Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 13 November 2025 at 09.00 to 12.30

Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1.	**Chair's welcome and introduction**			09.00
2.	**Apologies for absence**			
3.	**Declarations of interest (pertaining to agenda)**			
4.	**Minutes of previous meeting** • **11 September 2025**	Assurance	Report	09.05
5.	**Matters arising**			
6.	**Questions from the public**			09.10
7.	**Patient Story**			09.20
8.	**Chair's report,** *Deborah Evans, Chair*	Assurance	Report	09.35
9.	**Chief Executive's Report** *Kevin McNamara, Chief Executive Officer*	Assurance	Report	09.45
	MATERNITY SERVICES			
10.	**Maternity Services Regulatory Compliance Report (s31 Notice)** *Matt Holdaway, Chief Nurse & Director of Quality and Lisa Stephens, Director of Midwifery*	Assurance	Report	09.55
11.	**Perinatal Quality Surveillance Q2 2025/2026** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Report	10.05
	GOVERNANCE			
12.	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Report	10.15
13.	**Strategic and Operational Risk Report** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.25
14.	**National Health Service Provider Licence** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.35
15.	**2025-2030 Strategy approval** *Will Cleary-Gray, Director of Improvement and Delivery*	Approval	Report	10.45
	BREAK			
	PERFORMANCE & QUALITY			
16.	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Report	11.00
17.	**Integrated Performance Report** *Al Sheward- Chief Operating Officer*	Assurance	Report	11.10

	Matthew Holdaway – Chief Nurse. *Mark Pietroni – Medical Director.* *Claire Radley –Director for People and Organisational Development.* *Karen Johnson – Director of Finance*			
18.	**Learning from Deaths Report** *Mark Pietroni, Medical Director & Director of Safety*	Assurance	Report	11.30
19.	**Tower Decant Programme Update** *Mark Pietroni, Medical Director*	Assurance	Report	11.40
	PEOPLE			
20.	**People and Organisational Development Committee Report** *Deborah Evans, Chair or Marie-Annick Gournet, Non-Executive Director*	Assurance	Report	11.55
21.	**Workforce Race Equality Standard and Workforce Disability Equality Standard Report** *Claire Radley, Director for People & Organisational Development*	Assurance	Report	12.15
	FINANCE			
22.	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director*	Assurance	Report	12.25
	STANDING ITEMS			
23.	**Any other business**			12.30
24.	**Governor observations**			
	Date and time of next meeting: 15 January at 09.00 Lecture Hall, Sandford Education Centre, Cheltenham General Hospital			
	Close by 12.30			

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 11 September 2025, 09:00, Sandford Education Centre, Cheltenham General Hospital		
Chair	Deborah Evans	Chair, Non-Executive Director
Present	Vareta Bryan	Non-Executive Director
	John Cappock	Non-Executive Director
	Jaki Meekings-Davis	Non-Executive Director
	Sam Foster	Non-Executive Director
	Marie-Annick Gournet	Non-Executive Director
	Sally Moyle	Non-Executive Director
	John Noble	Non-Executive Director
	Andrew Champness	Associate Non-Executive Director
	Kaye Law-Fox	Gloucestershire Managed Services Chair/Associate Non-Executive Director
	Raj Kakar-Clayton	Associate Non-Executive Director
	Kevin McNamara	Chief Executive Officer
	Will Cleary-Gray	Director of Improvement and Delivery
	Matt Holdaway	Chief Nurse and Director of Quality
	Karen Johnson	Director of Finance
	Lee Pester*	Chief Digital Information Officer
	Mark Pietroni	Medical Director and Director of Safety
	Claire Radley	Director for People & Organisational Development
	Kerry Rogers*	Director of Integrated Governance
	Al Sheward	Chief Operating Officer
Attending	James Brown	Director of Engagement, Involvement and Communications
	Lisa Stephens	Director of Midwifery
	Simon Pirie	Chief of Service
	Christine Edwards	Consultant, Obstetrics Service Lead
	Sarah Favell	Trust Secretary
	Katherine Holland	Head of Patient Experience
Apologies	None	
Observers		
Governors	Douglas Butler, Mike Ellis, Andrea Holder and Emma Mawby	
Other	Shawn Smith, Members of the Phlebotomy team, Joanna Garrett, Karen Pudge	
Public	Six	

Ref	Item
1	**Chair's welcome and introduction**
	Deborah Evans, Chair, opened the meeting, welcoming all members of the public and governors in attendance. Those attending were reminded that this was a meeting of the Board in public as opposed to a public meeting. It was confirmed that the Chair was exercising her discretion not to accept questions from the public which did not relate to the meeting agenda as the focus of the meeting would be on the two external review reports relating to maternal and neonatal mortality. These external reviews had been commissioned by the Trust to ensure that there were no lessons that should have been learnt which had not been learnt. Deborah Evans expressed her apologies and thanks to Phlebotomy colleagues who had been keen to utilise the vehicle of the public board

	questions to highlight their position on the ongoing industrial action but who had accepted, in earlier discussions, that this would not be appropriate when the focus of the meeting must be on the maternity reports, for the benefit of affected families and staff. Deborah Evans assured the phlebotomists present that their concerns were not forgotten, and they remained valued members of staff. A welcome was extended to Shawn Smith, prospective Non-Executive Director, who was present as an observer.
2	**Apologies for absence**
	There were no apologies for absence. It was confirmed that the meeting was quorate.
3	**Declarations of interest**
	There were no declarations of interest in respect of agenda items.
4	**Minutes of previous meeting**
	The Chair expressed her gratitude to John Cappock who had chaired the July board meeting in her absence. The Board reviewed the minutes of the public board meeting held on 10th July 2025 with no amendments to the minutes other than minor changes to page 4 item 9 (final paragraph) where reference should be to 'functions' not 'organisations'. This amendment would be made by the Trust Secretary. **RESOLVED:** The Board APPROVED the minutes of the meeting held on 10th July 2025.
5	**Matters arising**
	There were no matters arising.
6	**Questions from the public**
	There were no questions submitted which related to the meeting agenda. Other questions submitted would be considered through usual Trust processes.
7	**Staff Story**
	To allow sufficient time for an examination of the maternity reports it had been decided that the Staff Story would be rescheduled to a future meeting.
8	**Chair's Report** *Deborah Evans, Chair*
	Deborah Evans, Chair, presented her report, focusing on her recent schedule of visits across the Trust, which had included visits to both maternity and neonatal services, the latter being a joint non-executive director and governor visit. Additionally, she had a recent opportunity to meet with Joanna Garrett, the Integrated Care Board's maternity and neonatal independent advocate. Her appointment, as part of a national pilot, was hugely welcome. The intention behind the project was to provide an additional source of support and independent advocacy for women who had experienced traumatic births or lost babies. She had also had an opportunity to spend time with Karen Pudge, senior manager of Children's Centre, including neonatal intensive care.

	The Chair described her recent visit, with Claire Radley, Director for People and Organisational Development, to Unison's regional office in Taunton. This meeting had been initiated by the Trust with the aim to fully explore potential routes to resolution of the ongoing industrial action. The meeting had been constructive, endeavouring to find a way forward and as an opportunity to discuss the ancillary social media campaign which targeted an individual rather than highlighting the issues related to the industrial action. The Chair emphasised the importance of trying to resolve the issues as no one wanted the situation to continue. In addition to this meeting the Chair had also ensured that she had met with all MPs for the local area during the Parliamentary recess over August. Finally, the Chair extended a warm welcome to the Governors in attendance. It was noted that there was a governor election in progress in some constituencies and the Char indicated she was looking forward to welcoming a new cohort of governors at a future board meeting. **RESOLVED:** The Board NOTED the report for information
9	**Chief Executive's Report** *Kevin McNamara, Chief Executive*
	Kevin McNamara, Chief Executive, presented his report to the Board, taking items as read. In addition to the content of the report he highlighted the recent restructuring within NHS regional structures with the appointment of the Chair for new NHS Bristol, North Somerset & South Gloucestershire Integrated Care Board. The importance of the ICB Cluster arrangements were highlighted as the Trust moves from a 'mono system' of one acute Trust, one mental health Trust and one local authority working closely together to a system with multiple acute Trusts and with a number of local authority partner organisations. The ongoing early discussions would be very important in establishing the Trust's role in that larger system It was confirmed that the Government had recently announced a national maternity investigation looking to explore issues within up to ten organisations. At the time of the board meeting the Trust had not received confirmation that it would be one of those ten organisations. Kevin McNamara indicated that, if selected, the Trust would be keen to engage in the process and understood that it was expected to be a review at pace with an anticipated conclusion by December. Also relevant to the provision of maternity services was the maternity health needs assessment being untaken across Gloucestershire. This was the first local maternity health needs assessment to be undertaken in fifteen years and would be vital in helping system partners to look collectively, particularly from a commissioning point of view, at a range of factors including population demographics, the declining birth rate, the increase in complexity of birth experiences and use that information to inform how future maternity services would be delivered, focused on the needs of the population the Trust serve. This assessment was being led by Matt Holdaway, Chief Nurse and Marie Crofts, Chief Nurse (ICB). Kevin McNamara also acknowledged the recent industrial action by the British Medical Association, representing the medical workforce. This had been managed well by the Trust but had unfortunately coincided with significant IT disruption caused by a server failure at Cheltenham General Hospital. This had adversely impacted a number of clinical services and other services, but he commended staff for their resilience. He confirmed that there would be a 'lessons learned' exercise with the support of an external adviser, which would focus on

