through our Staff Experience Improvement Programme, a programme initiated in 2022/2023 to drive activity and improvement across three interconnected workstreams

2024/2025 areas of focus:

- Workstream 1 – Teamwork and Leadership (aligned to People Promise 7: We are a Team)
- Workstream 2 – Anti-discrimination (aligned to sub score Equality and Diversity, part of People Promise 1: We are Compassionate and Inclusive)
- Workstream 3 – Building a Safe Speaking Up Culture (aligned to People Promise 3: We each have a voice that counts)

Our guiding principles for bringing about culture change in the Trust include:

- Change happens through relationships
- Change happens when people can talk, think and problem-solve together skilfully
- Change only really happens when you work at a behavioural level
- No change comes from stability
- We can't work with what we're not talking about
- People own what they help to create
- The process is as, if not more important, than the outcome
- Change will be sustained when we build internal capacity and capability

The activities under the Teamwork and Leadership workstream are fully underway with the way in which teams were identified to undertake the work via a risk assessment. Following an extensive tender process in 2023 we are continuing to work in partnership with an external facilitator to deliver a range of activities for leaders and teams across the organisation. The first 'wave' of service lines began their activities in March 2024. This includes leader workshops, team workshops and action learning sets.

The activities within the anti-discrimination workstream identified the need for a mechanism for colleagues to feel safe and confident in reporting cases of anti-discrimination. As a result, the workstream, working through task and finish groups, identified the Report and Support platform was able to fulfil our needs. Forward looking into 2025/2026 the Report Support and Learn process will launch whereby managers will be supported in addressing reports of inappropriate behaviour through the Restorative Just and Learning Culture.

Consultancy expenditure

The Trust produced and issued guidance in April 2017 on the engagement of staff off-payroll to ensure compliance with employment law, tax law and HM Treasury guidance for government bodies. This contains a procedure to ensure appointees give assurances to the Trust that they are meeting their Income tax and National Insurance obligations. On occasion the Trust will procure consultancy support for specific work programmes which follow appropriate governance routes for agreement.

Off-Payroll Engagements

The Trust only utilises the use of off-payroll arrangements where there are specific and immediate shortages or specific skill requirements that it cannot fulfil from the substantive workforce. By their nature, these arrangements are of a short, definitive period with clearly defined objectives and outcomes. In all circumstances the Trust complies with HM Revenue and Customs and NHS England rules and procedures.

Table 1: Highly paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater

T1.0	Number of existing engagements as of 31 March 2025	4
	Of which...	
T1.1	No. existed for less than one year at time of reporting	3
T1.2	No. existed for between one and two years at time of report	0
T1.3	No. existed for between two and three years at time of reporting	1
T1.4	No. existed for between three and four years at time of reporting	0
T1.5	No. existed for four or more years at time of reporting	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater

T2.0	Number of off-payroll workers engaged during the year ended 31 March 2025	14
	Of which:	
T2.1	Not subject to off-payroll legislation *	9 - self employed
T2.2	Subject to off-payroll legislation and determined as in-scope of IR35 *	0 Inside IR35
T2.3	Subject to off-payroll legislation and determined as out of-scope of IR35 *	5 Outside IR35
T2.4	Number of engagements reassessed for compliance / assurance purposes during the year	9 Reviewed
T2.5	Of which: number of engagements that saw a change to IR35 status following the review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0

Staff consultations and communication

The Trust has a range of mechanisms to involve staff in making decisions about future developments. This includes the annual NHS staff survey, the quarterly Pulse Survey, departmental feedback mechanisms, and staff networks. Performance updates are regularly communicated to encourage staff involvement in helping the Trust achieve its objectives. Our staff Governors also have an active role in staff communication and consultation and staff receive regular briefings on key issues via the intranet.

The Trust's Organisational Change Policy seeks to ensure the management and implementation of change in a way that is sensitive, constructive, and fair for all staff. The policy prioritises minimal disruption, engaging both staff and staff-side representation throughout the process through meaningful consultation and ensuring everyone understands the reasons for change. Core principles for all change are openness and transparency, ensuring the change is communicated clearly and openly to all affected staff.

Exit Packages

Any redundancy and other departing costs have been paid in accordance with the provisions of Agenda for Change. Ill health retirement costs are met by the NHS Pension Scheme and are not included.

Exit package cost band	Number of compulsory redundancies 2024/2025	Other agreed departures 2024/2025	Total exit packages 2024/2025
<£10,000	-	1	1
£10,000 – £25,000	-	1	1
£25,001 – £50,000	-	-	-
£50,001 – £100,000	-	-	-
£100,001 – £150,000	-	-	-
£150,001 – £200,000	-	-	-
Total number of exit packages	-	2	2
Total resource cost	-	£19,109.44	£19,109.44

Other non-compulsory departure payments

	Payments agreed 2024/2025	Total value of agreements 2024/2025
Voluntary redundancies including early retirement costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirement in the efficiency of the service contractual costs		
Contractual payments in lieu of notice		
Exit payments following employment tribunals or court orders	2	£25,000
Non-contractual payments requiring HMT approval (special severance payments)	1	£6,999
Total	3	£31,999
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary		

Partnership working with Trade Unions and Facility Time

Release time (based on membership numbers) from role is made available to representatives from the larger unions to enable them to fulfil their role in the partnership working processes within the Trust.

The following Trade Unions are allocated facilities time under the Trusts Facilities Agreement:

Trade Union	Facilities Time Per Month (days)
British Dietetic Association	1.0
British Orthoptic Society	1.0
Chartered Society of Physiotherapists	1.0
Royal College of Midwives	2.0
Royal College of Nursing	5.5
Society of Radiographers	1.0
Unison	4.5
Unite	3.0

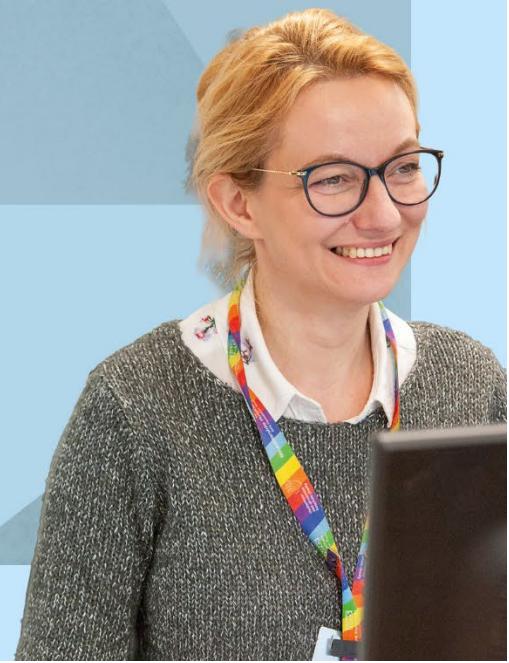
In addition to the above, the position of Staff Side chair is an elected secondment position, reviewed biannually. The pay of the post will equate to the earnings the employee would otherwise have received had he/she been at work, including any allowances and enhancements.

The total annual gross salary costs for Trust staff who are accredited representatives, and who have facilities time in accordance with the Trust Agreement is £105,588.06.

This includes the salary for the position of Staff Side Chair.

Accountability report:

Code of governance



The Code of Governance for NHS Provider Trusts (the Code) was published in October 2022 and has been applicable since 1 April 2023. It sets out a common overarching framework for the corporate governance of NHS providers (being NHS trusts and NHS foundation trusts) on a comply or explain basis, reflecting developments in UK corporate governance and the development of integrated care systems.

Disclosures are made throughout the Annual Report as required by the Code and NHS England's Foundation Trust Annual Reporting Manual.

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving standards of corporate governance and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life. The Code is implemented through key governance documents and policies, including:

- The Constitution (to be refreshed in 2025/2026)
- Standing Orders and Standing Financial Instructions
- Schedule of Reserved Matters
- Annual Plan
- Board Committee Structure

Trust Board

The Board is responsible for strategic oversight and management of the Trust, with a view to maximise success for the benefit of members and the public as a whole.

The Board comprises Non-Executive Directors and Executive Directors, as detailed in the Directors' Report.

Meetings and attendance throughout the year

The number of meetings of the Trust Board in public and individual members' attendance for 2024/2025 is detailed below.

Member	Role	Meetings held	Meetings attended
Deborah Evans	Chair	6	6
Vareta Bryan	Non-Executive Director	6	4
John Cappock	Non-Executive Director	6	6
Sam Foster	Non-Executive Director	6	6
Marie-Annick Gournet	Non-Executive Director	6	5
Balvinder Heran	Non-Executive Director	6	5
Jaki Meekings-Davis	Non-Executive Director	6	5
Mike Napier	Non-Executive Director	6	6
Kaye Law-Fox	Associate Non-Executive Director/ Chair, GMS	6	6
Sally Moyle	Associate Non-Executive Director	6	6
Kevin McNamara	Chief Executive	6	5
Will Cleary-Gray (commenced September 2024)	Director of Improvement and Delivery	3	3
Matt Holdaway	Chief Nurse, Director of Quality	6	6
Karen Johnson	Director of Finance	6	6
Mark Pietroni	Medical Director, Director of Safety and Deputy Chief Executive	6	6

Claire Radley	Director for People and Organisational Development	6	4
Al Sheward	Chief Operating Officer	6	6
Lee Pester (commenced March 2025)	Chief Digital and Information Officer	1	1
Kerry Rogers (commenced end April 2024)	Director of Integrated Governance	6	6
Helen Ainsbury (interim until February 2025)	Interim Chief Digital and Information Officer	5	4
Ian Quinnell (interim until August 2024)	Interim Director of Improvement and Strategy	3	3

Balance and completeness of the Board of Directors

The Executive and Non-Executive Directors of the Board provide a balance and breadth of knowledge, experience and skills. The Executive Directors have at a senior level considerable NHS experience in a range of areas including finance, medicine, nursing, strategic and operational planning, corporate governance, research and workforce development. Their expertise is complemented by the Non-Executive Directors who have extensive private and public sector experience in clinical practice, business, commerce, banking, accounting, audit, research, management and leadership, marketing, NHS service provision, health care and social policy, and local enterprise.

The Governance and Nominations Committee and the Appointments and Remuneration Committee, referred to below, consider the balance and breadth of knowledge, experience and skills required on the Board at each appointment and reappointment of directors and have ensured the maintenance of a balanced and complete Board throughout the year.

Board Committees

The Board's committee structure is comprised of:

- Statutory Committees
 - Appointments and Remuneration Committee
 - Audit and Assurance Committee
- Non-Statutory oversight and assurance committees
 - Finance and Resources Committee
 - People and Organisational Development Committee
 - Quality and Performance Committee

A summary of the role of each Board Committee is provided below and the number of committee meetings and individuals' attendance are also provided.

Appointments and Remuneration Committee

The role of the Remuneration Committee in setting senior managers' remuneration is detailed in the remuneration report, along with its meetings and attendance in 2024-25. In addition, the Committee is responsible for reviewing the performance and succession planning of the Chief Executive Officer and Executive Directors.

Audit and Assurance Committee

The Audit Committee is responsible for reviewing the adequacy of the governance, risk management, and internal control processes within the Trust, as described in the annual governance statement. The Committee also reviews and approves the annual external audit, internal audit, and counter fraud work plans, financial reporting and control arrangements, risk management processes, and the Trust's Annual Report and Accounts

Member		Meetings held	Meetings attended
John Cappock (Chair)	Non-Executive Director	5	5
Vareta Bryan	Non-Executive Director	5	4
Marie-Annick Gournet	Non-Executive Director	5	4
Jaki Meekings-Davis	Non-Executive Director	5	5
Karen Johnson	Director of Finance	5	5
Kerry Rogers	Director of Integrated Governance	5	4

Finance and Resource Committee

The Committee considers annual financial plans, financial and operational performance, and delivery and effectiveness of transformation programmes, and has delegated authority for recommending or approving major business cases in accordance with the Trust's standing financial instructions.

Members	Meetings held	Meetings held	Meetings attended
Jaki Meekings-Davis (Chair)	Non-Executive Director	12	11
Balvinder Heran	Non-Executive Director	12	6
Mike Napier	Non-Executive Director	12	10
Karen Johnson	Director of Finance	12	12
Ian Quinnell	Interim Director of Strategy and Transformation (interim appointment ended August 2024)	12(7)	7
Helen Ainsbury	Interim Chief Digital and Information Officer	12	8
Al Sheward	Chief Operating Officer	12	11
Mark Pietroni	Medical Director and Director of Safety	12	4
Kerry Rogers	Director of Integrated Governance	10	9

People and Organisational Development Committee

The Committee provides assurance to the Board that the People Strategy supports the corporate aims of the Trust and that key People, Workforce and Equality, Diversity and Inclusion strategies are being delivered. It provides the Board with assurance that risks associated with attraction, retention, and all workforce and people issues have been identified and appropriately controlled.

Member		Meetings held	Meetings attended
Balvinder Heran (Chair)	Non-Executive Director	6	5
Vareta Bryan	Non-Executive Director	6	5
Marie-Annick Gournet	Non-Executive Director	6	4
John Cappock	Non-Executive Director	2	2
Claire Radley	Director for People and OD	6	6
Matt Holdaway*	Chief Nurse and Director of Quality	6	2
Mark Pietroni*	Medical Director and Director of Safety	6	0
Karen Johnson*	Director of Finance	6	0
Al Sheward*	Chief Operating Officer	6	0
Kerry Rogers	Director of Integrated Governance (joined Trust 29 April 2024)	5	4

Attendance as required for specific reports *

Quality and performance committee

The Committee provides assurance to the Board that there are adequate controls in place to ensure high quality and safe care is provided to the patients using the services provided by the Trust and that risks to the quality of clinical care and to the safety of the Trust's staff, patients, their families, and visitors have been identified and appropriately controlled.

The Committee oversees the delivery of the Trust's key quality and safety strategies.

Member		Meetings held	Meetings attended
Sam Foster (Chair)	Non-Executive Director	10	9
Mike Napier (vice Chair from January 2025)	Non-Executive Director	3	3
Vareta Bryan	Non-Executive Director	10	10
Kevin McNamara	Chief Executive	10	7
Matt Holdaway	Chief Nurse and Director of Quality	10	7
Mark Pietroni	Medical Director and Director of Safety	10	7
Al Sheward	Chief Operating Officer	10	9
Kerry Rogers	Director of Integrated Governance	9	8

The Council of Governors' role is to hold Non-Executive Directors to account for the performance of the Board of Directors and influence the strategic direction of the Trust to ensure it reflects the views and needs of our members, the local community, and key stakeholders.

Key decisions taken by the Council of Governors include:

- Appointing or removing the Chair, Non-Executive Directors, and Chief Executive Officer.
- Determining the remuneration and other terms and conditions of office of the Chair and Non-Executive Directors
- Appointing or removing the Trust's external auditor
- Approving significant transactions

- Approving any changes to the Trust's Constitution.

Governors are encouraged to canvass opinions and concerns of the members they represent at a series of public constituency meetings (promoted as 'health events'), particularly on the Trust's plans, priorities, and strategies. They also canvass opinion at other Trust events, both formal and informal, and via their own initiatives and networks. Governors' and members' views are fed back to the Board at quarterly Council of Governors meetings and at other meetings with Directors, or directly, via the Chair or individual communications as appropriate.