	clarity of responsibilities and would involve both Trust and Gloucestershire Managed Services colleagues. In addition to the IT disruption services had also been disrupted as a result of the temporary loss of water on site in addition to other estate issues. With an older estate it would be vital to both focus on resilience whilst undertaking a wider piece of work would be undertaken to consolidate the learning from the incidents to inform the Trust's estate strategy. In the context of the doctors' industrial action the government was asking NHS Trusts to act on a number of interventions that would support the working lives of doctors. Whilst there were issues specific to this cohort of staff there were actions that would benefit all staff such as the provision of hot food at night. The government request would be worked through, but the Trust was mindful that it needed to be equally sighted on all staff groups and did not want to increase inequality amongst staff. Kevin McNamara spoke of the recent launch of 'Report, Support and Learn' tool. This was a project led by the People and Organisational Development team. The project was an evolution of the work undertaken over the past year and the focus on the equality, diversity and inclusion agenda. This project ensured an easier way for staff to identify and raise issues of concern and to receive feedback as to the actions taken. It would be monitored daily and could be anonymous to use. Additionally, the Trust had launched its sexual safety campaign in recent weeks with the People and Organisational Development Committee tasked with oversight to support the identification of any identify learning and necessary actions. Non-Executive Director colleagues commented on the immediate lessons learnt from the recent IT outages and estates issues and endorsed the approach being taken with the commission of an external review. With reference to the medical workforce, Mark Pietroni, Medical Director, observed that the planned renaming of Physicians Assistants to Associates was not moving forward as there was a statutory requirement to retain the current role descriptor. Finally, Kevin McNamara commented on the recent publication of Trust league tables. This was a government initiative around transparency, accountability and facilitating patient choice. Several indicators were taken into account, cancer performance, Emergency Department performance, waiting lists, staff survey and mortality data. The Trust had ranked 17th out of 134 Trusts and when compared with similar profile Trusts, had ranked 3rd. It was very positive, and a recognition of the hard work undertaken by the teams, but it was noted that there was still a huge amount of work the Trust needed and wanted to do. **RESOLVED**: The Board NOTED the report for information.
10	**Maternity Services Regulatory Compliance Report (section 31 Notice)** *Matt Holdaway, Chief Nurse and Director of Quality*
	Matt Holdaway, Chief Nurse, presented this report which he confirmed was a standing item before the Board, as a key element of the continued focus on maternity services. The report provided an update on progress/compliance against the s31 Enforcement Notice issued in May 2024. In recognition of the detailed discussions regarding the two external reviewed which would follow it was agreed that this report would be taken as read with the following hightlights:

	• The Trust has self-assessed that it has fully met 6 out of 8 conditions with ongoing work to sustain the position and to make further improvements. • Areas of continued focus were the implementation of risk management processes for post-partum haemorrhage and potential major obstetric haemorrhage, VTE risk assessments • All relevant data had been submitted to both the Care Quality Commission and the Integrated Care Board's Enhanced Oversight Group. Sam Foster, Non-Executive Director, commented on the evident improvement in the quality of the papers over the past year and the assurance provided to the Quality and Performance Committee. It was confirmed by Matt Holdaway, Chief Nurse, that the Care Quality Commission's inspection team had been on site during the previous two weeks, and he expressed his thanks to the senior maternity team on the continued delivery of the service and the excellent support of staff. **RESOLVED:** The Board NOTED the content of this report for assurance.
11	**Perinatal Quality Surveillance Q1/25 Report** *Matt Holdaway, Chief Nurse & Director of Quality*
	Matt Holdaway, Chief Nurse, presented the surveillance report providing oversight data in respect of maternity and neonatal services for the period April to June 2025 inclusive. It was intended to identify potential issues promptly and drive improvements in quality and care. It was confirmed that the report had been previously reviewed in detail by both the Maternity Delivery Group and Quality & Performance Committee, with the following key information highlighted for the attention of the Board. • There were 4 antepartum stillbirths during the quarter with all being reviewed and reported appropriately. All families had been engaged in the local review processes and duty of candour completed with support offered to families. The 12-month rolling stillbirth average continues to sit below the national average. • No neonatal and no direct maternal deaths during Quarter 1 • Decrease in the third and fourth degree tears at delivery rate. • Midwifery vacancy rate was at 4.6 whole time equivalent (WTE) with the risk register entry being downgraded. Obstetric staffing continues under mandated support and neonatal medical and nursing staffing meets required standards. **RESOLVED:** 1. The Board NOTED the report for assurance as per the report recommendations. 2. The Board NOTED the progress with action plans including one-to-one care in labour, transitional care expansion and the Care Quality Commission maternity survey.
12	**Commissioned External Review Reports** • **Maternal mortality report** • **Neonatal mortality report** *Matt Holdaway, Chief Nurse & Director of Quality, and Mark Pietroni, Medical Director*

	Matt Holdaway presented both reports and provided the Board with the context in which the two external reports were commissioned by the Trust. It had been identified by the Chief Executive, following a Panorama programme in January 2024 regarding the tragic deaths of two babies and the wider context of previous Care Quality Commission inspection reports, that it was important for the Trust to seek external assurance as to the quality of the services being provided by the Trust at that time and to ensure that any remedial actions that were undertaken. This was done in a spirit of openness and transparency with a desire to fully understand the issues and to identify whether there remained any gaps in care that still required attention and action. Two reports were commissioned; one focused on neonatal mortality between the years 2020 and 2023 and a second focused on the Trust's safety systems and maternal mortality between 2018 and 2022. It had been difficult to identify external leads initially, but the reviews were undertaken in Autumn 2024 and Spring 2025 respectively Before summarising the two reports Matt Holdaway, Chief Nurse, acknowledged the devastating impact of the loss of a baby or a mother on a family and expressed his sorrow personally and on behalf of the Trust. He confirmed that as part of this process members of the senior team had met with the affected families and had given their absolute commitment that the Trust would learn and ensure these events did not happen again. In early 2024, Professor Marian Knight, Mothers and Babies: Reducing Risk through Audits and Confidential Enquires (MBBRACE-UK) undertook a review of the Trust's maternal mortality data and concluded that the Trust's mortality rates were not statistically significantly different from the national rate. The Maternal Mortality Review had undertaken an assessment of the Trust's incident management processes for seven cases and had identified five improvements recommendations with the Trust undertaking a gap analysis against those recommendations, conscious that the Trust had been undertaking significant service improvement work since 2022. Of those five recommendations the Trust was satisfied that the relevant actions would be completed by the end of September 2025 with a fourth being completed the following month. The fifth recommendation was strategic and related to the way in which services were delivered county wide. The work to address that recommendation was broader than the Trust alone but the progress against the action plan would be reported to future Trust boards. Full details were set out in the papers before the Board and are a matter of public record. Deborah Evans, Chair, commented that there was evidence of how the clinical actions were being taken forward and was assured that the governance related actions were being monitored by reports to both the Quality and Performance Committee and the Trust Board. She was clear that the remaining action plan regarding county-wide delivery of services by the Trust and other partner agencies must continue to be monitored in the same fora. The Neonatal Mortality Review examined forty-four cases to identify any themes in respect of the care received and identify any learning from the same. That review identified nine deaths that warranted further investigation. It was confirmed that four of the nine had been investigated by the external Health Services Investigation Body and the recommendations for all had been acted on by the Trust and the action plans closed. One case has been closed with the agreement of the family and it had been identified that four of the cases had failed to identify them as requiring further investigation. This has been acted upon with the

	investigation process undertaken, with the engagement of the families involved in the learning response, depending on the families' wishes. The Board considered the neonatal mortality data (set out in section 4 of the report before Board) and noted the close alignment with the group average of similar size Trusts (in terms of birth rates) and a mortality indicator consistently lower than the national rate. The recommendations from the neonatal review had been subject to a similar gap analysis process with it being identified that many of the actions have been implemented and are included within the Trust's Perinatal Transformation Plan which is regularly reported to Board. After considering the presentation on the reports the members of the Board were invited to comment. Sam Foster, Chair of the Quality and Performance Committee, confirmed that the Committee had seen significant improvements in the quality of reporting with strengthened governance processes in place and a corresponding confidence in the service with colleagues feeling able and safe to raise issues for exploration. Matt Holdaway, Chief Nurse, commented on the new maternity governance structures which had been in place since November 2024 with oversight provided by the Perinatal Oversight Group. This was a monthly meeting which oversaw all escalations and any additional service support needs. There was also a full suite of reports against national improvement programmes including the Maternity Incentive Scheme, Saving Babies Lives and others. These were considered by both Quality & Performance Committee and Board. With increased capacity within the Maternity Services team there has also been an increased focus on improvement work, particularly in the health inequalities space. Vareta Bryan, Non-Executive Maternity Safety Champion commented on the work being undertaken from an Equality, Diversity and Inclusion perspective with a greater focus on the collection of data to inform service decisions to inform practical tools to improve access to the services, with improved access to translation and wider language services for ten core languages. She also commented on the work to ensure the Service hears from its staff and that from her visits to service areas she has seen improved confidence and a happier cohort of staff, particularly recognising the positive impact of increased staffing levels. Matt Holdaway commented that whilst there was a lot that had been achieved and which had made a positive impact there was no room for complacency. He commented that he was looking forward to working with Jo Garrett, patient advocate, to really focus on the how the Service can work with families and wider communities to improve their experience. Deborah Evans, Chair, commented that this was consistent with the focus in both the NHS Ten-year plan and the Trust's new strategy, on the Patient voice and experience. The Board heard from both Simon Pirie, Chief of Service for Women's and Childrens Division alongside Lisa Stephens, Director of Midwifery. Both acknowledged the devasting impact of such loss on families and emphasised the need and the desire of the Service to learn from this process. Simon Pirie acknowledged that, when he had met with families that, for many it was hard to have their loss brought back up by the external reviews but that generally families understood the need for continued learning and the families' comments and descriptions of their experiences had led to specific improvement actions with the family at the core of the service improvement work including work on supporting the partner who can feel unseen in the maternity process. His comments were echoed by Christine Edwards, Lead Consultant

	who also commented on the graciousness of the families. She also emphasised the need to work more closely with primary care colleagues to ensure the patient pathway was effective and joint. It was acknowledged that there were lots to be done in that area. Deborah Evans, Chair, was clear that although this was a shared responsibility with community-based colleagues it must continue to be a focus for the Trust with regular reports to Board. This led to a discussion of the impact of the recently initiated Gloucestershire Maternity Needs Assessment and the positive impact this will have on informing decision making for future maternity services. In a response to a question from Marie-Annick Gournet, Non-Executive Director as to what kept senior managers awake at night, Matt Holdaway did comment that the scale of the endeavour was huge with significant national and local recommendations/actions to consider and manage. However, with the new governance structure in place he was confident that the Service will meet those demands and remain focused on the patient experience. The Board also considered the impact of the reviews and surrounding scrutiny on the staff, many of whom have been deeply affected. The teams have been supported by a comprehensive programme of internal communications led by the senior team who have also ensured high visibility in clinical areas. Matt Holdaway also took this opportunity to commend the work of the Communications team who have been supportive to both senior and clinical staff through their support with briefings and with wider social media management. John Cappock, Non-Executive Director, commented on the evident culture of improved openness and candour and the creation of a safe space for learning. It was discussed how this could be built on and disseminate the lessons learnt by maternity services to other services. Deborah Evans, Chair, suggested that this was a topic that should be a focus at a future Board development seminar. Deborah Evans, Chair, brought the discussions to a close by expressing her thanks to all involved including the Service and the families affected for their engagement in such a difficult process. She also extended her thanks to Kevin McNamara who had, as a newly appointed Chief Executive, commissioned these external reviews. **RESOLVED:** 1. The Board RECEIVED the two external review reports. 2. The Board NOTED the conclusions from Professor Knight about maternal mortality rates and the finding that the Trust's maternal mortality rates were not statistically significantly different from the national rate. 3. The Board NOTED the neonatal mortality reports findings, the mortality rates and the improvement actions being taken by the Trust. 4. The Board was ASSURED that Recommendation One of the Maternity Mortality Review had already been completed and all actions related to the seven maternal deaths and the final action contained in the Action Plan were complete (Appendix 2) 5. The Board APPROVED the governance and the management of the recommendations and action plans.
13	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*
	It was confirmed that this report had been considered at the meeting of the Board in July. The Audit and Assurance Committee had not met in the interim period.

14	**Risk Management Report** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance presented this report summarising the continuing work to improve the Trust's risk management processes with a focus on the Board Assurance Framework. This work would include realignment against the proposed Trust Strategy and would address some of the commentary within the recently circulated Well-Led Review undertaken by Aqua at the Trust's request. It was recognised that, for the past six months, the Board Assurance Framework had been maintained in its existing form, pending the approval of the new Trust Strategy, with a focus on ensuring continuity and stability in risk oversight with regular executive reviews and oversight provided by Board committees. That work, including effective review of risks at Committee had continued but it was recognised that there were several Strategic Risks which would benefit from a significant review and realignment. Kerry Rogers canvassed with the Board the agenda for the planned full day Board Development Session (October), focused on strategic risk and a reset of risk appetite. In addition to seeking the Board's engagement with a refresh of the Trust's risk appetite, the proposal was that the Board would be asked to undertake a comprehensive refresh of the strategic risk profile and Board Assurance Framework. This would include an alignment of Strategic Risks to the new Strategic Aims, a refresh of definitions, scorings, controls and mitigation and an improved focus on triangulation with both corporate risks and other sources of assurance, including improved triangulation with the work of other Committees. Work would continue after the workshop with Executive Directors, supported by the Corporate Governance team, to finalise the new framework. This work would be completed during Quarter 3. Once the Board Assurance Framework was refreshed and implemented, there would be greater emphasis on Committees robustly assuring themselves of the effectiveness of the controls environment, in order to be assured that risks were being mitigated within tolerances and a newly set risk appetite. Samantha Foster, Non-Executive Director and Chair of Quality and Performance Committee commented that that the work was very welcome. She observed that the ongoing Care Quality Commission's inspection of maternity services had included requests for information on the Trust's risk registers and it would be helpful if this work could be progressed. Deborah Evans, Chair, confirmed that she was proposing a regular meeting of Committee Chairs, at which a standing agenda item would be a discussion as to the management of risks which have relevance across a number of committees. Kevin McNamara, Chief Executive, welcomed the planned programme of work and highlighted the need to re-evaluate the strategic risks in light of the new Strategy. He commented that the two current workforce risks did not capture the current position of the Trust. Claire Radley confirmed that those risks had been refreshed and would be considered at the September meeting of People & Organisational Development Committee. There was a consensus across the Board that this focus on risk against the new strategy was timely and welcome. **RESOLVED:**

	1. The Board NOTED the content of this report and subject to approval of the Trust Strategy at the September Board, SUPPORT the ongoing improvements to the Board Assurance Framework and to provide feedback on further enhancements to support effective risk management and assurance. 2. The Board AGREED members are assured of the focus of the Committees through the latest summary of the Board Assurance Framework activity since the June update (against the current strategic objectives).
15	**Board Committees: Effectiveness Review and Terms of Reference** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance, outlined the content of the report, which set out the output of the annual review of committee effectiveness. It was recognised that this review had not been undertaken on a consistent basis since 2019/2020. Whilst good performance was identified there were several areas of opportunity for improvement: • Improve triangulation of assurance between the respective committees; • Strengthened review of Strategic Risk, including improvements of the quality of minutes regarding strategic risks. This echoed the work identified in the risk management paper previous to this report; • Improved time allocation to facilitate adequate scrutiny of agenda items; and • Consistent (Committee wide) approach to report writing. It was intended, in light of the improved stability of resource within the Corporate Governance team, to return to an annual cycle and to further improve on the approach taken by this review by involving committee chairs and members in the design of a development plan for each committee. It was confirmed that all Committees had undertaken a review of their Terms of Reference during Quarter 1 with most amendments being housekeeping changes, apart from the Terms of Reference for Audit and Assurance Committee, which had been substantially amended. This exercise had been completed in advance of receipt of the Aqua Well-Led Review and it was intended that a further review would be undertaken later in the year to include any identified additional improvements or clarifications. Sam Foster, Chair of Quality and Performance Committee, noted the content of the report and commented that, in terms of attendance at Committee, she would like to see more Chief of Service attendance at committee. It was observed that with the recent appointment to the Director of Quality role, it was expected that such improvements would continue at pace. **RESOLVED**: 1. The Board **NOTED** the content of this report and took assurance from the process of the review of the effectiveness of the Board assurance committees and the proposed actions to be taken by the Corporate Governance team and Committee Chairs and as part of the wider well-led piece of work. 2. The Board **NOTED** the recommended changes to the Terms of Reference for each Committee
16	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*