Members can contact their respective governor using the [contact a governor form](#) which is available on the website and is promoted to members through bulletins and other communications they receive.

The link forwards a message to an inbox which is managed by the Office of the Director of Integrated Governance, with communications shared with the relevant governor and/or service to provide a response.

Members can also contact their governor by writing to the Director of Integrated Governance and to the Company Secretary at Gloucestershire Hospitals NHS Foundation Trust, Trust Headquarters, Sandford Road, Alexandra House, Cheltenham, GL53 7AN.

General Council meetings are open to the public and details are published on the website together with the papers and minutes of the meetings.

The Council of Governors is comprised of Public Governors (elected), Staff Governors (elected), and Stakeholder Governors (appointed).

In accordance with the Code, and the Trust's Constitution, Governors may be elected or appointed for a maximum of three consecutive terms of three years (total nine years). The composition of our Council of Governors is set out in the table below.

The lead Governor for 2024/2025 was Andrea Holder.

Constituency	Governor	Tenure	Meeting Attendance	
			Council of Governors	Governance and Nominations Committee
Public Governors				
Gloucester City Council Area	Emma Mawby	Apr 2024 – Sept 2026	4/5	-
	Fiona Hodder	Oct 2022 – Oct 2025	4/5	-
Cheltenham Borough Council Area	Mike Ellis	Oct 2021 – Oct 2024 Oct 2024 – Oct 2027	5/5	3/3
	Peter Mitchener	Oct 2022 – Oct 2025	5/5	3/3
Cotswold District Council Area	Bryony Armstrong	Sept 2023 – Sept 2026	2/5	-
	Douglas Butler	April 2024 – Sep 2026	5/5	-
Forest of Dean District Council Area	Matt Bishop	Sept 2023 – Sept 2026 <i>Resigned October 2024</i>	1/3	-
	Susan Mountcastle	April 2024 – Sept 2026	1/5	-
Stroud District Council Area	Deborah Balkwill	Oct 2024 – Oct 2027	2/2	-
	Pat Eagle	Oct 2016 – Oct 2019	2/5	-

		Oct 2019 – Oct 2022 Oct 2022 – Oct 2025		
Tewkesbury Borough Council Area	Ian Craw	April 2024 – Sep 2026	4/5	-
	Andrea Holder (lead governor)	Oct 2021 – Oct 2024 Oct 2024 – Oct 2027	3/5	3/3
Staff Governors				
Allied Healthcare Professionals	Samantha Bostock	April 2024 – Sep 2026	5/5	-
Medical/Dental Staff	Russell Peek	Oct 2020 – Oct 2023	2/5	-
Nursing/Midwifery Staff	Bilgy Laurence Pellissery	Oct 2023 – Oct 2026	1/5	-
	Asma Pandor Elected mid-term	Oct 2022 – Oct 2025	4/5	-
Other/Non-Clinical Staff	Oliver Warner	Oct 2023 – Oct 2026 (resigned)	4/5	0/3
Appointed / Stakeholder Governors				
Gloucestershire County Council	Matt Babbage	Sept 2019 – Sep 2022 Sept 2022 – Sept 2025	3/5	-
Healthwatch	Maggie Powell	Sep 2017 – Sep 2020	3/3	0/1

		Sept 2020 – Sept 2023 Sept 2023 – Sept 2026 <i>Resigned Sept 2024</i>		
	Amanda Naylor	Sept 2024 – Sept 2027	2/2	-
Age UK Gloucestershire	Helen Bown	Oct 2023 – Oct 2026	4/5	-
VACANCY				

Governance and Nominations Committee

The Governance and Nominations Committee is responsible for assessing the Board's structure, size, composition, and performance, identifying and nominating Non-Executive Directors for appointment to the Trust Board, and reviewing Non-Executive Directors' remuneration. The Nominations Committee considers any new non-executive appointments as necessary. The Committee's duties include consideration of equality, diversity and inclusion issues as and when required, to ensure that diversity of the Board reflects diversity of the Trust's workforce and wider membership.

Where a Non-Executive Director vacancy is identified, the Governance and Nominations Committee meets to agree the vacancy role profile, person specification, and recruitment process. The vacancy is then advertised, supported by Trust HR and external recruitment agencies where required. The Committee then shortlist and its members are involved in the interview of potential candidates, taking the views of stakeholders into account. Following interviews, the Governance and Nominations Committee recommends their selected candidate to the Council of Governors for appointment.

During the period of this annual report, the Governance and Nominations Committee had oversight of the appointment of two non-executive directors to succeed two whose terms expired in 2025/26. It also recommended to the Council of Governors those appointments and the reappointment of the Chair for a second term of three years. Finally, the Committee recommended for appointment two associate non-executive directors whose terms commenced on 1st May 2025.

Relationship with the Board

All Board members are invited to attend Council of Governors' meetings in order to gain an understanding of the views of the Trust's Governors and members. The Council of Governors may require individual Directors to attend for the purpose of providing assurance or to report on progress of any key matters of interest, in accordance with Schedule 7 of the National Health Service Act 2006.

The Board reports to the Council of Governors on the performance of the Trust and its progress against agreed strategic and corporate objectives and consults on its forward plan.

In the event of a dispute or disagreement between the Council of Governors and Board of Directors, in the first instance the Chair would endeavour to resolve this. Should a resolution not be reached, then a disputes resolution process would be engaged, as described in the Trust's Constitution. An Engagement Policy has been proposed and shared with the Governance Working Group and consultation will conclude in early to mid-2025/2026.

The Council of Governors' process for appointing the Chair and Non-Executive Directors is detailed in the Trust's Constitution and supported by the work of the Governance and Nominations Committee.

Governance Working Group

The Governance Working Group is a forum consisting of governors and board members, including the Chair and Director of Integrated Governance, responsible for the review of the Trust's Constitution and periodic review of other governance matters as required, and recommending changes or required action for agreement by the Board and Council of Governors. It also considers ways in which to encourage engagement with and of the wider community. It provides a focus on issues relating to both the quality and staff agenda. The Working Group will be consulted on the proposed redrafting of the Trust's constitution during early 2025/2026 following initial discussions taking place during 2024-2025 as to the need to substantially update the same.

Decision-making framework

The Trust's Constitution contains a schedule of decisions reserved for the Board, Council of Governors, Committees, individual Directors, and other individuals with delegated authority. More detail is provided in the Board's Reservation of Powers and Scheme of Delegation, and individual committee Terms of Reference. All documents relating to the Trust's decision-making framework are reviewed at public meetings of the Board or Council of Governors and are available on the Trust's website.

External Audit

The Trust's external auditor is currently Deloitte. They were initially appointed by the Council of Governors in 2021, and in 2024 were re-appointed for three years, approved by the Council of Governors, with an option to extend this by a further two 12-month periods up to a maximum contract term of five years.

The Audit and Assurance Committee normally undertakes an annual review of effectiveness of the external auditor, considering the Code and HFMA guidance, and including an assessment of their independence. This is reported to the Board and Council of Governors for discussion and assurance. This is next scheduled for September 2025 following the renewal of the contract in September 2024.

No non-audit services were undertaken by Deloitte in the year 2024-25.

Internal Audit

The Trust's internal audit function is provided through a contract with an independent provider of internal audit services, BDO United Kingdom. In September 2024, the Trust, alongside other Integrated Care System partner organisations, exercised an option to extend the contract for a period of two years. The role of the internal auditor is to provide independent, objective assurance on the risk management, control, and governance processes within the Trust, through a systemic approach to evaluation and improvement of such processes. The internal audit team agrees a programme of work with the Audit and Assurance Committee and provides reports to the Committee during the year.

Compliance with the Code of Governance:

The Trust has applied the principles of the Code of Governance on a 'comply or explain' basis

Providers are required to comply with each of the provisions of the Code or, where appropriate, explain in each case why the Provider has departed from the Code.

Whilst the Trust believes it remains compliant with the majority of the provisions of the Code it is recognised there are areas where the Trust needs to strengthen compliance. The following provisions are highlighted in order to explain the areas we feel there is further work to undertake in order to evidence full compliance.

Appendix A: Provision 2.10

The Trust has identified that, whilst a Register of Board members interests has been collated and published it has not published a Register of interests for 'decision making staff' in accordance with the relevant NHS England Guidance. The policy is being redrafted and a Trust-wide conflicts of interests' process will be undertaken during Quarter 1 2025/2026. A register of Board members interests is maintained and published. The

published register of Council of Governor's interests was not refreshed during 2024-2025 but is being reviewed and updated in May 2025.

Appendix C: Provision 5.6

The Trust has identified opportunities to reinstate a more focused training and development programme for governors. All governors received a welcome and introduction/induction session on appointment along with a copy of the governor handbook and code of conduct. Meetings with the Chair, Chief Executive and Director of Integrated Governance along with a bespoke induction session for new governors in the period of this report have emphasised the statutory role.

Appendix B: Provision 2.6

The Trust will develop a policy to facilitate engagement between governors and the Board of Directors, particularly regarding board performance, compliance with the provider licence, and the overall wellbeing of the NHS foundation trust and its collaboration with system partners. A policy has been developed but consultation via the Governors Working Group continue into 2025/2026 with an anticipated agreed implementation date of June/July 2025.

Appendix A, Section C, Provisions 2.9, 4.4, 4.8 Appendix B, Provisions 2.1 and 2.2

With the support of the Council of Governors the Trust will undertake a review of its Constitution. This review will consider the size and composition of the Council of Governors, the frequency of meetings of the Council of Governors and arrangements for the scheduling of governor elections. This review commenced in March 2025 and continues, in consultation with the Governors' Working Group, into 2025/2026.

Accountability report:

Statement of Accounting Officer's responsibilities



Statement of the Chief Executive's responsibilities as the accounting officer of Gloucestershire Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Gloucestershire Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Gloucestershire Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

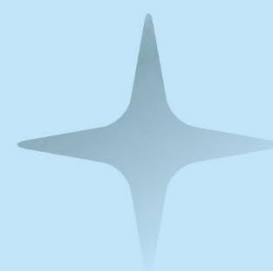
A handwritten signature in black ink that reads "K. McNamara." followed by a long horizontal flourish.

Kevin McNamara
Chief Executive

Date: 26 June 2025

Accountability report:

NHS oversight framework



NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
- additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

The segment in which the Trust has been placed by NHS England is segment 3. This remains unaltered from 2023/2024.

This segmentation information is the trust's position as at the end of March 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/>.

Accountability report:

Annual governance statement



Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Gloucestershire Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Gloucestershire Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our risk capacity is a measure of how much risk our organisation can take on without potential losses causing irreparable harm to our goals. It is determined primarily by three factors: timeframe for goals, the size of an investment relative to future rewards, and the amount and reliability of income from other sources to support loss.

Leadership

The Board of Directors has overall responsibility for risk management. This includes the identification and effective management of emerging and principal risks to the achievement of the Trust's strategic objectives. The Board is supported in this by a board committee structure and governance processes. These strategic risks are captured on and managed through the Board Assurance Framework (BAF).

As Accounting Officer, I ensure that sufficient resources are invested in managing risk. I am supported in this role by the Director of Integrated Governance who is the Executive Lead for governance and risk management. The Medical Director chairs the Risk Management Group. My executive director colleagues all share the responsibility, as a unitary Board, for the identification, assessment and management of risks within their portfolios and contribute and regularly report to the Board via the Board Assurance Framework mechanism. The Board is also supported in the management of risks by the Divisional Senior Management teams; consisting of a Chief of Service, Divisional

Operations Director and Divisional Director of Quality and Nursing with all Divisions regularly reviewing and managing operational risks relevant to the strategic risks.

Our Non-Executive Directors, as both Chairs and members of board committees, receive regular updates on both operational and strategic risks via committee level reviews of risk. Operational and clinical risks are regularly reviewed, to consider escalation to the Trust Risk Register, by the Risk Management Group, chaired by our Medical Director, who is also the Trust's Director for Safety. The Risk Management Group in turn reports to the Audit and Assurance Committee, chaired by a Non-Executive Director.

Recognising the significance of information governance, I am supported by both the Medical Director, as Caldicott Guardian, and our Chief Digital Information Officer, who hold responsibility for the correct use of patient identifiable information and protecting the confidentiality of patient's health information. Our Chief Digital Officer, as the Trust's Senior Information Risk Owner, is responsible for all information risks within the Trust. Both of these individuals have undertaken the necessary training to discharge their responsibilities effectively.

Training of staff to manage risk

The identification and subsequent assessment and management of risk is the responsibility of all staff, from ward to board. The Trust's mandatory training programme which forms part of the staff induction, attended also by new members to the Board includes responsibilities and processes relating to risk and health and safety management. Due to a number of changes on the Board of Directors and an impending next phase Strategy, there is recognition that there is an opportunity to refresh training to Board members and senior managers in the management of strategic risks and how these risks are informed by corporate and clinical risks. It has been determined that this training will be provided during 2025-2026 in conjunction with the development of the new Trust strategy and strategic objectives alongside specialist training on risk appetite and a refreshed Board Assurance Framework. Divisional staff receive training on operational risk management. The requirement to identify, assess and control risk is part of the Trust's mandatory staff induction programme and provides an introduction to risk management for all staff. Compliance with mandatory training is reported through workforce performance data in the Integrated Performance Report to Board and its relevant committees and operationally, via the monthly and quarterly Executive Review programme.

The Risk, Health and Safety Team are responsible for facilitating risk management processes across the Trust. Our staff are supported to manage risk based on their responsibilities, through the Trust's Risk Management Framework and further guidance including intranet resources, updates and divisional governance meetings and are supported by our Risk, Health and Safety team, who provide advice and support to staff on all aspects of risk management. It is recognised that this team has carried a number of vacancies during the year which has impacted on the support available to staff but A number of risk register management training provisions are provided to all staff who have a responsibility for operational risk management, including face to face training, online

modules, the Risk Register Guide and risk management resources provided on the intranet. The risk register course contains:

- Risk appetite and risk tolerance
- The difference between a risk and an issue
- Risk registers
- Inherent risks, cause and effect
- Controls and gaps in controls
- Risk categories and risk rating (initial, current and target)
- Risk assurance methods
- Escalating a risk and downgrading a risk
- Reviewing risks

In 2024-2025, 120 divisional staff completed risk management training.

An additional training course is offered to all staff who have a responsibility to carry out health and safety risk assessments. The risk assessment course includes:

- Risk assessment process – 5 steps
- Definition of a hazard, types of hazards and how to identify them
- Definition of risk
- Identifying people at risk and potential harm
- The hierarchy of controls, reducing risk to as low as reasonably practicable
- Risk rating
- Risk review

The Risk Register Guide is a document that contains step by step directions on raising a risk, scoring, evidencing, managing and reviewing the risk and how to escalate the risk on our registers. The Risk Management Framework sets out the governance process around risk also.

The risk and control framework

Risk Management Strategy

The Trust's risk management strategy supports the delivery of the Trust's strategy and determines how risks arising from our activities are identified, assessed and managed. It should be considered alongside enabling strategies such as the people, clinical and estates related strategies.

The Trust's risk appetite is set by the Board with the goal of aligning risk-taking with strategy, statutory and regulatory requirements and necessary clinical quality, safety and financial planning drivers. The Board recognises the importance of a consistent approach to avoid erratic risk taking or an overly cautious approach which may inhibit growth and opportunity for innovation. The current risk appetite was set in 2023, with an annual review due during 2024 at which point a decision was made to maintain the current risk appetite, recognising the new Trust Strategy would be published during summer 2025. A review will

then be undertaken to align both strategic risks and the Board's risk appetite with the objectives within the Strategy.

The Risk, Health and Safety team are responsible for facilitating risk management processes across the Trust, providing specialist advice and support to staff to identify, assess, record and manage risks in accordance with the risk management policy. This work, supporting divisional colleagues, informs the review and management of the Trust's strategic risks as set out within the Board Assurance Framework.

The identification and management of risk is a responsibility for all staff and this is achieved through the use of the Datix risk management system, local, divisional and corporate risk registers and the regular review of the latter. Each risk is assessed and scored, based on both consequence and likelihood of realisation with an initial score and a target tolerable score aligned to the Trust's risk appetite. This, in turn, informs the prioritisation of resource within the Trust and the proper ownership of the risk, with the aim to achieve a tolerable level of risk. The route of escalation for the management of risks commences with the individual risk managers, through the speciality and divisional structures to both executive management groups and Board assurance committees, as appropriate.

Board Assurance Framework

The Board is responsible for the identification, assessment and monitoring of the strategic risks via the Board Assurance Framework mechanism, with regular reports to Board and Board committees. Board Committees scrutinise risks relating to their areas of oversight and risk domains throughout the year as follows:

- Quality and Performance Committee: Oversight of patient safety, quality, reputation and statutory risks.
- People and Organisational Development Committee: Oversight of workforce, equality, diversity and inclusion, and health and safety.
- Finance and Resources Committee: Oversight of finance and business, digital, cyber and data security, and risks relating to estates and facilities, and the subsidiary company Gloucestershire Managed Services (GMS).
- Audit and Assurance Committee: Responsible for scrutinising the overall systems of internal control and for ensuring the provision of effective independent assurance via internal audit, external audit and local counter fraud services. The role of the Committee is to seek assurance on the current controls and mitigation plans.

The Board Assurance Framework acts as the Trust's primary mechanism for ensuring that the Board receives assurance that the Trust is actively pursuing its corporate objectives and the risks to these objectives are being treated and mitigated. It enables the Board to understand the risks which have the potential to impact on the organisational strategic objectives and how these are being managed.

The risks identified in the Board Assurance Framework cover the full range of strategic objectives and include consideration of present risks, future risks, risks arising from within

the organisation and risks occurring as a result of external pressures and changes. Executive Directors, with their senior teams, regularly review the content of the Strategic Risks within their portfolio with a wider consideration of the full Framework at both Board and Audit and Assurance Committee meetings. It is considered timely that on finalisation of the next phase of the Trust's strategy, a strategic review of the Board Assurance Framework and the associated risk appetite will take place in 2025/26.

An overview of the Trust's strategic (principal) risks is provided below:

Strategic Risk	Key controls applied in 2024-25
Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	<ul style="list-style-type: none"> ▪ Range of work programmes to support with managing demand internally and with system partners. (ECIST RIO) ▪ Trust Flow and Escalation Policies currently under review. ▪ Centralisation of Medical Take, establishment of SDEC and Assessment units in most Divisions. Direct Access Pathways initiated and under continuous review ▪ Urgent Emergency Care and Flow Improvement Board established and Chaired by GHFT Deputy Chief Operating Officer ▪ Clinical Vision of Flow Programme established and operational
Failure to successfully implement the quality governance framework	<ul style="list-style-type: none"> ▪ Trust Risk Register Report to Board ▪ Quality and Performance Report (QPR) to Board - Key Issues and Assurance Report (KIAR) ▪ Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted ▪ Implementation of Integrated Performance Report ▪ Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) ▪ Urgent and Emergency Care Board ▪ Monitoring of performance, access and quality metrics via Quality and Performance Report ▪ Revised process for complaints ▪ Inspection and review by external bodies (including CQC inspections) reported through the Regulatory Report ▪ Quality Strategy (insight, involve, improve) ▪ Risk Management processes ▪ Quality priorities and reporting through Quality Account

	<ul style="list-style-type: none"> ▪ Improvement programmes ▪ Development and implementation of Operational and Winter ▪ Annual Reports to Quality and Performance Committee and Board, as appropriate, for key programmes (complaints, FTSU, equality, safeguarding, infection prevention and control)
Culture Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve	<ul style="list-style-type: none"> ▪ Staff Experience Improvement Programme: ▪ Leadership and Team Working ▪ Anti – Discrimination ▪ Raising Concerns and Speaking Up ▪ Taskforce ▪ Colleague Communications and Engagement ▪ Restorative Just principles and practice, four steps approach and people polices and processes ▪ Divisional colleague engagement plans ▪ EDI Development Plan – specific work with the Divisions ▪ Steering Groups ▪ Health and Wellbeing Steering Group ▪ EDI Steering Group ▪ ELD Steering Group ▪ Local Mandatory Training Oversight Steering Group ▪ People Promise Partner and Safe Learning Environment Partner appointed (FT) ▪ Addressing HCSW remuneration T&Cs
Recruitment and Retention Inability to attract a skilful, compassionate workforce that is representative of the communities we serve	<ul style="list-style-type: none"> ▪ International recruitment pipeline ▪ UK RN graduate cohorts ▪ Increased apprenticeships, TNA Cohorts and student placement capacity ▪ Induction pilot of cohorts for HCA/HCSW ▪ Advanced Care and other alternative speciality roles ▪ Accreditation of Preceptorship module ▪ Annual workforce Operational Plan submission to NHSE, integrated with the ICS ▪ Wide-reaching Workforce Sustainability Programme

<p>Failure to implement effective improvement approaches as a core part of change management</p>	<ul style="list-style-type: none"> ▪ Quality and Performance Committee Report to Board ▪ Strategy and Transformation Board Report to Board ▪ PSIRF implementation that requires a prioritised approach
<p>Individual organisational priorities and resources are not aligned to deliver integrated care</p>	<ul style="list-style-type: none"> ▪ System wide development and agreement of Operational Plan (2024/25) ▪ Systemwide STRATEGIC and TACTICAL escalation Groups (SEG, TEG) established as BAU ▪ System Quality and Performance Committee oversees progress of improvement plans in areas of significant concern. ▪ Delivery Group exception reporting (Maternity, Quality, Unscheduled Care, Planned Care and Cancer) ▪ Urgent and Emergency Care (UEC) boards at System and Acute Provider level ▪ Monitoring of key performance metrics via Quality and Performance Report (QPR) GHFT ▪ Quality Strategy, Risk Management and Executive Review processes in place as BAU ▪ Efficiency Board in place ▪ Key issues and assurance reporting (KIAR) ▪ ICB attendance at Q&P Committee ▪ Triumvirates in place for the Operational/Clinical Divisions ▪ Continued delivery of Estate Strategy on both GRH and CGH
<p>Failure to deliver recurrent financial sustainability</p>	<ul style="list-style-type: none"> ▪ Communication out into the organisation from CEO regarding the financial position – clearly articulating the why and what we need to focus on during the financial year ▪ Workplan to look at developing a timeframe around engagement on the long-term operational and financial plan. ▪ The national grip and control assurance checklist is being reviewed and actions identified where gaps appear with a tracker to capture progress. ▪ A Trust wide non pay oversight group has been established which looks at in year issues and year on

	<p>year changes to identify areas of opportunity for each division.</p> <ul style="list-style-type: none"> ▪ Understanding the drivers of the deficit – an exercise has been completed in December to understand the drivers which will be used to help explain the organisational position and to seek areas of opportunity. ▪ Quarterly exec reviews to focus on forward planning, not the here and now. This will need to evolve into longer term planning. ▪ Corporate executive review to ensure all areas are held to account in terms of delivery of the Financial Sustainability Programme. Managed through the Accountability Framework. Extended meetings to ensure financial sustainability has the right level of discussion. ▪ Financial Sustainability Programme targets are communicated to divisions and corporate areas. The savings programme is developed through engagement with divisional Boards and by using tools such as benchmarking, drivers of the deficit and productivity opportunities. These targets are then reviewed and where material gaps are identified divisions are required to present to the Finance and Resources Committee to provide assurance on how the gaps will be addressed. ▪ Senior representation of the Trust at System transformational programmes through a portfolio structure. This focuses on end-to-end pathway redesign to drive out duplication and reduce cost. ▪ Regular reporting to the System governance process to provide further oversight. ▪ To test whether the Trust has the right capability to develop a medium to long term plan and if not what's the gap and how will the Trust close this gap down
<p>Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an</p>	<ul style="list-style-type: none"> ▪ Trust Board and ICB sighted on the scale of GHFT estates backlog and Critical Infrastructure Risk ▪ All NHSE/I capital bids include costs of address backlog maintenance risks in immediate and/or linked development areas ▪ Improved risk reporting of estates risks through GMS, RMG, Committee, Board and ICS

<p>environment that colleagues are proud to work in.</p> <p>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</p>	<ul style="list-style-type: none"> ▪ Transition to develop 5-year estates capital programme to provide assurance and timescale of when highest risks will be addressed ▪ Exploring options to dispose of estate with capital receipt used to address backlog risks (whilst assessing the IFR16 implications on leased accommodation) ▪ Developing 'library' of GHFT and ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes ▪ Improved awareness across ICS partners of level of risk GHFT is carrying across estate and equipment via monthly meetings taking place.
<p>Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040</p>	<ul style="list-style-type: none"> ▪ All new strategic estate schemes designed to meet BREEAM good (refurb) or excellent (new build) ratings ▪ Continue to pursue external grant funding (Public Sector Decarbonisation Scheme – PSDS) to retrofit existing buildings and migrate energy supplies away from fossil fuels ▪ Invest in GHFT electrical infrastructure to support transition to Hybrid and Electric Vehicles (EV) for i) GHFT/ ICS fleet ii) visitors and colleagues ▪ Board approved Green Plan and supporting governance structure: Executive Lead, Green Champions, Green Council, Climate Emergency Leadership Group reporting into F&R Committee ▪ ICS Sustainability Group established to oversee delivery of ICS Green Plan (Statutory requirement).
<p>Failure to detect and control risks to cyber security</p>	<ul style="list-style-type: none"> ▪ ICS Cyber strategy 2025-2030 approved across the Integrated Care System. Early priorities have been identified and are currently being implemented, supported by a developing action plan and a risk framework. A Digital Cyber and Infrastructure programme is in place to support the delivery of this Strategy, with governance established at both project and programme levels. ▪ Cyber Security action plan in place, reviewed annually and gaps in security and investment identified ▪ Monitoring systems in place and dedicated cyber security team

	<ul style="list-style-type: none"> ▪ Backup systems and disaster recovery in place and regularly updated ▪ Cyber security delivery workstreams – monitoring safety and access ▪ Investment in cyber tools and software ▪ Regular phishing tests and firewall tests (planned system hacks) ▪ Regular security updates and patches
Inability to optimise digital systems functionality and progress as a digital Trust	<ul style="list-style-type: none"> ▪ Electronic Patient Record (Sunrise EPR) becomes single source of clinical information, wherever possible, removing the need for patient case notes in a number of settings. ▪ Data Warehouse providing one version of the truth supporting clinical and operational dashboards used for planning across the ICS. ▪ New digital governance structure in place across clinical divisions, and Trust oversight and prioritisation provided by Digital Delivery Group. ▪ Implementations must provide quantifiable benefits; financial, patient care and/or safety benefits – and reduce risk ▪ Optimisation of EPR for users as part of a continuous improvement, responding to clinical demand ▪ Ongoing work with Philips re. PACS to ensure improvements in stability and performance
Failure to invest in research active departments that deliver high quality care	<ul style="list-style-type: none"> ▪ Review of Research Office processes by new senior manager ▪ Research office working with interested clinical teams to support them

All of the Strategic Risks detailed above are continuously reviewed and overseen by the relevant Board committees. No additional strategic risks were identified during the year other a broad risk relating to the management of health and safety governance processes which will be entered on the Board Assurance Framework in 2025/2026.

Estates related risks have continued to be an area of focus and a more deliberate alignment to a Group assessment that better incorporates our subsidiary Health and Safety risks will strengthen our approach accordingly, but our attention to relevant management systems in areas such as asbestos, water safety and fire safety in particular have required dedicated attention to improvement and better control. Other key estate areas continue to be identified and addressed and with our ageing estate will no doubt

continue to be a key area of focus in the coming years strengthened through the development of a new Health and Safety Management Framework to support earlier identification of emerging risk.

During the year, there were no material inconsistencies between the Trust's assessment of key risks and either subsequent NHSE ratings or Care Quality assessments with aspects of the Board Assurance Framework being consistent with regulatory notices received in the previous year. The risks of not making the necessary improvement in maternity and urgent and emergency care services for instance and those posed by the constant challenges of demand and capacity management have been under regular scrutiny by members of the Board and as part of system approaches to improvement.

The Trust recognises that effective risk management relies on a range of contributions, and collaborative work is undertaken with many stakeholders to identify risks that may impact on them, including Gloucestershire Integrated Care System, local authorities, Healthwatch, associated charities, patients and carers. We encourage stakeholders to raise concerns or potential risks through engagement opportunities, our Council of Governors, complaints and enquiries, social media commentary, friends and family tests, patient stories delivered at Board, and patient experience surveys.

Embedding risk management within the organisation

Good practice and learning are shared within the organisation through a range of measures including impact assessments, business continuity plans, risk assessments, incident reporting, safety huddles, routine communications, training, meetings and de-brief sessions. The Trust has a strong culture of safety, aligned to the new national Patient Safety Incident Response Framework (PSIRF). Whilst the application of this Framework is in its infancy it is evident that it has improved the way in which the Trust, and the wider NHS, responds to patient safety incidents, focusing on learning and improvement. All staff are trained in incident reporting and are encouraged to report and assess all incidents through Datix, to take forward any learning or actions required. Incidents are reviewed on a daily basis through the incident response safety huddle, attended by senior clinicians and managers. Robust governance processes with clear routes of escalation are in place, from Ward to Board to ensure appropriate prioritisation of incidents and risks.

Quality governance arrangements

At the heart of the Trust's strategy and development is the ongoing improvement of the quality of services we provide for our local populations. Improving the quality of care and outcomes for patients drives the decisions taken by the Board of Directors and the systems established in the Trust. The role of the Quality Committee in leading quality oversight and improvement is set out earlier in this report. Each Executive Director has a clearly defined portfolio and is responsible, individually and collectively, for the quality and safety of services provided. The Board and Executive Team have regular development sessions to ensure they are aligned on their goals and their different roles are effective.

The Board and its committees have been supported by regular reporting against a range of key quality metrics that make up high quality, personalised and equitable care. The

reporting includes a bi-monthly integrated performance report with a range of quality, activity and workforce measures aligned to the objectives in the Trust's Strategy.