	The Report was presented by Sam Foster, Chair of Quality and Performance Committee, summarising the key issues and assurance considered at the June and August meetings of the Committee. The Report highlighted a recent 'never event' within Surgery Division. This had been the subject of an early alert briefing to Board and was now subject to a PSIRF review. Mark Pietroni, Medical Director, confirmed there had been two surgical 'never-events' within the period, both of which had been categorised as 'no-harm' events. It was noted that the system had worked, albeit belatedly as it was the checks before the surgery had finished that had resulted in the error being identified. This had enabled the surgeon to make a clinically appropriate decision. The second incident was within the same service line but a different surgical team. These events had renewed focus on WHO checklists and other forms of assurance with a multi-disciplinary team reviewing at the pathway to ascertain why the initial checks had not identified the issue. That focused Quality Improvement Group was due to report its findings at the end of September. Mark Pietroni, Medical Director, would be meeting with the Service line in a 'summit' meeting to ensure confidence that these events had been properly reviewed and any learning implemented. It was confirmed that maternity remained a focus for the Committee with the August meeting being an extraordinary meeting to receive and review the two external review reports. Other areas of focus remained compliance levels for safeguarding, in particular the quality of Level 3 Children Safeguarding training and performance in echo, flexi sigmoidoscopies and cardiology. **RESOLVED:** The Board NOTED the report for assurance.
17	**Integrated Performance Report** *Al Sheward- Chief Operating Officer, Matt Holdaway – Chief Nurse. Mark Pietroni – Medical Director. Claire Radley –Director for People and Organisational Development, Karen Johnson – Director of Finance*
	Al Sheward, Chief Operating Officer, presented the performance section of the Integrated Performance Report for July. It was identified that this had been a challenging month as a result of a combination of factors; the IT outage, flooding in the endoscopy units and industrial action by the British Medical Association (non-consultant doctors). With two weeks of disruption there had been a significant impact on performance. Whilst the report was taken as read the following items were highlighted: **Performance** <u>Urgent and Emergency Care</u> Attendance had remained stable during the period with ambulance handover delays continuing to reduce and that reflects a continuing improvement over a six-month period. The work is being shared with neighbouring Trusts who have expressed an interest in understanding the approach the Trust has taken to sustain the improvement. There had been marginal deterioration in performance (4-hour target) from 63.1% compliance to 62.1 and (12-hour target) which had reduced from 91.7% compliance to 90%. Paediatric Emergency Department performance remained an area of concern with planned actions to

address this, including early escalation of paediatric patients that that been waiting for 150minutes.

It was noted that South West Ambulance Service (SWAS) have recently reissued their handover guidance without detailed discussion with the Trust's team and it was anticipated that the approach may present challenges for the Emergency Department teams.

Elective: 45 Week wait

The number of 52-week breaches had reduced in-month but those waiting over 45 weeks had stagnated, impacted by both industrial action and the IT outage, which was of concern for future performance. The figures had increased (unsubmitted) from approximately 850 to 1000 patients impacted but the team was working hard to improve the backlog.

Cancer RTT (referral to treatment)

Validated 62-day standard was 77.7% against the standard of 85% with the focus being on urology and lower Gastro-intestinal (GI). The decline in the latter was inked to delay in diagnostic and surgical capacity. A revised trajectory and recovery plan had been submitted to the Integrated Care Board.

Diagnostics

The performance trend for diagnostics was an issue of concern with July showing a moderate deterioration, largely as a result of workforce capacity issues but a recovery plan was being put in place with a deep-dive exercise planned for Quality and Performance Committee (September meeting).

Discharge ready (previously 'no criteria to reside'

There had been a deterioration in the 'discharge ready' figures with improvements required being behind trajectory. Internal actions were demonstrating positive improvements, but it was identified that there was a need to strengthen the system wide focus on the issue and its potential impact on the planned Tower decant programme. The deterioration in performance was having an impact on the planned timetable for the work on the fire alarm systems. These issues had been raised at the recent ICB Strategic meeting and this had resulted in improvements in the approach with daily meetings with Gloucestershire Health & Care Trust's Chief Operating Officer leading to an improved recovery plan.

Quality and Safety Metrics

Matt Holdaway, Chief Nurse and Director of Quality highlighted the relevant performance metrics with improved scores for inpatient areas and emergency departments with the overall Friends and Family Test (FFT) score remaining static at 92.3% for July. The Patient Advice and Liaison Service (PALS) reported a higher volume of cases during July, and this was anticipated to continue during August. There were improvements in the rates for case closure within 5 days, remaining at 83% against a target of 75%.

Mixed sex accommodation rates remained low but had seen an increase during the relevant period, particularly in critical care which had been impacted by decreased rates of patient transfers.

Mark Pietroni, Medical Director and Director of Safety highlighted the continuing positive impact of the work on the Mortality Data and improved coding. July had seen the ninth

continuing month of reducing mortality with the Trust's data within expected limits. The Quality Improvement Group had been disbanded with continued monitoring within the 'business as usual work'. The Team was commended for the improvements achieved.

The continued improvements in the position regarding complaints management were noted with the backlog now minimal and the focus moving to an assessment of the quality of complaints responses. This was largely due to the Trust-wide engagement of divisions and services in resolving complaints through proactive engagement with individuals making complaints.

Use of Resources/Finance metrics

Karen Johnson, Director of Finance provided an update on financial performance as at Month 4 (July), confirming the recent extraordinary meeting of the Finance and Resource Committee focused on the deviation against plan with revenue at £482K adverse to plan. Areas of concern were the deterioration in controls of agency and bank spend. It was acknowledged that there were concerns about the ability to deliver the Financial Sustainability Programme with sufficient recurrent savings. This was and continued to be a focus of the Executive team and divisions. The Board were advised that other regional trusts were experiencing similar challenges and that respective finance teams were working closely together to learn from respective Trusts experience.

Capital spend against target remained behind with £4.9m spent against a planned spend of £10.2. Areas of concern are the impact of planning delays on large projects and the delays in providing approved business cases for a number of schemes. This was being addressed by the relevant teams with several business cases coming to Committee or Board (depending on capital cost) over the next few months.

People

Claire Radley, Director for People & Organisational Development provided an update on the results from the recent National Quarterly Pulse Survey. The July 2025 results demonstrated a consistent decline in positive sentiment compared with April 2025 and July 2024. The Trust's results were broadly consistent with the national picture with areas of concern identified as 'motivation' and 'initiative'. It was noted that there had been a reduced survey reduced response rate and so it was difficult to be confident as to how far the data could be extrapolated across the workforce. New metrics had been introduced to measure 'Well-being' and whilst the benchmarks rates were unknown the high indicator for 'stress' was a concern which the Trust would be proactively monitoring.

The indicators for inappropriate behaviours indicate that 88.6% of respondents had not experienced inappropriate behaviours but the counter position was that meant 11% of staff had experienced behaviours which should not be present in a workplace. It was confirmed that this remains a priority area with the recent introduction of the 'Report, Support and Learn scheme across the Trust. Data from that scheme would be used to respond to individual incidents appropriately but also feed into the cultural heatmap work to identify and support areas of challenge.

Appraisal compliance was at its highest in over two years and it was anticipated that would continue with the implementation of a new appraisal process and paperwork. With regards to bank performance, it was noted that whilst there had been improvements over the past 12

	months the Trust target of 6.5% had not been achieved in July. This would be an area of continued scrutiny, and it was hoped that the introduction of the e-rostering solution for medical workforce would start to deliver reduction in medical temporary staffing. Mark Pietroni, Medical Director, commented on the job planning process as a new metric included in the reporting. The national aim was to achieve most job planning by Q3 to feed into business planning but this would be challenging for the Trust to achieve as it as previously worked on job planning being linked to work anniversary. The work to shift the process was continuing at pace. In response to a question from John Noble, Non-Executive Director, Karen Johnson confirmed that there was good confidence in the quality of data used for financial forecasting and business planning. Jaki Meekings-Davis asked for additional data on the cash position to be provided in future Integrated Performance Reports. There was an extended discussion on the bank/agency rates, particularly for medical workforce. It was noted that there was continuing work to instigate additional controls on agency spend including the reduction on demand for specialist enhanced care agency workers with the recruitment to an in-house team. The Chair noted the concerns of the Non-Executive Directors as to the financial position of the Trust and noted this would remain an area of focus. Sam Foster, Non-Executive Director commented on the monitoring of delay related harm with Al Sheward, Chief Operating Officer, outlining recent discussions with system partners and advised that whilst there was system engagement, he could not give assurance that the target for 'discharge ready' patients to be discharged to community supported resource would be met. Therefore, he could not give assurance that it would not negatively impact on the Tower decant programme. This was being escalated to a Chief Executive level with system partners with Kevin McNamara confirming the ongoing discussions with Gloucestershire County Council's recently appointed Chief Executive. Kevin McNamara commented on the recent Standard Operating Procedure introduced by South West Ambulance Service and the challenges that will create for Emergency Departments. It was noted that whilst there had been significant improvements in handover delays because of the work by the Trust there was no evidence of a corresponding improvement in Category 2 response times which was of concern across the system as there had been no corresponding improvement in response times for patients requiring an ambulance. This would be a continued area of discussion across the region. **RESOLVED**; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
18	**Appraisal Revalidation Report** *Mark Pietroni, Medical Director*
	Mark Pietroni presented this annual report which was required to be reviewed by the Board prior to submission to NHS England. The Board confirmed that it had been provided with an opportunity to review the report and noted that there were no concerns identified regarding the Trust's process **RESOLVED:** The Board NOTED the report for assurance and approved its submission to NHS England.
19	**Infection Prevention & Control Annual Report**

	Craig Bradley, Deputy Chief Nurse and Director of Infection and Control
	The report was presented on the basis that it had been fully reviewed and approved by the Quality and Performance Committee. It provided a comprehensive review of the Trust's performance against the Health & Social Care Act 2008: Code of Practice on the Prevention & Control of Infection. **RESOLVED**: The Board NOTED the report for assurance noting that it had been reviewed and approved by the Quality & Performance Committee.
20	**Winter Plan Report (Board Assurance Statement)** *Al Sheward, Chief Operating Officer*
	Al Sheward, Chief Operating Officer, introduced the item and explained that there was a requirement to submit the Trust's Winter Plan to NHS England by 30 September. He confirmed that whilst work was progressing well on the Trust's Winter Plan alongside the wider System Plan, a combination of delays to the system plan and the Trust's governance calendar meant it was not possible for the completed document to be before the Board at the September meeting (that day). It was proposed that the Board delegate authority to the Quality and Performance Committee meeting on 25th September to consider the final Winter Plan and complete the Board Assurance Statement. All Board members, including those not normally in attendance at the Committee would be requested to attend to review and confirm the Board Assurance Statement. **RESOLVED:** The Board APPROVED the delegation of authority to the Quality and Performance Committee to review the Winter Plan and complete the Board Assurance Statement at the Committee's meeting on 25th September 2025. All board members would be requested to attend.
21	**Listening, Learning, Improving: Addressing the 2024 Staff Survey Key Challenges** *Claire Radley, Director for People & Organisational Development*
	Claire Radley, Director for People & Organisational Development presented the report setting out an overview of the Trust's 2024 Staff Survey, focusing on the key challenges and detailing the trust-wide and individual divisional action plans to address the twenty-five priority areas. The report was taken as read with the focus of the presentation being the allocation of the priorities requiring divisional ownership. Each of those priorities allocated to divisions had been reviewed with local action plans in place and oversight provided by both the People Boards and service line reviews. As a result, action plans were unique to the challenges faced by individual divisions and consequently divisional leadership were engaged and responsive in driving the improvement agenda for those plans. It was acknowledged that there were risks to the achievement of the priorities. The primary risk was leadership capacity at a time when the Trust was experiencing considerable operational and financial pressures including the workforce reduction plans. It was anticipated these issues would have a consequent impact on both retention and morale if the action plans were delayed or not achieved. It was also recognised that the governance structures across the divisions were different with some divisions having well-established People Boards but with the Womens & Childrens' and Corporate People Boards only newly established. A Trust-wide initiative which should address some of the negative survey commentary was the project to improve hot food provision at night. This was a project that was making progress with the engagement of Gloucestershire Managed Services colleagues, but which has not yet

	been achieved. It was recognised that this would have a significant impact on staff and would remain a priority this year. The risks identified in the report would continue to be monitored by both Workforce Delivery Group and via the Strategic Risks within the Board Assurance Framework relevant to retention and culture. **RESOLVED:** 1. The Board NOTED the progress made in staff experience since 2023 and the recognition of our improved position against the national average. 2. The Board ENDORSED the dual-track approach combining Trust-wide cultural transformation through the Staff Experience Improvement Programme (SEIP) and related programmes) with divisional accountability and action planning. 3. The Board SUPPORTED the continued focus on embedding Staff Experience Improvement Programme priorities: teamwork development, tackling inappropriate behaviours, and supporting a safe speaking up culture. 4. The Board AGREED to receive regular updates through People and Organisational Development Committee, including assurance of ongoing divisional accountability and momentum.
22	**Finance and Resource Committee Report** *Jaki Meekings-Davis, Non-Executive Director*
	Jaki Meekings-Davis, Finance and Resources Committee Chair, presented the Committee's Key Issues and Assurance Report for July 2025, focusing on the red risks and taking the majority of the report as read. The financial issues (rated as red) had been discussed within previous agenda items, in particular the Integrated Performance Report. The digital work programme was the focus of the recent Committee meeting and it had been confirmed that Lee Pester, Chief Digital Information Officer, would be providing a report to a future Board development session on the digital implications of the NHS 10-year plan and the Trust's Strategic Aim 'Digital first'. It was recognised that there was a need to provide sufficient time at Committee for consideration of the digital agenda. **RESOLVED:** The Board NOTED the report for assurance.
24	**Any other business**
	There were no items of business to note.
25	**Governor observations**
	Andrea Holder, Lead Governor, provided observations on behalf of the attending governor observers and acknowledged both maternity services reports and commenting that there were lessons that could be learnt across the Trust from the approach taken to the learning, in particular the putting the families/patients at the heart of communications. In response to a comment regarding the re-opening of maternity units Kevin McNamara acknowledged that this would form part of the Maternity Needs Assessment but that the primary driver in any decisions would be the safety of the service provided to the communities.

Close: 12:30

Date and time of next meeting: 13 November 2025, 09:00, Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

ACTIONS/DECISIONS

Item	Action	Lead / Due Date	Update
14/May	Provide a report to Board focusing on the areas within the Staff Survey results which are negative, with low satisfaction rates and providing an action plan for how these areas of concern will be addressed, both Trust-wide and divisionally (including corporate).	July Board meeting Director for People and Organisational Development	Completed
21/July	To review the compliance for Level 3 safeguarding training of junior doctors and locums and consider any mitigations/actions required to improve compliance. Report to Quality and Performance Committee	October Quality and Performance Committee Medical Director/Chief Nurse	

Chairs Report November 2025

1. Purpose

This report highlights some of my activities since the September board meeting and those of my colleagues.

2. Visits

- Meeting with Unison, Southwest, just prior to the September Board meeting, Clair Radley and I visited Kerry Baigent, Unison Regional secretary and Chris Roche, Unison SW regional organiser to discuss the phlebotomy industrial action in detail and to understand their tactical campaign. Subsequently, the Trust has intensified its efforts to resolve the dispute, led by our Chief Executive Kevin McNamara and our Director for People Claire Radley.
- Black history month – October was Black History Month and included a range of fascinating online events including Dr Anita Takwale, our Consultant Dermatologist telling her story, about moving to the UK, having to do basic medicine and then all her postgraduate dermatology training again. This was the most positive possible contribution, and we can be proud of Anita and all our other internationally trained colleagues who have shown huge personal determination and commitment to the NHS and to our Trust. Other notable sessions which I attended included Gifty Markey Associate Chief Nursing Officer for Mental Health, Learning Disability and Neurodiversity for North Bristol Trust and Bernadette Thompson, Director of People and Culture, Royal Free NHS FT.
- Annabel Summers, Physician Associate, Gloucestershire Royal Emergency Department – having heard an inspiring presentation from Annabel and her colleagues at the Quality Academy graduation, I visited Annabel in the Emergency Department to hear about her sustainability work and to shadow her. Annabel is a physician associate and told me that they are well supported in our Trust under the leadership of Mark Pietroni our Medical Director.
- Elective hub accreditation – the national elective hub accreditation process has a policy on including a Non-Executive Director in their accreditation visits to Trusts and I was fortunate enough to be able to stand in for Sam Foster and see our surgical services at Cheltenham General through the visiting team's eyes. The specialties of urology and ophthalmology have made tremendous progress over the last eighteen months, and this was evident to our visitors. We have further to go in orthopaedics and Tim Briggs, the programme leader and himself an orthopaedic surgeon gave us very direct and constructive feedback. In advance of the formal feedback, the Trust is already mobilising an action plan
- Visit to estates with Gloucestershire Managed Services (GMS) – Jaki Meekings Davis and I joined Kaye Law Fox and two of her non-executive directors and a number of governors in a visit to some of the estates facilities at Cheltenham General. It was a fascinating display of the challenges of working with an aged estate and with hazards such as asbestos.
- Asma Pandor – I completed my round of shadowing staff governors with a morning with Asma starting at Gallery 2 ward and learning more about how she supports patients and families where a person is living with dementia. Asma is one of 13 Admiral nurses supported by dementia UK who are based in acute hospitals. Asma has worked in this Trust for a long time and is a Gloucester resident who had an enormous range of contacts both within our hospitals and in the wider community. There were many

interesting aspects to my visit with her and the standout one is that she is the epitome of partnership working for patient and family benefit.