Board committees are able to delve into deeper detail. For instance, the Quality and Performance Committee receives regular reports such as the Quality Performance Report and an update regarding programmes of Quality Improvement (QI). The Audit Committee leads on the internal audit programme which helps to provide assurances on a range of key governance and control areas.

The Trust holds divisional performance reviews providing the opportunity for Executive Directors to review divisional performance against a range of metrics and hold management teams to account for performance. The reviews also assist divisions in identifying resources to tackle problem areas.

Care Quality Commission (CQC) registration requirements

The Trust continues to be registered with CQC and the overall Trust rating remains at 'Requires Improvement'. CQC 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

CQC inspected Maternity Services at the Gloucestershire Royal Hospital's site in March 2024. On 9 May 2024, the Trust was notified of CQC's decision to serve an enforcement notice under section 31 of the Health and Social Care Act. CQC 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 CQC 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 CQC 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, in January 2025 CQC published the final maternity service inspection report from the March 2024 inspection. The Maternity Service retained an inadequate rating received in 2022.

Also in January 2025, CQC published the Emergency Department report for the Gloucestershire Royal Hospital site from an unannounced inspection in December 2023. The service retained a “requires improvement” rating. To note the Trust received a section 29a warning notice from the CQC on 23 December 2023. This notice was then withdrawn and reissued by CQC on 5 January 2024 (due to an CQC administrative error). The warning notice required the Trust to make significant improvements within the Emergency Department for 3 issues. The Department needed to have an up-to-date fire plan; to be compliant with fire training targets; and to have all equipment in the department to be Portable Appliance Tested (PAT). The CQC expected the service to have made significant improvements by 22 January 2024.

On 29 April 2024, the Trust proactively invited the CQC onto site and showed CQC inspectors around the department and were able to demonstrate that significant improvements had been made in response to the notice. At this visit the CQC provided feedback that they were satisfied that progress had been made in response to the notice.

Inspection activity

There has been only one CQC inspection in medicine and oncology services at the Cheltenham General site in July 2024 and the service was rated as “good” overall).

Reported Never event

There has been one Never Event reported (March 2025) and CQC have access to this incident report via the new electronic reporting system (Learn from Patient Safety Events Service (LFPSE)). This incident relates to an incorrectly sized implant. The incorrect implant was detected prior to completing the procedure during (standard) check 4; “the scrub practitioner should check the retained implant boxes against the implants recorded on the scrub board to reconfirm that the correct prosthesis has been used, before the wound is closed”. The patient did not come to harm. Duty of Candour has been discharged and it is being investigated in accordance with Trust processes.

Health and Safety and Occupational Health

The Trust’s arrangements in relation to its Occupational H&S Management system are set out in its [Health and Safety Policy](#). This includes a statement of intent, roles and responsibilities and a broad outline of our arrangements for risk assessment, inspections, COSHH assessments, safety information and training, consultation, PPE, and first aid provisions. The Policy is underpinned by a suite of fourteen legislation-specific policies and procedures which provide more detailed guidance for the implementation of our arrangements such as hazardous substances, health surveillance, abuse, violence and aggression, lone working and blood born viruses.

A recent refresh of health and safety governance has provided a renewed focus on 'Group' governance, accountability and responsibility between the Trust and its subsidiary. The new Health and Safety Management Framework intends to provide the Trust Board with clear oversight of health and safety compliance and to promote a collaborative approach with synergy-generating measures to health and safety issues. This governance road map should help to achieve group-wide optimisation in health and safety decision-making and an agile environment in which to execute improvements. Forward focusing, there is a programme of work to improve health and safety governance in 2025-26.

This year the Trust has focused on year one milestones in relation to the objective outlined in our Health and Safety Strategy 2024-2026. Significant investment and resource have been placed in reducing the occurrence and impact of abuse, aggression and violence enacted by patients and visitors. This has included an externally led review of our security provisions and the implementation of interim security resource into our Emergency Department which experiences daily adverse events. A body-camera trial provided successful, and the Trust has introduced this resource in four hotspot areas as well as in our security response team. Further investment is planned in our security provisions in 2025-26, including a revitalised training programme.

The Trust has conducted an audit in relation to hazardous substances and is currently working with departments with a view to reviewing and reducing any high-risk substances. This work has extended to include a review of health surveillance requirements and the testing of a 'reporting and recording' application for these records. Work is also being undertaken to address ventilation requirements in Theatres, Maternity and Endoscopy.

Fire safety has been identified as an area for improvement both through internal reviews and a Section 31 issued by the Care Quality Commission. A review of fire risk assessments and an evaluation of the effectiveness of our fire safety governance, has led to a comprehensive on-going action plan designed to bring together critical elements and priorities will support investment in our fire infrastructure and evacuation training. Close oversight of progress against the action plan will be delivered through the Group Health and Safety Committee.

Significant progress has been made in relation to water safety over the past 12 months, with over 100 actions completed as part of a broad approach to both good governance, compliance and reporting. Our independent Authorised Engineer found high compliance across the suite of requirements with a small number of areas for ongoing improvement. Further independent assessments of our progress and opportunities for ongoing improvement will assist our assurance that we are delivering a robust water safety programme in accordance with good practice.

A further area of work relates to asbestos management in which significant work is underway to conduct a full management survey across both sites. In the course of the survey, and through the 2024 audit by the Authorised Engineer, weaknesses in the management system have been identified and immediate safety measures have been implemented. A revised policy is in its final stages of approval and will be supported by a new Asbestos Management Plan. An improvement action plan has been developed to

tighten and streamline controls. This will extend to a broader review of any links between asbestos and the Control of Contractors Policy.

This reporting period has seen a number of estates related concerns raised by staff which demonstrate common themes around the age and condition of the estate. An increase in workplace inspections is likely to have driven an amplified focus on issues within our environment that will require management via an Estates Strategy. Further work is required to ensure that all areas are conducting and recording timely inspections to provide a complete picture of the issues at hand.

Compliance is good for Health, Safety and Welfare training (HSW), Conflict Resolution, DSE, Sharps (non-clinical teams) and Manual Handling – Level 1. Sharps training for clinical teams and Manual handling – Level 2 remain amber. Whilst manual handling incident have decreased, sharp incidents have seen an increase. This has mainly related to Theatres.

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

In 2024-25 the Trust reported 43 RIDDOR reportable incidents. This is equal to the number of RIDDORs in the previous financial year and demonstrates a sustained reduction on the number of RIDDORS compared to 2020-2022. Slips, trips and falls remain the most prominent cause of RIDDOR reportable accidents and was the driver for an audit on slips and trips risk assessments.

There have been no HSE inspections or investigations during 2024-2025. However, a routine inspection in the previous financial year on violence and aggression and manual handling resulted in a Letter of Contravention. The letter highlighted a number of breaches related to security and the Trust was required to produce an action plan, with particular focus on improving the security response provisions. This was provided to the HSE on 24 May 2024. The Inspector recorded the action plan as constituting compliance with the letter but outlined five expectations. Four of these have been completed, the fifth, related to security resources, is on-going as described above.

As the Trust moves into year two of the Health and Safety Strategy, it is likely to re-focus its priorities to accommodate greater oversight of compliance within its subsidiary.

Data Security

The Trust complies with NHS Digital guidance for reporting, managing and investigating data security risks and breaches. Data risks are monitored through the corporate risk register, by the Board via both the Board Assurance Framework and separate reports and operational delivery forums including the digital senior leadership team. Further

information is provided in the information governance and data governance sections of this report.

Well-Led

The Trust's governance processes are informed by the CQC and NHS England well-led framework, as discussed in the directors' report. During the year the Medical Director and Chief Nurse have progressed a quality governance restructure in order to implement the areas for improvement highlighted in the external review of components of the well-led framework undertaken back in 2023 by the Good Governance Institute. This work will conclude in the first half of 2025.

Work to procure an externally delivered full Well Led Governance Development Review concluded in the period of this Annual Report. The review will commence in the first quarter of the 25/26 financial year and will seek to support the Board identify developmental opportunities to deliver continuous improvement in our governance and assurance apparatus and its effectiveness.

NHS Provider licence requirements

The Trust is compliant with the NHS Provider Licence section 4 (governance). Risks to compliance and mitigations are in place as set out in the table below:

	Risk	Mitigation
Effective governance structures	Ineffective governance structures, noncompliance with the Code of Governance for NHS Provider Trusts and accepted standards.	Internal corporate governance audit planned for 2025-2026 Annual Board and Committee effectiveness reviews Utilisation of the Code of Governance for NHS Providers Annual Board Committee Terms of Reference reviews.
Responsibilities of directors' sub-committees	Lack of clarity, duplication or omission of duties, ineffective oversight, monitoring and escalation processes	Directors' role profiles issued on appointment and reviewed via the appraisal process Annual review of the reservation of powers, standing financial instructions and related schemes of delegation (including Gloucestershire Managed Services) Committee Terms of Reference reviews and work plans
Reporting lines and accountability	Lack of clarity and accountability, ineffective escalation processes.	Clear Board committee lines of responsibility Each assurance committee led by a Non-Executive Director Executive committee and Trust Leadership Team group led by the Chief Executive Officer All Committees provide regular 'Key Issues and Assurance Report' to Board Organisational structure charts are maintained and regularly updated. Performance Accountability Framework launched in year.
Timely and accurate	Inaccurate assessment of	Annual self-certification against Fit and Proper Person Regulations and Board

information to assess risks with compliance	compliance with the provider licence, unidentified gaps	certification of compliance with the NHS Provider Licence.
Board oversight of performance	Reduced assurance of performance, poor patient experience, non-compliance with health care standards, reduced leadership and decision-making ability	Integrated Performance Report reviewed at Quality and Performance Committee, Finance and Resource Committee and People and Organisational Development Committee Performance reports to monthly executive review meetings and Trust Leadership Team meetings Integrated Performance Report to all public Board meetings

Updated Licence Conditions for NHS Providers came into effect on 1st April 2023 and compliance is monitored via the Integrated Care Board through the Single Oversight Framework. As required annually, the Board self-certified its compliance with the General and Trust conditions as outlined in its Licence requirements, legislation and NHS Constitution. The Board also assesses the extent with which it complies with the Code of Governance, and this is detailed in the annual Code of Governance report as part of Annual Reporting requirements.

Business Continuity

The Trust has arrangements in place in accordance with the Civil Contingencies Act 2004, the Health and Social Care Act 2012 and the NHSE Core Standards for Emergency Preparedness, Response, and Recovery, overseen by the Chief Operating Officer, in their capacity as the Authorised Emergency Officer. We have a Trust-wider Surge and Escalation Plan, reviewed and refreshed this year, and all departments within the Trust are responsible for maintaining dovetailed business continuity plans, which are reviewed regularly and validated by assurance, live testing or exercises. The Trust deploys a 'lessons learned' and debriefing processes following all critical serious incidents, to take learning forward in future risk mitigation.

Stakeholders

Effective performance and risk management relies on a range of contributions, and collaborative work is undertaken with external stakeholders to support the identification of risks that may impact on them, including Gloucestershire Integrated Care System, local authorities, Healthwatch and other forums for both patients and carers, directly and through involvement with our Council of Governors. Other vehicles for engagement include complaints and patient feedback, friends and family test responses and patient stories delivered at Board meetings.

Workforce strategies and risks

Significant workforce risks are monitored through the corporate risk register, the People and Organisational Development Committee and the Board including via the Board Assurance Framework. The People Strategy sets out the Trust's commitment to ensuring staffing processes are safe, sustainable and effective.

How do we comply with the 'Developing Workforce Safeguards' recommendations

Workforce risks are monitored through the corporate risk register, Board Assurance Framework, Executive Performance Reviews, the People and OD Delivery Group, the People Committee, and the Board.

Risk reports reflect an overview of the risks currently held on the risk register across the People and OD Function which directly relate to the delivery of the priorities across the wide-reaching People and OD agenda. The context of which is described in the Trust's overarching People Strategy and are a focus of the Directorate's well-led priorities.

An insufficient level of control of each risk will realise a number of adverse implications on recruiting, training, and sustaining an engaged workforce, compliance with targets and statutory duties, and the ability to maintain financial sustainability. Mitigations and controls are therefore in place and regularly managed by the assigned Risk Leads.

The People Strategy implemented in 2019, is due for renewal in 2025 but will closely align to the new Trust Strategy setting out our commitment to ensuring staffing processes are safe, sustainable and effective.

NHSE Developing Workforce Safeguards recommendations are regularly monitored to ensure compliance, from ward to Board, with assurance gained through the Quality and Performance Committee and the Board. Monthly data is available on the Trust's website for public scrutiny.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Service change and business cases are subject to Quality and Equality Impact Assessments to ensure that proposals do not adversely impact on the quality and equality of services. An area for

focus this coming year will be to further improve our approach to equality, diversity and inclusion in the context of the wider culture work taking place within the Trust.

Register of Interests

The foundation trust has published on its website an up-to-date register of interests in respect of its Board members as key decision makers for the Trust, including gifts and hospitality. It has been identified that a Trust-wide register has not been adequately maintained for decision-making staff (as defined by the trust with reference to the guidance) nor has it been made publicly available within the past twelve months as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

To provide assurance that the Trust has now properly defined "decision-making" staff according to its own context and to any material influence they have on how Trust funds are spent. The Trust Secretary, having joined the Trust in January 2025, has been identified to review current policies and to ensure publication of a register that captures those with a material influence on spending in addition to those on the Board of Directors. The Internal Auditors will conduct a review of policy and procedure in the first quarter of the 25/26 to ensure we are managing conflicts in accordance with best practice, to include appropriately publishing our register of interests.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Inclusion

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Climate Control

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board is responsible for establishing an effective system of internal control to ensure that resources are used economically, efficiently, and effectively, aided by monitoring and scrutiny through the:

- Audit and Assurance Committee.
- Finance and Resource Committee.
- Quality and Performance Committee; and
- People and Organisational Development Committee.

The Board receives, at each meeting, a Key Issues and Assurance Report detailing the use of resources generally and the controls in place, when relevant updates as to business cases and specific projects.

Controls to ensure the effective, efficient and economic use of resources include:

- The implementation of the accountability framework that is managed through the divisional and corporate executive reviews, escalation into enhanced oversight or mandated support will be an outcome if deviation to plans are material.
- Regular finance and performance reports to Committees and Board;
- Detailed annual review of the reservation of powers, standing financial instructions, and related schemes of delegation by the Audit and Assurance Committee and Board (last review January 2025);
- Business planning approach to clearly articulate the level of risks and mitigation;
- Executive to Executive review with GMS and Trust colleagues to focus on high risk areas relating to compliance, workforce and financial position;
- Regular system updates where system wide challenges can be addressed;
- Regular regional reports both on finance and performance where further scrutiny will be applied if required.

There have been no significant issues identified in relation to the financial statements in 2024-2025.

Internal Audit

The Trust's Internal Auditors, BDO, undertake an annual risk-based audit plan, agreed by the Audit and Assurance Committee and key executive directors. The plan is aligned with the Trust's strategic risks and is intelligence based. The Internal Auditors provide assurance reports on the design and effectiveness of controls, and follow-up on implementation of recommendations to mitigate risk. Any issues relating to engagement with the internal audit programme are escalated to both the Director of Integrated Governance and Director of Finance and reported to the Audit and Assurance Committee. For 2024-25, the Head of Internal Audit provided a Moderate assurance opinion on the system of internal control.