3. Ambassadorial

- "Hate has no home in Gloucestershire" - our communications team, working with colleagues from the Integrated Care Board and Gloucestershire Health and Care produced a statement from the Chairs of each organisation speaking out against racially motivated attacks and incidents towards our communities and our colleagues. We restated our commitment to inclusion and creating a safe working and living environment for everyone, in which our multinational workforce is a proud symbol. We have received positive feedback from many sources, so thanks are due to James Brown and his colleagues for this thoughtful work.
- Women in business lunch – I was invited to join the Gloucestershire Women in Business lunch and talk on the theme of "What I've learned about influence and connection from a career in health and social care"
- VE day peace garden opening - the oral/maxillo facial outpatient department has commissioned GMS to create a courtyard "VE day peace garden" as a tranquil area for colleagues and patients to enjoy.
- Lions farewell event - it was pouring with rain when I visited Cheltenham Racecourse to view the collected pride of lions who had been on display over the summer across Gloucester and Cheltenham as part of our Big Space Cancer Appeal. Families were undeterred by the weather, and I was able to enjoy the beauty and creativity on show with many children and their parents/ grandparents
- Lions auction – Gloucester Cathedral is an unlikely but stately venue for an auction and was the final collective viewing before enthusiastic bidding started.
- Gloucestershire Integrated Care System Non-Executive Directors network – this online opportunity for Gloucestershire Health and Care, the Integrated Care Board and our Non-Executive Directors to meet has been given new purpose during the change process for Integrated Care Boards. John Cappock, our vice chair is one of the rotating chairs for this meeting, having taken over from Vareta Bryan. The focus of the meeting is about the change process and Jeff Farrar the chair of the BNSSG/ Gloucestershire Integrated Care Boards has introduced himself to colleagues
- New Governors – we are welcoming new governors Kate Usmar (Gloucestershire County Council stakeholder nominee), Nicola Hayward (Cheltenham)Khady Gueve, patient engagement and Angharad Wilson (both Forest of Dean) and Gwyn Morris (Stroud) As usual I have meetings with each new governor as part of their induction process. We are in the process of talking with governors about how their role can evolve in the period until governors are replaced by other means of securing patient and public engagement as envisaged by the NHS 10-year plan

4. Non-executive directors link with colleague inclusion networks.

We have non-executive directors nominated as links with each of our inclusion networks with a defined role which complements that of the Executive Directors.
The inclusion networks are organic, and some are able to be more active than others at the moment. In this context Marie Annick Gournet (BME network) John Cappock (disability network) John Noble (veterans' network) and Deborah Evans

(neurodisability network) have all been meeting with their respective network leads and attending events where appropriate.

5. Gloucestershire Managed Services and Equality, diversity and inclusion

Our colleagues working within Gloucestershire Managed Services (GMS) our wholly owned subsidiary are invited to join the relevant network, effectively making them “Group” rather than Trust networks.

Equality diversity and inclusion is actively included in the following activities: -

- manager / supervisor /colleague discussions during bi-weekly site visits by Chair and MD
- GMS Resilient Leaders training, including
    - behaviours, treatment and respect of others
    - recruitment and how to recognise / address bias
    - Equality Act, protected characteristics
- local ownership of people metrics in dashboards used at supervisor levels and above. GMS has recently been given access to its EDI data, and these will be incorporated into future iterations
- triangulation with staff survey and customer survey data by the leadership team
- development of options to support staff for whom English is not the first language, and with specific skills needs (such as IT)
- preparing for the Equality (Race and Disability) Bill: mandatory ethnicity and disability pay gap reporting.
- representative engagement in GMS [colleagues'] focus groups; campaigns development and co-created action plans

Penny Bickerstaff, the GMS recruitment officer is reaching out to communities of neuro diverse young people to support them to access work experience and internships and is collaborating with the National Star College on placements for some of their students.

6. Freedom to Speak Up

It was Freedom to Speak Up week during October, and to complement the work which Louisa Hopkins our Freedom to Speak Up Guardian is doing on “closing the loop” and ensuring that action results when colleagues speak up, we invited Louisa to join on of our non-executive director meetings. Louisa took us through a couple of recent anonymised case studies and illustrated where follow up had been seen as successful by the colleague concerned and a second where it was less conclusive.

Non-Executive Directors have also been doing the online training offered by the National Guardians Office.

7. Recommendation

The Board is asked to note this report.

Chief Executive Report to Board – November 2025

1 Patient Experience

1.1 Hate has no home in Gloucestershire

In early October, the Chairs of the two Trusts and the Chair of the new integrated care board cluster wrote an open letter in response to the rise in racially motivated incidents in our communities and aimed at our staff. Key elements of the letter are included here, as we continue to hear from staff their first-hand experiences.

Political debate and peaceful protest is a democratic right and we support the sharing of alternative views when done respectfully. However, some recent acts of protest and marches have been used by a small minority to create an unwelcome environment. This has led to an increase in verbal and physical threats, and our staff have been directly impacted while working to care for our community.

This is unacceptable. Our health and social care system relies on a skilled, multi-national workforce. Without them, we could not provide the high-quality care that Gloucestershire deserves. We stand with our multi-national colleagues and hear their concerns. We are committed to making sure everyone feels safe and supported, and we will not allow hateful rhetoric to divide us.

National symbols like the Union Flag and St. George's Cross represent our shared values and diversity. They should be symbols of pride for all and not used to spread fear and division. True British citizenship is found in everyday acts of kindness and the NHS represents the best of it.

In talking to our own staff the impact is clear and we will stand with them in taking action to tackle hate crimes against. We are working with local police and community groups to support neighbourhood policing, promote inclusion and encourage everyone who has experienced or witnessed a hate crime to report it. It is important that our staff are heard and that support is available.

Internally, our 2024 Staff Survey results told us that 18% of staff had experienced harassment, bullying or abuse at work from a colleague and 52% of those did not report it. Nearly 4% of staff also experienced at least one incident of unwanted behaviour of a sexual nature from staff or colleagues. These figures are concerning and are not just statistics; they represent real people in our Trust.

Despite the best efforts and zero tolerance approaches toward discrimination, bullying and sexual misconduct in the past, more change and action is needed. As a result, a new campaign aimed at tackling inappropriate behaviours and creating a safer, more respectful workplace for everyone has started.

The aim of the campaign is to empower everyone to act when they see or experience inappropriate behaviours, not just those directly affected. Linking with the new Report, Support and Learn system, which enables people to share experiences anonymously if they wish, the Trust can build a picture of patterns of issues to support with action.

The campaign is a visible and active commitment to culture change, and will be everyone's responsibility.

1.2 Resident Doctors and BMA Industrial Action

The British Medical Association has announced five days of industrial action in England, starting on Friday 14 November until 19 November 2025.

The union and government have been trying to resolve these issues since the last industrial action at the end of July and it will be the 13th time since March 2023 that the BMA and doctors have taken action, and is expected to cause disruption nationally and locally.

As part of the Trust's contingency planning, we will review all services and seek to ensure that any disruption is kept to a minimum and that patients can continue to access care normally.

During the five days of industrial action in July Cheltenham General Hospital's Emergency Department was temporarily reconfigured, operating as a Minor Injury and Illness Unit during daytime hours and closed overnight. We also had to cancel a total of 266 outpatient appointments (out of around 2000) and 59 of over 500 planned operations were cancelled, and our teams worked to reschedule affected patients.

1.3 Phlebotomy Industrial Action – update

Further talks have been held between the Trust and Unison regarding the ongoing strike by phlebotomists at Gloucestershire Hospitals NHS Foundation Trust.

At the time of writing this report, the latest meeting held on 20 October involved ACAS (Arbitration and Conciliation Advisory Service) to seek to make progress in the dispute and follows two other senior-level meetings held between both organisations over recent weeks.

In these meetings, the Trust has made several offers to Unison to seek a resolution to the current dispute. This includes an offer of:

1. **More pay** – a Band 3 Healthcare Support Worker (HCSW) role in outpatients for all phlebotomy staff.

2. **Backpay** – in recognition of the dispute, the Trust has offered to pay the difference between the current band and the new Band 3 HCSW role back to April 2025.

3. **Protection of current enhancements** – Some phlebotomy colleagues currently work a 1 in 4 rota covering 8am-12pm Saturday and Sunday, and receive pay on top of their contracted hours for this work.

   Under the new role, the weekend pay will be protected for a period of time, while a new model for weekend work is developed and put in place.

4. **Better training** – the Band 3 HCSW role is not only higher paid but also includes better training, leading to gaining a recognised Care Certificate (in line with other Healthcare Support Workers across the Trust).

   The Trust has offered up to 12 months of support for the transition to the new role and training, including paid time to complete any relevant aspects of training.

   The role also opens opportunities for career development and access to apprenticeships, including nurse associate or registered nurse roles.

5. **Improved facilities** – a better location for patients and staff for this service within the outpatients department. This will also improve the patient experience by addressing the issue the service had previously, where patients sometimes had to wait in the corridor to be seen.