The Trust notes the positive position as at March 2025 with the Head of Internal Audit Opinion improving from limited assurance for 2023/2024 to moderate assurance for this year. This reflects the focused efforts of the Trust by promoting the importance of the role of internal audit across the senior management team. Full engagement from executives around the development of the plan provided ownership. Accountability and responsiveness. Sharing the Audit plan with the Trust Leadership Team meeting allowed emphasis on the importance of learning and improvement, providing opportunities for the senior leadership to engage in thoughtful and timely scoping of audits alongside the need for timely management responses to audits and actions.

External Audit

The Trust’s external auditors, Deloitte, provide assurance through the Audit and Assurance Committee and their annual audit of the Trust’s Annual Report and Accounts. For 2024-2025, the external auditor issued a modified opinion with significant weaknesses being identified in relation to Value for Money in light of the Care Quality Commission report into the Trust’s maternity services, which remained in place as at March 2025 and having regard to the identified potential over-reliance on the non-recurrent nature of the Trust’s financial sustainability plans.

Information Governance

Information Governance incidents are reviewed and investigated throughout the year and reported internally. Incident reports are triaged and any incident which meets the criteria set out within the NHS Digital Guidance were reported via the Data Security Incident Reporting Tool.

There have been three incidents reported to the Information Commissioner’s Office between April 2024 and March 2025 (inclusive).

Date reported to ICO	Incident	ICO action
24/05/2024	Personal identifiable data shared in error, in response to a Freedom of Information (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 were not aware of this hidden data and attached the spreadsheet in its entirety.	ICO confirmed no further action in Sep 2024.

Date reported to ICO	Incident	ICO action
16/07/2024	A member of staff took a photo of an email referral on his phone to facilitate taking bloods listed in the email. Blood tests include HIV and hepatitis screening. Patient identifiers were thought to have been excluded, but name and local hospital identifier were captured. The photo was subsequently posted on Facebook.	No further contact from ICO since.
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 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 from ICO since.

The first incident was closed by the Information Commissioner's Office (ICO) with the ICO being satisfied as to the steps taken to mitigate the risk of recurrence. The remaining two incidents are open pending conclusion of the ICO investigation. There has been a separate internal investigation to identify lessons learnt.

Summary of Information Governance reported incidents during 2024-2025

The following have been submitted as Data Security and Protection (Information Governance) incidents within the Trust during the period April 2024 to March 2025 (inclusive) and were assessed and determined to not meet the threshold for notification.

Classification	Number
Confidentiality	146
Integrity	31
Availability	7

The effectiveness of these systems has been monitored by the Trust's Digital and Information Service Governance Group, the Digital Care Delivery Group with an annual report presented to the Finance and Resource Committee on a six-monthly basis. This forms the basis of the Trust's annual submission for the Data Security Protection Toolkit. The governance in place ensures the Trust is implementing the ten data security standards recommended by the National Data Guardian and that we are meeting our legal obligations as to data protection and data security.

During the year ended 31 March 2025 a total of 187 breaches in relation to information governance were reported in line with the Trust's incident reporting policy. A 'personal data breach' under General Data Protection Regulation Article 4 (12) is defined as 'a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed'. There are three types of personal data breaches:

- Confidentiality breach is unauthorised or accidental disclosure of, or access to, personal data.
- Availability breach is an unauthorised or accidental loss of access to, or destruction of, personal data.
- Integrity breach is an unauthorised or accidental alteration of personal data.

Data quality and governance

The Trust recognises that reliable data and high-quality information are essential for delivering safe, effective patient care and informing service design and improvement efforts. High-quality information is defined as complete, accurate, relevant, up to date (timely), and free from duplication.

Data quality and governance is monitored through the Trust Leadership Team Forum, chaired by the Chief Executive, with the Caldicott Guardian (Medical Director) and Senior Information Risk Officer (Chief Digital and Information Officer) present, and the Board, through specific risk, performance, and assurance reports, and the Board Assurance Framework.

To enhance data quality, the Trust has undertaken the following actions:

- Identification, review, and resolution of potential duplication of patient records.
- Review of processes to ensure correct payment for activity undertaken and to reduce unnecessary administrative burden.
- Daily Data Quality (DQ) reports monitored by Support Teams.
- Monitoring of day case activity and regular attenders.
- Gathering of user feedback.
- Review and revision of all existing reports.
- Automation of routine data quality reports, making them routinely available to all staff on the Trust intranet via the Business Intelligence portal 'BI Hub'.
- Collaboration with an external partner to optimize the recording of clinical information and the capture of clinical coding data.
- Regular submission of mandatory secondary user services (SUS) data to NHS Digital, with actions taken based on SUS DQ reports to improve data quality.
- Attendance at Provider User Groups for national submissions to review best practices and benchmark against other Trusts.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and assurance committee and the other committees of the board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process of maintaining and reviewing the effectiveness of the system of internal control and the plans to address weaknesses and improvement includes:

- The structure and content of Board meetings during the year which ensures an environment within which the Board can provide adequate challenge on and gain appropriate assurance in relation to issues impacting patient services and our staff, namely issues relating to performance, quality and safety.
- A robust board committee structure providing assurance on quality, safety, operational and financial performance, and workforce strategy implementation
- A robust Audit and Assurance Committee which provides assurance that the system of internal controls is sound and agrees both an annual internal audit plan and an annual counter-fraud plan in addition to approving the external audit plan and reviewing the ISA260 and monitors the control recommendations within it.
- The effective engagement with Internal Audit and an internal audit plan targeted at areas where the control environment can be strengthened.

- Assurance from the Board Committees and senior risk managers, including Executive Directors and Divisional management on issues ranging from quality and safety, information governance, risk management and effective clinical leadership.
- A comprehensive clinical audit programme prioritising national statutory and mandatory audits.
- An effective Council of Governors, which obtains assurance regarding the performance of the Board from the Non-Executive Directors and holds them to account for the same.

Continuous improvement and development work within the governance arena throughout the Trust is undertaken to strengthen internal controls and mitigate gaps on an ongoing basis and key issues and escalations from board committees to the board of directors ensures oversight of areas where weaknesses in the control environment need to be addressed.

Conclusion

The Gloucestershire Hospitals NHS Foundation Trust Board is committed to continuous improvement of its governance arrangements to ensure that robust systems are in place which ensure risks are both correctly identified and managed. Also to ensure that serious incidents and incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action, so that the patients, service users, staff and stakeholders can be confident in the quality and effectiveness of the service we deliver and the economic and efficient use of resources.

Significant progress has been made during 2024/2025 but I, and my Board colleagues, recognise that there is more to be done over the coming months to continuously improve our governance and control system. I am confident that control issues identified during the year have been or are being addressed. There remain potentially significant risks for the Trust as we enter 2025/2026, recognising the financial constraints in place and the wider uncertainty as to NHS structures but I am confident that the Trust keeps at its core a focus on those under our care – patients and our colleagues.

We have identified and implemented mitigations for a number of risks during the year. Additionally, we have worked hard to improve systems of control, a position in part supported by our Internal Auditors, including evidencing timely improvements as a result of audit recommendations thus ensuring control systems are strengthened at greater pace. Newly developed frameworks for performance management and health and safety management will only serve to improve further those areas where tighter control is necessary. We have continued to carry forward provisions within our accounts to provide for valid expectations of the legal costs of not having fully discharged our health and safety obligations in previous reporting periods.

The improvement activity and scrutiny of delivery across the Medicine and Women and Children Divisions have no doubt shifted the dial on the improvements necessary in the Emergency Department and in Maternity services respectively but we recognise there is more to do.

Acknowledging the ongoing nature of some of the challenges we faced at the beginning of the year and the areas we have focused on during the last year, I conclude that we have largely addressed the significant control issues identified in the last period and we will continue that trend of improvement to continue to strengthen controls. The specifics of that focus on improvement include the Trust's financial position, the Care Quality Commission enforcement notices and conditions remaining on the Trust's registration on which considerable progress has been made but which can only be removed by our Regulators following re-inspection and recognition of the required level of improvement and a small number of limited assurance reports from our Internal Auditors. There are improvement plans and mitigations in place to address all these issues, which are monitored by the Board and its committees, and for Maternity specifically, in addition to the Board, support and oversight is provided through the Integrated Care Board.

As we embark on the challenges of the next financial year, I am committed to continuing to lead implementation of the required improvements and am satisfied that we continue to develop the right conditions and control frameworks that once fully embedded will successfully achieve that and will help us to consolidate this position in the future.

A handwritten signature in black ink, reading "K. McNamara." with a horizontal line underneath.

Kevin McNamara, Chief Executive

Date: 26 June 2025

Accountability report conclusion

This concludes the Accountability Report of Gloucestershire Hospitals NHS Foundation Trust for the year ending 31 March 2025.

A handwritten signature in black ink, reading "K. McNamara." with a horizontal line underneath.

Kevin McNamara, Chief Executive

Date: 26 June 2025

Independent auditor's report



Independent auditor's report to the council of governors and board of directors of Gloucestershire Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Gloucestershire Hospitals NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2025 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group and foundation trust statements of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 40.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller and Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial

statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit, local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, IT, and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following area, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2025, are subjective: we tested a sample of expenditure to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the

following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, reviewing internal audit reports and correspondence with CQC.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

In our audit report dated 27 June 2024 on the 2023/24 financial statements, we reported to the foundation trust significant weaknesses in its governance arrangements and its arrangements to secure financial sustainability, impacting the economy, efficiency and effectiveness in the use of resources.

The significant weaknesses reported were:

- in respect of the foundation trust's arrangements to secure financial sustainability, specifically how the Trust is able to achieve its cost improvement target for the year and the reliance on non-recurrent savings. Our recommendations for improvement included that the Trust accelerate its efforts to identify and realize specific opportunities to deliver its plan, and in planning for future periods, begin the identification of savings opportunities and project planning for their delivery further ahead of the start of the period to identify greater recurrent saving opportunities.

- in respect to the foundation trust's governance arrangement in how the Trust monitors and ensures appropriate standards; and weaknesses in its use of resources, in how the Trust uses information about its performance to improve the way it manages and delivers its service. These weaknesses reflect the findings of the Care Quality Commission's (CQC) inspection report issued in October 2022 and May 2024. The report had an overall rating of "Requires Improvement" and this was the rating given to safe, responsive and well-led domains of the quality rating and maternity care services. A recent CQC assessment

carried out in January 2025 assessed 'Maternity' services as 'Inadequate' and 'Urgent and Emergency' services as 'Requires Improvement' within Gloucestershire Royal Hospital, including concerns over staffing, infection prevention and safe environment standards not being met. We recommended the foundation trust continued to monitor the detailed action plan to address the findings of the CQC report and to review the monitoring controls in place to identify any further issues as they arise .

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller and Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller and Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report..

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or
- a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

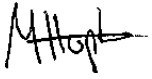
Delay in certification of completion of the audit

As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Gloucestershire Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

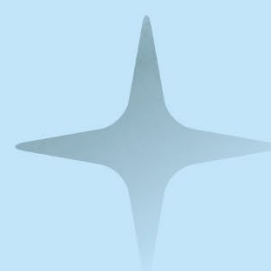
Use of our report

This report is made solely to the Council of Governors and Board of Directors (“the Boards”) of Gloucestershire Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Michelle Hopton FCA (Key Audit Partner) For
and on behalf of Deloitte LLP Appointed
Auditor
Bristol, United Kingdom,
27 June 2025

Annual Accounts 2024–2025



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**Gloucestershire Hospitals NHS
Foundation Trust**

**Annual Accounts for the year
ended 31 March 2025**

Foreword to the accounts

Gloucestershire Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Gloucestershire Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

A handwritten signature in black ink, reading 'K. McNamara.', with a long horizontal line underneath.

Signed

.....

Name Kevin McNamara
Job title Chief Executive
Date 26.06.2025

Consolidated Statement of Comprehensive Income

		Trust	Group	Trust	Group
		2024/25	2024/25	2023/24	2023/24
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	806,026	806,828	741,334	741,907
Other operating income	4	52,849	61,072	55,160	62,945
Operating expenses	6,8	(882,783)	(888,609)	(801,033)	(809,000)
Operating deficit from continuing operations		(23,908)	(20,709)	(4,539)	(4,148)
Finance income	10	6,087	4,361	4,898	4,287
Finance expenses	11	(4,277)	(4,277)	(6,599)	(6,599)
PDC dividends payable		(6,729)	(6,729)	(7,086)	(7,086)
Net finance costs		(4,919)	(6,645)	(8,787)	(9,398)
Other (losses) / gains	12	(172)	(192)	9	75
Corporation tax expense		-	(754)	-	(306)
Deficit for the year from continuing operations		(28,999)	(28,300)	(13,317)	(13,777)
Deficit for the year		(28,999)	(28,300)	(13,317)	(13,777)
Other comprehensive income					
Will not be reclassified to expenditure:					
Impairments	7	(1,135)	(1,135)	-	-
Revaluations	7,14	1,700	1,700	4,067	4,067
Total other comprehensive Income		565	565	4,067	4,067
Total comprehensive expense for the period		(28,434)	(27,735)	(9,250)	(9,710)
Deficit for the period attributable to:					
Gloucestershire Hospitals NHS Foundation Trust		(28,999)	(28,300)	(13,317)	(13,777)
TOTAL		(28,999)	(28,300)	(13,317)	(13,777)
Total comprehensive expense for the period attributable to:					
Gloucestershire Hospitals NHS Foundation Trust		(27,299)	(27,735)	(9,250)	(9,710)
TOTAL		(27,299)	(27,735)	(9,250)	(9,710)

Statements of Financial Position

		Trust	Group	Trust	Group
		31 March	31 March	31 March	31 March
		2025	2025	2024	2024
Note		£000	£000	£000	£000
Non-current assets					
	13	15,263	15,263	15,221	15,221
	14	327,196	327,204	345,538	345,575
	17	21,545	21,545	22,168	22,168
	18	-	1,790	-	1,944
	22	3,356	3,356	3,424	3,424
	24	600	-	600	-
Total non-current assets		367,960	369,158	386,951	388,332
Current assets					
	21	11,376	12,160	11,736	12,504
	22	29,116	30,059	27,261	27,055
	25	41,966	49,650	54,845	59,421
Total current assets		82,458	91,869	93,842	98,980
Current liabilities					
	26	(91,974)	(98,375)	(93,644)	(96,654)
	28	(9,556)	(9,556)	(8,356)	(8,356)
	29	(6,519)	(6,519)	(4,001)	(4,001)
	27	(13,606)	(13,606)	(15,354)	(15,354)
Total current liabilities		(121,655)	(128,056)	(121,355)	(124,365)
Total assets less current liabilities		328,763	332,971	359,438	362,947
Non-current liabilities					
	28	(51,658)	(51,658)	(57,034)	(57,034)
	29	(3,444)	(3,444)	(3,299)	(3,299)
	27	(6,478)	(6,478)	(5,787)	(5,787)
Total non-current liabilities		(61,580)	(61,580)	(66,120)	(66,120)
Total assets employed		267,183	271,391	293,318	296,827
Financed by					
		409,948	409,948	407,649	407,649
		32,535	32,535	31,970	31,970
		210	210	210	210
		(175,510)	(175,510)	(146,511)	(146,511)
	20	-	4,208	-	3,509
Total taxpayers' equity		267,183	271,391	293,318	296,827

The notes on pages 9 to 60 form part of these accounts.