6. **Maintaining the identity of the phlebotomy role** – We understand how important the phlebotomy identity is to the individuals, so the Trust has offered to strengthen the current Band 3 HCSW Outpatient job description to include specific references to phlebotomy as an integral part of the role.

As a Trust, maintaining the integrity of the national Agenda for Change Pay, Terms and Conditions framework is important in ensuring proper process is followed and that all staff groups across the Trust are treated fairly and equally.

The offers made to our phlebotomy teams ensure that, and will also mean the improvements made in the services and for patients during this strike are maintained and built on.

Over the past six months we have seen no drop in the quality of the blood samples being taken by HCSW staff and we have seen an improvement in discharges of inpatients before midday due to samples being processed.

This has helped the Trust with improving flow and ultimately care for patients throughout the hospital and contributing towards the improvements in ambulance handovers.

In summary, the Trust has made an offer for more pay, better training and better facilities for phlebotomy staff. A further meeting was held on Thursday 6 November 2025.

1.4 Supporting patients with "*This Is Me*"

A new programme of work to support patients with dementia, delirium, or communication difficulties, who often feel anxious and disoriented in hospital settings has started on Knightsbridge Ward in Cheltenham.

The "*This Is Me*" document helps ease this distress by giving staff essential insights into a patient's preferences, routines, and what matters most to them. This simple tool transforms care from generic to truly personalised, ensuring patients feel safe and understood.

On Knightsbridge Ward, the approach is practical and effective. Single rooms allow staff to keep the document visible and accessible, so vital details—such as preferred names, interests, and sensitivities—are immediately available. This reduces confusion and prevents distress, for example by avoiding sudden lights or unexpected knocks. While widely used in dementia care, the form also benefits patients with learning disabilities or autism, offering guidance for procedures and reducing agitation.

The benefits extend beyond patients. Families feel reassured and involved, knowing their loved one's preferences are respected. Ultimately, "This Is Me" strengthens compassionate, individualised care. It helps staff work efficiently while creating a welcoming environment where patients and families feel heard and supported.

1.5 Lions at Large auction

Over the summer, thousands enjoyed the free Wild in Art sculpture trail, which was a first in Gloucestershire and featured 32 large lions and 54 little lions in their vibrant colours and stunning designs across Gloucester and Cheltenham.

On 9 October, I had the privilege of joining nearly 200 guests who attended the live auction that took place at Gloucester Cathedral. The evening was a huge success, with people bidding in the room and online to give their favourite pride member a forever home. Hosted by BBC's Steve Knibbs, the event was overseen by auctioneers Harper Field Auctioneers and Valuers.

All the large lions and three little lions went to auction, while the remaining cubs have returned to stay at the schools and community groups who decorated them. In total, £220,000 was raised for

our Hospital Charity and the Big Space Appeal. Each lion sold for between £2,500 and £30,000, with 20 sculptures achieving £5,000 or more under the hammer.

The campaign has made a significant contribution to staff and patients, as well as truly engaging people across Gloucestershire and beyond who came to the county to follow the tour. This could not have been possible without the support of our charity team and they deserve the thanks of the Board for all their efforts over the past 18 months to make this all happen.

2. People, Culture and Leadership

2.1 Small Fire Tower Block at Gloucestershire Royal Hospital

On Tuesday 4 November 2025 there was a small fire that occurred just before 8am on the 8th Floor of the Tower Block at Gloucestershire Royal Hospital.

The fire was caused by a battery unit that powers the mobile computers that had malfunctioned. Staff from Gloucestershire Managed Services (GMS) responded immediately and, using their training were able to contain and move the battery to a non-clinical area. There was a lot of smoke and to ensure the safety of our patients, they were moved to the other wards, following our fire and evacuation plan.

The Fire and Rescue Service attended site quickly and were able to assess the area and ensure there were no further risks. They praised the response and care shown by the staff on the wards, clinical teams who came to assist and the GMS teams for the management of the situation.

Around 40 staff were assessed and some were treated for smoke inhalation and a small number were monitored for a longer period. Ongoing wellbeing support was put into place for all those affected and there will be a planned debrief for all staff involved.

Although the incident was resolved quickly, it caused some disruption and a Business Continuity Incident was declared to help with patient flow across the hospital.

Relatives of patients on the 8th Floor were proactively contacted to let them know what had happened and to reassure them if their loved one had been moved to another ward temporarily.

It is really important to recognise the way in which staff responded to the incident and colleagues did not hesitate to help one another and ensure that patients were always safe. It really was a phenomenal effort by everyone.

The incident underlines the importance of the Board's decision to support the essential works to upgrade fire infrastructure in the Tower Block and work has already begun.

3 Quality, Safety and Delivery

3.1 Medium Term Planning Framework

On 24 October 2025 NHS England (NHSE) and the Department of Health and Social Care (DHSC) jointly published a Medium Term Planning Framework covering the financial years 2026/27 to 2028/29.

Unlike most recent planning guidance that would cover only one year, the latest planning framework covers three years, following the three-year revenue and four-year capital spending review settlements published in the summer.

The framework commits to more ambitious targets across cancer, urgent care, waiting times, access to primary and community care, mental health, learning disabilities and autism, and dentistry, with an ambition to achieve constitutional standards by 2028/29 where possible.

It also 'returns to some of the basics that have taken a back seat over the last decade' incorporating expectations around patient and staff feedback, and is aligned to support delivery of the NHS 10-year health plan (10YHP).

There are some key changes the Trust will need to reflect in our own planning, including 4-hour A&E performance, with the expectation that every trust must maintain or improve to 82% by March 2027, up from 78 presently, and to 85% set by 2028/29.

Trust will need to deliver a minimum of a 7% improvement in 18-week performance, or deliver care to 65% of patients within 18 weeks, to meet the national performance target of 70% in 2026/27 and then achieve the standard of at least 92% of patients waiting 18 weeks or less for treatment by 2028/29.

There will also be annual limits on bank and agency spend, based on the national target of 30% reduction in agency use in 2026/27 and 10% year-on-year reduction in spend on bank staffing, working towards zero spend on agency by August 2029.

3.2 Temporary test of change - Community Theatres

The Trust is working with the ICB to pilot a new way of running community theatre services, which affects Cirencester, Stroud and Tewkesbury community hospitals.

For six months there will be a trial 'Centres of Excellence' bringing together specialist teams, equipment and best practice in a more focused way to explore whether this approach could improve care.

- Tewkesbury will continue to undertake Ophthalmology, ENT and Orthopaedic day cases
- Stroud will continue to undertake Breast surgery with plans to explore Urology surgery during the test period
- Other specialities which are currently performed at the three community theatre sites will be centralised during the test period at Gloucestershire Royal or Cheltenham General.

To make this possible, theatre activity in Cirencester will pause for six months during the test.

By concentrating services in fewer locations, the test of change aims to make more effective use of specialist staff and equipment, while reducing delays, including last-minute cancellations and inefficiencies caused by resources being spread across multiple sites.

This change could also help staff in the two centres to access more training and development opportunities, becoming more highly skilled in their speciality, which could lead to better care and outcomes for patients.

During this test, patients may need to travel to a different hospital for their treatment, but we will work to minimise disruption and ensure appointments continue as smoothly as possible, and people will still have some choice about where to go for treatment.

After the six-month trial, there will be a review of how well the changes have worked. This will include looking at patient outcomes, staff feedback and how efficiently services have run. The evaluation findings, including patient and public feedback, will be shared at Board and through the Gloucestershire County Council Health Overview and Scrutiny Committee.

3.3 Tower Block Gloucestershire Royal Hospital essential works

The Tower Block is 50 years old this year and has provided care for thousands of patients over the decades. While the exterior has recently benefited from a £11 million upgrade to help improve energy efficiency and an improved external appearance, it is essential to upgrade the inside of the building.

A critical area of work will be upgrading the fire infrastructure system in the tower, including the fire alarm and fire doors, to meet the latest safety regulations, protect our patients, staff and visitors, and ensure our buildings are fit for the future.

In order to replace the fire infrastructure system there is a need to carry out works on each ward within the Tower. The scope of the work will include the replacement of the fire infrastructure system, the nurse call bell system, planned work to develop same-day emergency services in the Tower and improve the overall ward environments.

To undertake this work, there is a need to decant each ward within the Tower. The approach will be to empty two wards on a floor of the Tower and to use this as a decant space, enabling the contractors to upgrade two wards, one floor, at a time. It is estimated that the work will take approximately 4-6 months per floor, meaning an overall timeframe of around 4 years to complete the works.

The proposals for the essential works for the Tower at Gloucestershire Royal were presented to Health Overview and Scrutiny Committee for discussion and supported.

3.4 National Maternity and Neonatal Investigation

It was confirmed on 15 September 2025 that Gloucestershire Hospitals NHS Foundation Trust would be included in the National Maternity and Neonatal Investigation led by Baroness Valerie Amos.

The Trust was included as one of 14 Trusts originally to be part of the investigation, although Leeds and Shropshire will now have standalone investigations, and we are expecting the visit from the national team between 4 -5 December 2025.