K. McNamara

Signed

Name

Position

Date

Kevin McNamara

Chief Executive

26.06.2025

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	407,649	31,970	210	(146,511)	293,318
Total Comprehensive Income					
Deficit for the year	-	-	-	(28,999)	(28,999)
Impairments	-	(1,135)	-	-	(1,135)
Revaluations	-	1,700	-	-	1,700
Total Comprehensive Income (expense) for the year	-	565	-	(28,999)	(28,434)
Public dividend capital received	2,326	-	-	-	2,326
Public dividend capital repaid	(27)	-	-	-	(27)
Taxpayers' and others' equity at 31 March 2025	409,948	32,535	210	(175,510)	267,183

Statement of Changes in Equity for the year ended 31 March 2024

Trust	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	397,288	27,903	210	(121,073)	304,329
Total Comprehensive Income					
Deficit for the year	-	-	-	(13,317)	(13,317)
Revaluations	-	4,067	-	-	4,067
Total Comprehensive Income (expense) for the year	-	4,067	-	(13,317)	(9,250)
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	(12,121)	(12,121)
Public dividend capital received	10,385	-	-	-	10,385
Public dividend capital repaid	(24)	-	-	-	(24)
Taxpayers' and others' equity at 31 March 2024	407,649	31,970	210	(146,511)	293,318

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	407,649	31,970	210	(146,511)	3,509	296,827
Total Comprehensive Income						
Surplus/(deficit) for the year	-	-	-	(28,999)	699	(28,300)
Impairments	-	(1,135)	-	-	-	(1,135)
Revaluations	-	1,700	-	-	-	1,700
Total Comprehensive Income (expense) for the year	-	565	-	(28,999)	699	(27,735)
Public dividend capital received	2,326	-	-	-	-	2,326
Public dividend capital repaid	(27)	-	-	-	-	(27)
Taxpayers' and others' equity at 31 March 2025	409,948	32,535	210	(175,510)	4,208	271,391

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	397,288	27,903	210	(121,073)	3,969	308,298
Total Comprehensive Income						
Deficit for the year	-	-	-	(13,317)	(460)	(13,777)
Revaluations	-	4,067	-	-	-	4,067
Total Comprehensive Income (expense) for the year	-	4,067	-	(13,317)	(460)	(9,710)
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	(12,121)	-	(12,121)
Public dividend capital received	10,385	-	-	-	-	10,385
Public dividend capital repaid	(24)	-	-	-	-	(24)
Taxpayers' and others' equity at 31 March 2024	407,649	31,970	210	(146,511)	3,509	296,827

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

On the original setting up of the Trust in 2003 there was an error made on the initial PDC to cover the value of the net assets of the organisation. The adjustment was credited to other reserves and will remain with the Trust until the Trust is dissolved.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 20.

Statements of Cash Flows

		Trust 2024/25 £000	Group 2024/25 £000	Trust 2023/24 £000	Group 2023/24 £000
	Note				
Cash flows from operating activities					
Operating deficit		(23,908)	(20,709)	(4,539)	(4,148)
Non-cash income and expense:					
Depreciation and amortisation	6.1	35,653	35,682	32,177	32,225
Net impairments	7	29,041	29,041	19,187	19,187
Income recognised in respect of capital donations	4	(1,557)	(1,557)	(8,059)	(8,059)
(Increase) / decrease in receivables and other assets		(935)	(2,056)	16,709	20,163
(Increase) / decrease in inventories		360	344	(457)	(193)
Decrease in payables and other liabilities		(3,663)	(665)	(1,119)	(4,378)
Increase / (decrease) in provisions		2,630	2,630	(4,371)	(4,371)
Movements in charitable fund working capital		-	218	-	5
Tax paid		-	(754)	-	(306)
Net cash flows from operating activities		37,621	42,174	49,528	50,125
Cash flows from investing activities					
Interest received		3,956	4,196	3,979	4,083
Purchase of intangible assets		(5,028)	(5,028)	(2,847)	(2,847)
Purchase of PPE		(33,547)	(33,547)	(41,457)	(41,457)
Sales of PPE		3	3	93	93
Initial direct costs or up front payments in respect of new right of use assets (lessee)		-	-	(46)	(46)
Receipt of cash donations to purchase assets		1,086	1,086	7,659	7,659
Net cash flows from charitable fund investing activities		-	300	-	204
Net cash flows used in investing activities		(33,530)	(32,990)	(32,619)	(32,311)
Cash flows from financing activities					
Public dividend capital received		2,326	2,326	10,385	10,385
Public dividend capital repaid		(27)	(27)	(24)	(24)
Movement on loans from DHSC		(1,729)	(1,729)	(1,729)	(1,729)
Capital element of lease liability repayments		(5,307)	(5,307)	(5,048)	(5,048)
Capital element of PFI, LIFT and other service concession payments		(2,969)	(2,969)	(1,657)	(1,657)
Interest on loans		(673)	(673)	(750)	(750)
Interest paid on lease liability repayments		(392)	(392)	(277)	(277)
Interest paid on PFI, LIFT and other service concession obligations		(2,090)	(2,090)	(2,153)	(2,153)
PDC dividend paid		(8,094)	(8,094)	(8,534)	(8,534)
Cash flows from other financing activities		1,985	-	844	-
Net cash flows used in financing activities		(16,970)	(18,955)	(8,943)	(9,787)
Increase / (decrease) in cash and cash equivalents		(12,879)	(9,771)	7,966	8,027
Cash and cash equivalents at 1 April - brought forward		54,845	59,421	46,879	51,394
Cash and cash equivalents at 31 March	25	41,966	49,650	54,845	59,421

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the corporate trustee to the Gloucestershire Hospitals charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Gloucestershire Hospitals Subsidiary Company Ltd

The Trust wholly owns Gloucestershire Hospitals Subsidiary Company Ltd. (known as Gloucestershire Managed Services, GMS) which form part of the consolidated accounts. GMS provides the estates, facilities, sterile services and materials management services for the Trust. Its turnover for the period ended 31st March 2025 was £97m (2023-24 £95m) and its gross assets at 31st March 2025 totalled £18.1m (2023-24 £15.9m).

The Gloucestershire Hospitals Subsidiary Company Ltd statutory accounts are prepared to 31 March in accordance with UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the company's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High cost drugs and devices excluded from the calculation of national prices are reimbursed by commissioners based on actual usage. Or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from Government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

A full revaluation is required every 5 years. A full revaluation, on an MEA basis and excluding VAT, was undertaken by the Trust's independent valuer as at 31 March 2025.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences in the quarter after the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position Private Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	8	79
Dwellings	32	52
Plant & machinery	2	16
Transport equipment	5	11
Information technology	5	15
Furniture & fittings	7	10

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	1	5
Development expenditure	1	5
Software licences	1	5

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy inventory is measured on a weighted average basis and all other inventories are measured using the first in, first out (FIFO) method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income. Within the group accounts shares held by the charity are held at fair value.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables and contract receivables the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses are determined by type and age of receivable with differing percentages applied to the various categories of receivables.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Depreciation

Right of Use Assets are depreciated over the term of the lease. Depreciation starts in the same period that the lease commences.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 29.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 30 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to Corporation Tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust's activities are related to core health care and are not subject to tax. However, the Trust's commercial subsidiary is subject to Corporation Tax.

The Trust operates a wholly owned subsidiary limited liability company Gloucestershire Managed Services (GMS) which has a liability for Corporation Tax due on surpluses at financial year end. Corporation Tax payable on surpluses at financial year end is assessed by a qualified financial advisor and a Corporation Tax liability is recorded in the Trust balance sheet.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS17 Insurance Contracts standard will be adopted by the FreM from April 2025. An initial assessment has not identified any Trust contracts that contain an insurance contract.

IFRS18 Presentation and disclosure in the financial statements standard is not yet adopted by the FReM.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £258m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £253m at 31 March 2025.

The revised valuation assumption may have a material or significant impact on PPE measurement in future periods.

Note 1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property Valuation

Land, buildings and dwellings were valued at £286,588k by the Trust's independent valuer with a valuation date as at 31st March 2025. The valuation has been made by applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 Red Book. The value does not take into account potential future changes in the market value which cannot be predicted with any certainty. The valuer is an expert therefore there is a high degree of reliance on the valuers expertise.

Impairments

Impairments are based on the Revaluation Offices revaluation, on application of indices or on revaluation of individual assets e.g when brought into operational use or identified for disposal. Estimates and judgements are used where the valuations and the assumptions are used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances where an impairment has occurred.

Provisions

For the purposes of calculating provisions balances, estimates are informed by information supplied by third parties such as NHS Resolution and NHS Pension Agency. Inflation and discount rates are notified to the Trust. The probability and timing of settlements are also estimated, based upon previous experience and robust estimation techniques. Provisions in respect of payments to NHS Pension Agency are calculated based on actuarial tables covering life expectancy and are regularly reviewed.

Note 2 Operating Segments

The financial information presented to the Trust Board by the Director of Finance regarding performance of the Trust is based on the whole Trust as one entity (i.e. it is not split over operating segments). The Trust's internal management structure is based on operating divisions i.e. Surgery, Medicine, Diagnostics and Specialties, Women and Children, Estates and Facilities and Corporate Services. The Divisional boards are provided with financial information specific to their operational areas. The group position includes the Trust's subsidiary company and its charity (which is not separately shown due to materiality).

For segmental reporting, information is provided to the Board to inform them of the Trust, GMS and overall group position. This is shown below.

	2024/25			2023/24		
	Trust	GMS	Consolidated Group	Trust	GMS	Consolidated Group
	£000	£000	£000	£000	£000	£000
Expenditure	893,961	95,974	900,561	814,709	94,411	822,991
Income	864,962	98,105	872,261	801,392	95,330	809,214
Operational surplus / (deficit)	(28,999)	2,131	(28,300)	(13,317)	919	(13,777)

Assets and Liabilities of the group are not reported separately to the board

Reconciliation of Statement of Comprehensive Income (SOCl)

	2024/25	2023/24
	£000	£000
Statement of Comprehensive Income	(28,999)	(13,317)
Net Impairments charged to operating deficit	29,041	18,106
IFRIC 12 Adjustments	365	1,783
Grants and donations	(340)	(7,107)
Adjusted financial performance surplus / (deficit)	67	(535)

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Income from acute services	762,717	762,717	715,159	715,159
All services				
Private patient income	5,084	5,084	4,374	4,374
National pay award central funding***	2,924	2,924	345	345
Additional pension contribution central funding**	32,975	33,777	19,869	20,442
Other clinical income	2,326	2,326	1,587	1,587
Total income from activities	806,026	806,828	741,334	741,907

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)**Income from patient care activities received from:**

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
NHS England	179,763	180,565	179,158	179,731
Integrated care boards	609,588	609,588	548,304	548,304
Other NHS providers	411	411	363	363
NHS other	7,027	7,027	6,996	6,996
Non-NHS: private patients	5,084	5,084	4,374	4,374
Non-NHS: overseas patients (chargeable to patient)	277	277	282	282
Injury cost recovery scheme	1,091	1,091	714	714
Non NHS: other	2,785	2,785	1,143	1,143
Total income from activities	806,026	806,828	741,334	741,907
Of which:				
Related to continuing operations	806,026	806,828	741,334	741,907
Related to discontinued operations	-	-	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	277	282
Cash payments received in-year	201	174
Amounts added to provision for impairment of receivables	8	122
Amounts written off in-year	61	91

Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract	Non-		Contract	Non-	
	income	contract	Total	income	contract	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,299	-	3,299	3,353	-	3,353
Education and training	24,557	1,323	25,880	20,072	1,407	21,479
Non-patient care services to other bodies	12,787	-	12,787	12,643	-	12,643
Income in respect of employee benefits accounted on a gross basis	4,245	-	4,245	3,708	-	3,708
Receipt of capital grants and donations and peppercorn leases	-	1,557	1,557	-	8,059	8,059
Charitable and other contributions to expenditure	-	270	270	-	545	545
Charitable fund incoming resources	-	2,535	2,535	-	1,735	1,735
Other income	10,499	-	10,499	11,423	-	11,423
Total other operating income	55,387	5,685	61,072	51,199	11,746	62,945
Of which:						
Related to continuing operations			61,072			62,945
Related to discontinued operations			-			-

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

* Analysis of Other operating income: Other contract income

	2024/25	2023/24
	Total	Total
	£000	£000
Car parking	4,835	4,274
Creche services	1,060	963
Catering	1,457	1,387
Other	3,147	4,799
Total	10,499	11,423

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	15,354	11,023

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March	31 March
	2025	2024
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	13,606	15,354
after one year, not later than five years	3,476	2,515
after five years	3,002	3,272
Total revenue allocated to remaining performance obligations	20,084	21,141

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and noncommissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	797,591	735,394
Income from services not designated as commissioner requested services	9,237	6,513
Total	806,828	741,907

Note 5.4 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

Where fees exceed £1m these have been recorded in note 4 analysis of other operating income.

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 6.1 Operating expenses (Group)	Trust 2024/25 £000	Group 2024/25 £000	Trust 2023/24 £000	Group 2023/24 £000
Purchase of healthcare from NHS and DHSC bodies	24	24	1,252	1,252
Purchase of healthcare from non-NHS and non-DHSC bodies	4,114	4,114	5,514	5,514
Purchase of social care	-	-	-	-
Staff and executive directors costs	516,714	546,363	465,714	493,344
Remuneration of non-executive directors	203	249	183	221
Supplies and services - clinical (excluding drugs costs)	52,688	74,913	47,075	62,564
Supplies and services - general	102,378	38,278	91,433	39,813
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	101,974	101,985	97,403	97,404
Consultancy costs	1,304	1,344	1,447	1,455
Establishment	2,189	2,344	1,556	1,632
Premises	2,853	17,256	1,465	14,273
Transport (including patient travel)	2,963	3,822	2,162	2,947
Depreciation on property, plant and equipment	30,667	30,696	28,013	28,061
Amortisation on intangible assets	4,986	4,986	4,164	4,164
Net impairments	29,041	29,041	19,187	19,187
Movement in credit loss allowance: contract receivables / contract assets	1,406	1,473	2,344	2,256
Change in provisions discount rate(s)	(1)	(1)	9	9
Fees payable to the external auditor				
audit services- statutory audit	367	419	397	445
other auditor remuneration (external auditor only)	-	-	-	-
Internal audit costs	80	99	104	125
Clinical negligence	20,049	20,049	20,843	20,843
Legal fees	1,622	1,851	4,005	4,112
Insurance	629	967	621	930
Research and development	78	78	142	142
Education and training	4,181	4,363	3,628	3,819
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,774	1,774	2,259	2,259
Car parking & security	-	65	-	71
Hospitality	30	30	31	31
Losses, ex gratia & special payments	16	16	21	21
Other NHS charitable fund resources expended	-	1,494	-	2,022
Other	454	517	61	84
Total	882,783	888,609	801,033	809,000
Of which:				
Related to continuing operations	882,783	888,609	801,033	809,000
Related to discontinued operations	-	-	-	-

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2023/24: £1,000k).

Note 7 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	1,081
Notional multi storey building impairment due to revaluation	20,189	17,173
Other buildings impairment due to revaluation	8,864	933
Changes in market price	(12)	-
Total net impairments charged to operating surplus / deficit	29,041	19,187
Impairments charged to the revaluation reserve	1,135	-
Total net impairments	30,176	19,187

Note 8 Employee benefits (Group)

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Salaries and wages	377,524	401,990	341,895	364,185
Social security costs	42,831	44,354	40,021	41,960
Apprenticeship levy	2,140	2,218	2,001	2,099
Employer's contributions to NHS pensions	82,830	84,558	65,226	67,095
Temporary staff (including agency)	12,112	13,479	17,490	18,479
NHS charitable funds staff	-	487	-	443
Total gross staff costs	517,437	547,086	466,633	494,261
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	517,437	547,086	466,633	494,261
Of which				
Costs capitalised as part of assets	723	723	917	917

Note 8.1 Retirements due to ill-health (Group)

During 2024/25 there were 10 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £913k (£118k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2024, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Interest on bank accounts	3,956	4,196	3,979	4,083
NHS charitable fund investment income	-	165	-	204
Other finance income	2,131	-	919	-
Total finance income	6,087	4,361	4,898	4,287

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Interest expense:				
Interest on loans from the Department of Health and Social Care	667	667	754	754
Interest on lease obligations	392	392	277	277
Finance costs on PFI, LIFT and other service concession arrangements:				
Main finance costs	2,090	2,090	2,152	2,152
Remeasurement of the liability resulting from change in index or rate	1,058	1,058	3,396	3,396
Total interest expense	4,207	4,207	6,579	6,579
Unwinding of discount on provisions	70	70	20	20
Total finance costs	4,277	4,277	6,599	6,599

Note 11.2 The late payment of commercial debts (interest) Act 1998 (Group)

The Trust did not incur any late payment penalties (2023/24 Nil).

Note 12 Other gains / (losses) (Group)

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Gains on disposal of assets	-	-	73	73
Losses on disposal of assets	(172)	(172)	(64)	(64)
Total gains / (losses) on disposal of assets	(172)	(172)	9	9
Fair value gains / (losses) on charitable fund investments & investment properties	-	(20)	-	66
Total other gains / (losses)	(172)	(192)	9	75

Note 13.1 Intangible assets - 2024/25

Group	Software licences £000	Internally generated information technology £000	Development expenditure £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	12,105	-	12,807	-	1,364	26,276
Additions	27	344	828	-	3,829	5,028
Reclassifications	-	-	884	-	(884)	-
Valuation / gross cost at 31 March 2025	12,132	344	14,519	-	4,309	31,304
Amortisation at 1 April 2024 - brought forward	3,863	-	7,192	-	-	11,055
Provided during the year	2,729	-	2,257	-	-	4,986
Amortisation at 31 March 2025	6,592	-	9,449	-	-	16,041
Net book value at 31 March 2025	5,540	344	5,070	-	4,309	15,263
Net book value at 1 April 2024	8,242	-	5,615	-	1,364	15,221

Note 13.2 Intangible assets - 2023/24

Group	Software licences £000	Internally generated information technology £000	Development expenditure £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023 - as previously stated	15,703	-	10,471	-	2,117	28,291
Additions	111	-	1,630	-	1,161	2,902
Reclassifications	(3,709)	-	706	-	(1,914)	(4,917)
Valuation / gross cost at 31 March 2024	12,105	-	12,807	-	1,364	26,276
Amortisation at 1 April 2023 - as previously stated	6,305	-	5,503	-	-	11,808
Provided during the year	2,577	-	1,587	-	-	4,164
Reclassifications	(5,019)	-	102	-	-	(4,917)
Amortisation at 31 March 2024	3,863	-	7,192	-	-	11,055
Net book value at 31 March 2024	8,242	-	5,615	-	1,364	15,221
Net book value at 1 April 2023	9,398	-	4,968	-	2,117	16,483

A separate note for the Trust is not provided as the Group figures relate to the Trust only.

Note 14.1 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	12,400	239,880	256	37,501	57,677	140	46,468	115	394,437
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	12,421	-	11,438	8,738	-	2,854	-	35,451
Impairments	-	(30,395)	-	-	-	-	-	-	(30,395)
Reversals of impairments	-	192	15	-	-	-	-	-	207
Revaluations	-	(8,934)	-	-	-	-	-	-	(8,934)
Reclassifications	-	32,350	1	(36,575)	5,103	-	797	1	1,677
Disposals / derecognition	-	(454)	-	-	(2,042)	-	(6,709)	-	(9,205)
Valuation/gross cost at 31 March 2025	12,400	245,059	272	12,364	69,476	140	43,410	116	383,238
Accumulated depreciation at 1 April 2024 - brought forward	-	5	-	-	23,646	99	25,069	42	48,862
Provided during the year	-	11,066	-	-	6,836	12	7,447	12	25,373
Revaluations	-	(10,634)	-	-	-	-	-	-	(10,634)
Reclassifications	-	17	-	-	1,494	-	(45)	-	1,466
Disposals / derecognition	-	(454)	-	-	(1,904)	-	(6,675)	-	(9,033)
Accumulated depreciation at 31 March 2025	-	0	-	-	30,072	111	25,796	54	56,034
Net book value at 31 March 2025	12,400	245,059	272	12,364	39,404	29	17,614	62	327,204
Net book value at 1 April 2024	12,400	239,874	256	37,501	34,031	41	21,399	73	345,575

Note 14.2 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	12,000	228,339	253	42,341	53,640	140	41,199	60	377,972
Additions	-	12,730	-	23,491	4,145	-	1,319	55	41,740
Impairments	-	(19,118)	-	(1,081)	-	-	-	-	(20,199)
Reversals of impairments	400	1,089	3	-	-	-	-	-	1,492
Revaluations	-	(5,623)	-	-	-	-	-	-	(5,623)
Reclassifications	-	22,463	-	(27,250)	2,603	-	3,950	-	1,766
Disposals / derecognition	-	-	-	-	(2,711)	-	-	-	(2,711)
Valuation/gross cost at 31 March 2024	12,400	239,880	256	37,501	57,677	140	46,468	115	394,437
Accumulated depreciation at 1 April 2023 - as previously stated	-	-	-	-	18,816	87	17,980	34	36,917
Provided during the year	-	9,695	-	-	5,906	12	7,039	8	22,660
Revaluations	-	(9,690)	-	-	-	-	-	-	(9,690)
Reclassifications	-	-	-	-	1,551	-	50	-	1,601
Disposals / derecognition	-	-	-	-	(2,627)	-	-	-	(2,627)
Accumulated depreciation at 31 March 2024	-	5	-	-	23,646	99	25,069	42	48,862
Net book value at 31 March 2024	12,400	239,874	256	37,501	34,031	41	21,399	73	345,575
Net book value at 1 April 2023	12,000	228,339	253	42,341	34,824	53	23,219	26	341,055

Disclosure

Included within the dwelling figures above at 31st March 2025 are a number of properties formerly in the ownership of Gloucestershire Royal NHS Trust and East Gloucestershire NHS Trust (which now form the Gloucestershire Hospitals NHS Foundation Trust) sold to a registered Housing Association in April 2000 and June 2004 respectively. These units were for residential accommodation mainly to NHS staff and families. The registered Housing Association is now responsible for this provision with the Trust having nomination rights. Both separate agreements contain a 99 year lease with a Trust option to break at 30 years and every 5 years, which if exercised will enable the Trust to take back the freehold of the land and buildings with vacant possession at no cost. They have been valued by the independent professional advisor on a residual value basis.

Included within buildings is the PFI scheme consisting of a Diagnostic & Treatment centre, therapy services, a new accident and emergency department and 75 inpatient bed spaces. The scheme was handed over in April 2002 and runs for 31 years and 10 months from that date. The initial scheme cost including all fees was £39.6m. The value of the building at the Statement of Financial Position date is £52.2m (2023/24 £52.3m).

Land and Buildings values have been determined by the Trust's Independent Valuer, their revaluation of the Trust estate to DRC values is consistent with Department of Health and Social Care guidance.

The residential accommodation properties have been valued at residual value.

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 14.3 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	12,400	187,160	272	12,343	36,093	-	17,614	48	-	265,930
On-SoFP PFI contracts and other service concession arrangements	-	52,170	-	-	-	-	-	-	-	52,170
Owned - donated/granted	-	5,729	-	21	3,311	29	-	14	-	9,104
NBV total at 31 March 2025	12,400	245,059	272	12,364	39,404	29	17,614	62	-	327,204

Note 14.4 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	12,400	184,697	256	27,988	30,151	-	21,399	53	-	276,944
On-SoFP PFI contracts and other service concession arrangements	-	52,317	-	-	-	-	-	-	-	52,317
Owned - donated/granted	-	2,860	-	9,513	3,880	41	-	20	-	16,314
NBV total at 31 March 2024	12,400	239,874	256	37,501	34,031	41	21,399	73	-	345,575

Note 15 Donations of property, plant and equipment

Donated Additions - relate to assets either purchased wholly or items partially funded from the Trust's own charitable funds. The Charitable Funds are administered by the Trust's Main Board as Corporate Trustee. Funds are registered with the Charity Commissioner as registration number 1051606. Additionally from time-to-time, an external charity working closely with the Trust may provide funding directly for a capital project. The Trust received donated medical equipment valued at £309k (2023/24 donated total valued at £400k).

Note 16 Revaluations of property, plant and equipment

The value and remaining useful asset lives of land and buildings assets are estimated by the Trust's Independent Valuer. The valuations are carried out in accordance the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

The Modern Equivalent Asset Optimised Alternative Site model was updated and a full valuation was undertaken by the Trust's independent valuer as at 31 March 2025. The underlying principle is that the valuation of land and buildings should reflect a modern configuration of the estate required for the provision of the same services as already provided by the existing estate. With service delivery requirements evolving, this requires the Trust to consider whether the existing buildings are optimal in terms of number and size. If the Trust were starting with a "clean sheet", the Modern Equivalent Asset aligned to service delivery would be very different to the current layout in terms of buildings configuration and the number of sites.

Note 17 Leases - Gloucestershire Hospitals NHS Foundation Trust as a lessee

The Trust leases various properties for the provision of services and accommodation, medical equipment and vehicles.

Note 17.1 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
Group	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	13,229	24,263	618	227	38,337	425
Additions	616	258	593	-	1,467	384
Remeasurements of the lease liability	285	3,179	8	-	3,472	-
Movements in provisions for restoration / removal costs	(37)	-	-	-	(37)	-
Reversal of impairments	12	-	-	-	12	-
Revaluations	(87)	-	-	-	(87)	-
Reclassifications	371	(2,165)	1	-	(1,793)	-
Disposals / derecognition	(529)	(344)	(163)	-	(1,036)	(425)
Valuation/gross cost at 31 March 2025	13,860	25,191	1,057	227	40,335	384
Accumulated depreciation at 1 April 2024 - brought forward	2,548	13,350	266	5	16,169	425
Provided during the year	2,045	2,981	283	14	5,323	77
Revaluations	(87)	-	-	-	(87)	-
Reclassifications	209	(1,792)	1	-	(1,582)	-
Disposals / derecognition	(529)	(344)	(160)	-	(1,033)	(425)
Accumulated depreciation at 31 March 2025	4,186	14,195	390	19	18,790	77
Net book value at 31 March 2025	9,674	10,996	667	208	21,545	307
Net book value at 1 April 2024	10,681	10,913	352	222	22,168	-
Net book value of right of use assets leased from other NHS providers						307
Net book value of right of use assets leased from other DHSC group bodies						-

Note 17.2 Right of use assets - 2023/24

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	8,048	22,289	421	-	30,758	425
Additions	5,918	2,455	229	227	8,829	-
Remeasurements of the lease liability	110	1,686	28	-	1,824	-
Movements in provisions for restoration / removal costs	898	-	-	-	898	-
Impairments	(480)	-	-	-	(480)	-
Revaluations	(366)	-	-	-	(366)	-
Reclassifications	-	(1,766)	-	-	(1,766)	-
Disposals / derecognition	(899)	(401)	(60)	-	(1,360)	-
Valuation/gross cost at 31 March 2024	13,229	24,263	618	227	38,337	425
Accumulated depreciation at 1 April 2023 - brought forward	1,811	12,127	157	-	14,095	210
Provided during the year	2,002	3,225	169	5	5,401	215
Revaluations	(366)	-	-	-	(366)	-
Reclassifications	-	(1,601)	-	-	(1,601)	-
Disposals / derecognition	(899)	(401)	(60)	-	(1,360)	-
Accumulated depreciation at 31 March 2024	2,548	13,350	266	5	16,169	425
Net book value at 31 March 2024	10,681	10,913	352	222	22,168	-
Net book value at 1 April 2023	6,237	10,162	264	-	16,663	215
Net book value of right of use assets leased from other NHS providers						-
Net book value of right of use assets leased from other DHSC group bodies						-

A separate note for the Trust is not provided as the Group figures relate to the Trust only.

Note 17.3 Revaluations of right of use assets

ROU assest were remeasured in line with lease contracts.

Revaluations were carried out on peppercorn leases.

Note 17.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 28.1.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April	21,581	16,022	21,581	16,022
Lease additions	1,305	8,783	1,305	8,783
Lease liability remeasurements	3,472	1,824	3,472	1,824
Interest charge arising in year	392	277	392	277
Lease payments (cash outflows)	<u>(5,699)</u>	<u>(5,325)</u>	<u>(5,699)</u>	<u>(5,325)</u>
Carrying value at 31 March	<u>21,051</u>	<u>21,581</u>	<u>21,051</u>	<u>21,581</u>

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 17.5 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	5,216	86	5,216	86
- later than one year and not later than five years;	11,299	259	11,299	259
- later than five years.	6,906	-	6,906	-
Total gross future lease payments	23,421	345	23,421	345
Finance charges allocated to future periods	(2,370)	(31)	(2,370)	(31)
Net lease liabilities at 31 March 2025	21,051	314	21,051	314
Of which:				
Leased from other NHS providers		314		314
Leased from other DHSC group bodies		-		-

Note 17.6 Maturity analysis of future lease payments at 31 March 2024

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	4,364	-	4,364	-
- later than one year and not later than five years;	11,405	-	11,405	-
- later than five years.	8,301	-	8,301	-
Total gross future lease payments	24,070	-	24,070	-
Finance charges allocated to future periods	(2,489)	-	(2,489)	-
Net finance lease liabilities at 31 March 2024	21,581	-	21,581	-
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		-		-

A separate note for the Trust is not provided as the Trust figures are immaterially different from the Group.

Note 18.1 Other investments / financial assets (non-current)

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	-	1,944	-	1,885
Acquisitions in year	-	428	-	432
Movement in fair value through income and expenditure	-	(20)	-	66
Disposals	-	(562)	-	(439)
Carrying value at 31 March	<u>-</u>	<u>1,790</u>	<u>-</u>	<u>1,944</u>

Note 18.2 Other investments / financial assets (current)

The Group has no current investments/financial assets (2023/24 nil).

Note 19 Disclosure of interests in other entities

The Trust has no interests in other non-consolidated subsidiaries, joint ventures, associates or unconsolidated entities (2023/24 nil).

Note 20 Analysis of charitable fund reserves

The Gloucestershire Hospitals Charitable Fund has been consolidated within this set of accounts.

	31 March 2025 £000	31 March 2024 £000
Unrestricted funds:		
Unrestricted income funds	1,410	1,547
Restricted funds:		
Other restricted income funds	2,798	1,962
	4,208	3,509

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 21 Inventories

	Trust 31 March 2025 £000	Group 31 March 2025 £000	Trust 31 March 2024 £000	Group 31 March 2024 £000
Drugs	5,005	5,005	5,446	5,446
Consumables	6,076	6,860	5,995	6,763
Energy	295	295	295	295
Total inventories	11,376	12,160	11,736	12,504
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £140,263k (2023/24: £137,432k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £209k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 22.1 Receivables

	Trust	Group	Trust	Group
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Current				
Contract receivables	25,899	26,954	25,383	24,381
Allowance for impaired contract receivables / assets	(5,239)	(5,345)	(3,917)	(3,957)
Prepayments (non-PFI)	4,058	4,437	4,026	4,481
PDC dividend receivable	852	852	-	-
VAT receivable	3,501	2,969	1,748	2,010
Other receivables	45	45	21	21
NHS charitable funds receivables	-	147	-	119
Total current receivables	29,116	30,059	27,261	27,055
Non-current				
Contract receivables	1,951	1,951	2,080	2,080
Other receivables	1,405	1,405	1,344	1,344
Total non-current receivables	3,356	3,356	3,424	3,424
Of which receivable from NHS and DHSC group bodies:				
Current	6,481	6,481	7,826	7,826
Non-current	1,405	1,405	1,344	1,344

Note 22.2 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - brought forward	3,957	-	3,917	-
New allowances arising	1,473	-	1,406	-
Utilisation of allowances (write offs)	(85)	-	(84)	-
Allowances as at 31 Mar 2025	5,345	-	5,239	-

Note 22.3 Allowances for credit losses - 2023/24

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2023 - as previously stated	1,797	-	1,670	-
New allowances arising	2,362	-	2,411	-
Reversals of allowances	(106)	-	(67)	-
Utilisation of allowances (write offs)	(96)	-	(97)	-
Allowances as at 31 Mar 2024	3,957	-	3,917	-

Note 22.4 Exposure to credit risk

The Trust considers there is currently no material exposure to credit risk, the majority of receivables value is for the NHS contracts, the remaining values are for Road Traffic accidents which has a Compensation Recovery Unit bad debt percentage notified to the Trust

Note 23 Finance leases (Gloucestershire Hospitals NHS Foundation Trust as a lessor)

The Trust does not receive any lease income.

Note 24 Other assets

Other assets represent Gloucestershire Hospitals 100% holding in its subsidiary company GMS which is a limited company registered within England and Wales. The company is a trading subsidiary providing estates, facilities, sterile services and material management.

Note 25.1 Non-current assets held for sale and assets in disposal groups

There are no non-current assets held for sale or in assets in the disposal group.

Note 25.2 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
At 1 April	54,845	59,421	46,879	51,394
Net change in year	(12,879)	(9,771)	7,966	8,027
At 31 March	41,966	49,650	54,845	59,421
Broken down into:				
Cash at commercial banks and in hand	-	7,684	-	2,897
Cash with the Government Banking Service	41,966	41,966	54,845	56,524
Total cash and cash equivalents as in SoFP	41,966	49,650	54,845	59,421

Note 25.3 Third party assets held by the Trust

The Trust does not hold any cash or cash equivalents which relate to monies held on behalf of patients or other parties (2023/24 nil)

Note 26.1 Trade and other payables

	Trust	Group	Trust	Group
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Current				
Trade payables	15,983	21,079	12,398	21,029
Capital payables	2,445	2,445	850	850
Accruals	55,670	55,695	61,937	55,212
Social security costs	11,024	11,415	11,462	11,891
PDC dividend payable	-	-	513	513
Pension contributions payable	6,852	7,260	6,484	6,925
NHS charitable funds: trade and other payables	-	481	-	234
Total current trade and other payables	91,974	98,375	93,644	96,654
Non-current				
Total non-current trade and other payables	-	-	-	-
Of which payables from NHS and DHSC group bodies:				
Current	9914	11,164	11241	11,940
Non-current	-	-	-	-

Note 27 Other liabilities

	Trust	Group	Trust	Group
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	13,606	13,606	15,354	15,354
Total other current liabilities	13,606	13,606	15,354	15,354
Non-current				
Deferred income: contract liabilities	6,478	6,478	5,787	5,787
Total other non-current liabilities	6,478	6,478	5,787	5,787

Note 28.1 Borrowings

	Trust	Group	Trust	Group
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Current				
Loans from DHSC	1,729	1,729	1,735	1,735
Lease liabilities	4,772	4,772	4,051	4,051
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	3,055	3,055	2,570	2,570
Total current borrowings	9,556	9,556	8,356	8,356
Non-current				
Loans from DHSC	10,446	10,446	12,175	12,175
Lease liabilities	16,279	16,279	17,530	17,530
Obligations under PFI, LIFT or other service concession contracts	24,933	24,933	27,329	27,329
Total non-current borrowings	51,658	51,658	57,034	57,034

Note 28.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2024/25	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	13,910	21,581	29,899	65,390
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,729)	(5,307)	(2,969)	(10,005)
Financing cash flows - payments of interest	(673)	(392)	(2,090)	(3,155)
Non-cash movements:				
Additions	-	1,305	-	1,305
Lease liability remeasurements	-	3,472	-	3,472
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,058	1,058
Application of effective interest rate	667	392	2,090	3,149
Carrying value at 31 March 2025	12,175	21,051	27,988	61,214

Group - 2023/24	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	15,635	16,022	16,040	47,697
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,729)	(5,048)	(1,657)	(8,434)
Financing cash flows - payments of interest	(750)	(277)	(2,153)	(3,180)
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	12,121	12,121
Additions	-	8,783	-	8,783
Lease liability remeasurements	-	1,824	-	1,824
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	3,396	3,396
Application of effective interest rate	754	277	2,152	3,183
Carrying value at 31 March 2024	13,910	21,581	29,899	65,390

Note 29.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure			Total
	costs	Legal claims	Other	
	£000	£000	£000	£000
At 1 April 2024	1,155	92	6,053	7,300
Change in the discount rate	(1)	-	(50)	(51)
Arising during the year	131	20	2,591	2,742
Utilised during the year	(106)	(37)	(26)	(169)
Unwinding of discount	28	-	113	141
At 31 March 2025	1,207	75	8,681	9,963
Expected timing of cash flows:				
- not later than one year;	106	40	6,373	6,519
- later than one year and not later than five years;	1,101	35	170	1,306
- later than five years.	-	-	2,138	2,138
Total	1,207	75	8,681	9,963

GMS do not have any provisions

The pensions provisions relate to payments made to NHS Pensions for staff members who have had to retire early. Payments are made quarterly.

The Legal claims provision relates to clinical negligence legal costs where the Trust is liable to pay the excess costs.

Other provisions include £1,450k (2023-24 £1,365k) relating to an NHSI requirement to provide for tax charges relating to pensions, this is offset by a long term debtor for the same value.

Note 29.2 Clinical negligence liabilities

At 31 March 2025, £284,421k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Gloucestershire Hospitals NHS Foundation Trust (31 March 2024: £286,050k).

Note 30 Contingent assets and liabilities

	Trust	Group	Trust	Group
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(16)	(16)	(44)	(44)
Other	(252)	(252)	(252)	(252)
Gross value of contingent liabilities	(268)	(268)	(296)	(296)
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	(268)	(268)	(296)	(296)
Net value of contingent assets	-	-	-	-

Note 31 Contractual capital commitments

	Trust	Group	Trust	Group
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
Property, plant and equipment	4,508	4,508	6,165	6,165
Intangible assets	7	7	224	224
Total	4,515	4,515	6,389	6,389

Note 32 Other financial commitments

The Trust has no non-cancellable contracts (which are not leases,PFI contracts or other service concession arrangements) (2023/24 nil).

Note 33 Defined benefit pension schemes

The Trust's past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

Information on PFI is included in note 14.2

Note 34.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Trust	Group	Trust	Group
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	41,325	41,325	44,604	44,604
Of which liabilities are due				
- not later than one year;	4,938	4,938	4,593	4,593
- later than one year and not later than five years;	19,269	19,269	18,775	18,775
- later than five years.	17,118	17,118	21,236	21,236
Finance charges allocated to future periods	(13,337)	(13,337)	(14,705)	(14,705)
Net PFI, LIFT or other service concession arrangement obligation	27,988	27,988	29,899	29,899
- not later than one year;	3,055	3,055	2,570	2,570
- later than one year and not later than five years;	13,999	13,999	12,706	12,706
- later than five years.	10,934	10,934	14,623	14,623

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Trust	Group	Trust	Group
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	75,313	75,313	82,112	82,112
Of which payments are due:				
- not later than one year;	7,616	7,616	7,374	7,374
- later than one year and not later than five years;	32,417	32,417	31,385	31,385
- later than five years.	35,280	35,280	43,353	43,353

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Trust	Group	Trust	Group
	2024/25	2024/25	2023/24	2023/24
	£000	£000	£000	£000
Unitary payment payable to service concession operator	7,430	7,430	7,194	7,194
Consisting of:				
- Interest charge	2,090	2,090	2,152	2,152
- Repayment of balance sheet obligation	2,968	2,968	1,657	1,657
- Service element and other charges to operating expenditure	1,774	1,774	2,259	2,259
- Capital lifecycle maintenance	598	598	1,126	1,126
Total amount paid to service concession operator	7,430	7,430	7,194	7,194

Note 36 Financial instruments

Note 36.1 Financial risk management

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

IFRS 7, Financial Instruments Disclosure and Presentation, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Credit Risk

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Intergrated Care Boards and NHS England and the way those bodies are financed, the NHS Foundation Trust is not exposed to the degree of credit risk faced by many other business entities. The maximum exposures at 31 March 2025 are in receivables from customers as disclosed in note 22.1 to the accounts. The Trust mitigates its exposure to credit risk through regular review of the debtor balances and calculating a bad provision at the year end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised.

	31 March 2025	31 March 2024
	£000	£000
By up to 3 months	2,098	1,086
By three to six months	252	478
By more than 6 months	723	499
	<u>3,073</u>	<u>2,063</u>

Market Risk

This is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices.

The NHS Foundation Trust has limited powers to borrow or invest surplus funds. Cash is held on deposit with a number of safe harbour institutions which are deemed to have significantly low risk and high liquidity.

100% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The Trusts PFI scheme unitary payments are linked to RPI.

Liquidity risk

This is the risk that the NHS Foundation Trust will encounter difficulties meeting obligations associated with financial liabilities.

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Intergrated Health Boards, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed limit. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Inflation risk

There is a risk moving forward that charges in relation to the PFI may be affected by excess inflationary pressures in the economy.

Note 36.2 Carrying values of financial assets (Group)

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2025			
Trade and other receivables excluding non financial assets	25,010	-	25,010
Cash and cash equivalents	46,898	-	46,898
Consolidated NHS Charitable fund financial assets	2,899	1,790	4,689
Total at 31 March 2025	74,807	1,790	76,597

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2024			
Trade and other receivables excluding non financial assets	23,869	-	23,869
Cash and cash equivalents	57,741	-	57,741
Consolidated NHS Charitable fund financial assets	1,799	1,944	3,743
Total at 31 March 2024	83,409	1,944	85,353

Note 36.3 Carrying values of financial assets (Trust)

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2025			
Trade and other receivables excluding non financial assets	24,914	-	24,914
Cash and cash equivalents	41,966	-	41,966
Total at 31 March 2025	66,880	-	66,880

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2024			
Trade and other receivables excluding non financial assets	23,589	-	23,589
Cash and cash equivalents	54,845	-	54,845
Total at 31 March 2024	78,434	-	78,434

Note 36.4 Carrying values of financial liabilities (Group)**Carrying values of financial liabilities as at 31 March 2025**

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	12,175	12,175
Obligations under leases	21,051	21,051
Obligations under PFI, LIFT and other service concessions	27,988	27,988
Trade and other payables excluding non financial liabilities	73,780	73,780
Consolidated NHS charitable fund financial liabilities	481	481
Total at 31 March 2025	135,475	135,475

Carrying values of financial liabilities as at 31 March 2024

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	13,910	13,910
Obligations under leases	21,581	21,581
Obligations under PFI, LIFT and other service concessions	29,899	29,899
Trade and other payables excluding non financial liabilities	79,048	79,048
Consolidated NHS charitable fund financial liabilities	234	234
Total at 31 March 2024	144,672	144,672

Note 36.5 Carrying values of financial liabilities (Trust)**Carrying values of financial liabilities as at 31 March 2025**

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	12,175	12,175
Obligations under leases	21,051	21,051
Obligations under PFI, LIFT and other service concessions	27,988	27,988
Trade and other payables excluding non financial liabilities	68,659	68,659
Total at 31 March 2025	129,873	129,873

Carrying values of financial liabilities as at 31 March 2024

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	13,910	13,910
Obligations under leases	21,581	21,581
Obligations under PFI, LIFT and other service concessions	29,899	29,899
Trade and other payables excluding non financial liabilities	76,800	76,800
Total at 31 March 2024	142,190	142,190

Note 36.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Trust	Group	Trust	Group
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
In one year or less	81,122	86,724	88,158	90,640
In more than one year but not more than five years	38,954	38,954	38,908	38,908
In more than five years	27,776	27,776	35,256	35,256
Total	147,852	153,454	162,322	164,804

Note 37 Losses and special payments

	2024/25		2023/24	
Group and trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	984	89	787	108
Total losses	984	89	787	108
Special payments				
Compensation under court order or legally binding arbitration award	2	17	-	-
Ex-gratia payments	21	13	20	14
Special severance payments	1	15	-	-
Total special payments	24	45	20	14
Total losses and special payments	1,008	134	807	122

Note 38 Gifts

There are no gifts which require disclosure.

Note 39 Related parties

Gloucestershire Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State

During the period, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Gloucestershire Hospitals NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the period, Gloucestershire Hospitals NHS Foundation Trust, including in carrying out its role of host to the Gloucestershire Finance, Procurement and Estates Shared Services, has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Related parties may include but are not limited to:

- Department of Health and Social Care Ministers
- Board members of the Trust
- The Department of Health and Social Care
- Other NHS providers
- ICB's and NHS England
- Other Health Bodies
- Other Government Departments
- Local authorities

Note 40 Events after the reporting date

There have been no events after the reporting date.

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Annual report and accounts

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