During the visit Baroness Amos will meet with senior leadership and staff across the maternity and neonatal services and have a tour of the facilities to also meet families. There will be interviews with selected colleagues, as well as requests for key documents for revie as part of an evidence panel.

The national investigation will consist of two parts. The first will investigate the 12 maternity and neonatal units and identify ways to improve care and safety. The second will undertake a system-wide look at maternity and neonatal care, bringing together lessons from past inquiries to create one clear, national set of actions to improve care across every NHS maternity service.

Recent maternity data published by NHS England shows that Gloucestershire continues to perform well against key national safety indicators and in the past two years has been focusing heavily on improving governance, electronic access to maternity notes, and enhanced risk assessments, as well as extensive recruitment of midwives and obstetricians. However, our improvement journey continues and is the focus of a significant proportion of our time as a Board.

The Trust is working with families, staff, and the wider community to assure them that it remains dedicated to transparency and continuous improvement. The service is listening to the voices of families and staff, and this review is a valuable part of the journey to ensure every woman, birthing person, baby, and family receives the care they deserve and continues to engage openly with communities throughout this process.

4 Regulatory

4.1 CQC Inspection – Maternity Services

A full inspection of Gloucestershire's maternity services has been completed, covering all five Care Quality Commission (CQC) domains: Safe, Effective, Caring, Responsive, and Well-Led. The review included services at Gloucestershire Royal Hospital (GRH), Stroud Maternity, and community maternity care.

The inspection took place at GRH on 9–10 September and at Stroud and community sites on 16–17 September. The Trust expects two separate reports: one for Gloucester and community services, and another for Stroud. Each report will carry its own ratings. CQC has indicated that reports will be available within six to eight weeks.

4.2 National Neonatal Audit Programme (NNAP).

The Trust has been recognised for outstanding performance in two key areas of neonatal care, based on the 2024 data from the National Neonatal Audit Programme (NNAP). These achievements reflect the commitment to high-quality care for newborns and its leadership in improving outcomes for vulnerable babies.

The first recognition is for the use of antenatal magnesium sulphate, a treatment given to mothers before birth to help protect babies from brain injury. Gloucestershire Royal Hospital achieved a perfect score, with 100% of eligible babies receiving this treatment, significantly higher than the national average of 86.7%, placing the hospital well above the expected performance range.

The second recognition is for non-invasive ventilation, a method of helping babies breathe without using more invasive procedures. The service showed a strong positive impact, with babies receiving this care doing better than expected compared to similar babies treated elsewhere. This was confirmed through a detailed analysis that adjusts for differences in baby characteristics across hospitals.

These results highlight the dedication and expertise of our staff and services. The full NNAP report will be published in October 2025.

Kevin McNamara
Chief Executive

Report to Trust Board of Directors			
Agenda item:		**Enclosure Number:**	
Date	13 November 2025		
Title	**Report to the Care Quality Commission - Section 31 Summary Reports**		
Authors **Presenter**	Women's and Children's Division Speciality Director – Chris Edwards /Rebecca Swingler (Supported by Deputy Director of Quality - Suzie Cro) **Director of Quality and Chief Nurse – Matt Holdaway**		

Purpose of Report		Tick all that apply ✓	
To provide assurance	✓	**To obtain approval**	
Regulatory requirement	✓	**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Background

The purpose of this coversheet is to summarise the key steps taken to eliminate immediate risk with respect to each point in the CQC Section 31 letter dated 9 May 2024. In summary, the CQC have received monthly reports and all these reports have been provided to Board members in the virtual "Reading Room" (Board access only).

In May 2024, Maternity Clinical Teams were set up to lead the improvement work and they have completed quality improvement (QI) training. The teams are all making progress with their improvement projects and will continue to report on a monthly basis to the Executive Led Perinatal (Maternity) Delivery Group and for assurance to the Quality and Performance Committee. There is an improvement programme for Perinatal Governance and a new Framework has been published for staff internally.

Position

Please note:

- We have rated 7 conditions (self-assessed) as blue (complete and compliance sustained).

- We have assessed PPH as amber (requires improvement) as we want to be able to demonstrate that we continually **risk assess and manage** the risk of post-partum haemorrhage (PPH).

- Our booking (81.6%) and 36/40 (72.4%) PPH risk assessment checklists are not being consistently completed within Badgernet (target 85-90%).
- In response to this we have completed a thorough review to look at the barriers of completion with key staff and have found that not all the information is all available at the time of booking and this is the barrier to fully completing the assessment.
- We have further reviewed the "general booking risk assessment" and this is being completed.
- The general risk assessment contains mandatory fields and so the completion compliance is high at 99.7%. This general booking risk assessment is a holistic assessment and encompasses all the PPH risk factors you would want the midwife to identify at booking. Once women are identified with risk factors for PPH then the midwife is able to book women Consultant Team appointments. Team PPH will then make a decision about the usefulness of the additional booking PPH risk assessment.

Position	Self-assessment	Total 8
Conditions met	Fully met and sustained (condition)	7
	Target met	0
Improvement required	Targets not all met	1 (1 PPH)

Continuous improvement

Our **5-key quality improvement work streams** continue to enact changes and improvements that will keep mothers, babies and birthing people safe. The impact of our **improvement projects** has been:

Postpartum haemorrhage (PPH)

- Early recognition and prompt action are crucial in preventing severe complications and by maternity clinicians using the REDUCE checklist this ensures that critical steps are not missed during high-stress situations and support the effective management of PPH.
- We have improved outcomes for women as we have sustained the reduction of our PPH rate, of 1500 ml or more (rate per 1000), to be in line with national average as our rolling **6-month average** is 34.67 and national rate 32 (rate per 1000).

Venous Thromboembolism (VTE) risk assessment completion >95% (target 95%)

- VTE risk assessments are crucial in maternity care to identify pregnant and postpartum individuals at increased risk of developing blood clots, which can lead to serious complications like pulmonary embolism (PE) and maternal death.

- By assessing risk factors (booking, admission, and postpartum) our colleagues are able to implement preventative measures like anticoagulant medications to reduce the likelihood of blood clots.

Electronic Fetal Monitoring

Peer Reviews now being completed 90% of the time (target 85%)

- Fetal monitoring peer reviews are conducted to ensure consistent and accurate interpretation of fetal heart rate patterns during labour, which is crucial for identifying potential fetal distress and guiding appropriate interventions. These reviews help standardise practices, minimise errors in interpretation, and ultimately improve fetal outcomes.

Accurate interpretation of electronic fetal monitoring (CTG) 90% and escalation of concerns 95%

- Accurate CTG interpretation and timely escalation of concerns are crucial for ensuring the safety of the baby during labour and delivery. Incorrect interpretation can lead to delayed or inappropriate interventions, potentially resulting in stillbirth, brain injury, or other adverse outcomes. Escalating concerns ensures that expert opinion is sought when needed and that appropriate action is taken promptly.

Agency midwives

- Our use of midwifery agency staff has decreased and when we do book agency staff we ensure that they have the support they need to work in our hospital.

Maternal early warning scores

- Maternal Obstetric Early Warning Scores (MOEWS) are used to identify and respond to signs of clinical deterioration in pregnant women.
- By monitoring vital signs and other physiological parameters, early warning scores help clinicians to quickly recognise when a woman's condition is worsening and escalate care appropriately.

As required by CQC, the enclosed Reports and the Maternity Dashboards were sent to the CQC by the deadlines. The next report will be prepared and sent to CQC by 29 September 2025. The Trust are also providing assurance externally to the ICB Enhanced Oversight Group (EOG) (next meeting 9 September 2025). Progress continues to be made with the Maternity Senior Leadership Team preparing for the next CQC inspection.

Recommendation

The Board is asked to note the contents of the table and receive assurance that a robust improvement programme of work is underway.

Enclosures

- Appendix 1 – summary position against conditions (see end of coversheet)

Reading Room (board access only)

- September and October CQC S31 2025 Reports

Appendix 1

Table: Brief summary of metrics and targets

<table>
<tr><th>Condition</th><th>Condition description</th><th>Met/ not met</th><th>Focus</th></tr>
<tr><td>1.</td><td>Implement an effective system for ensuring staff at Gloucestershire Royal Hospital continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH).</td><td>Improvement required

Not meeting targets for risk assessments documentation</td><td>Risk assessment

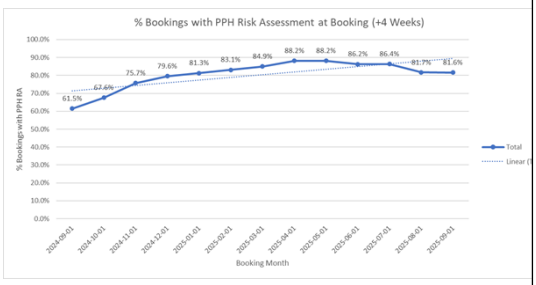
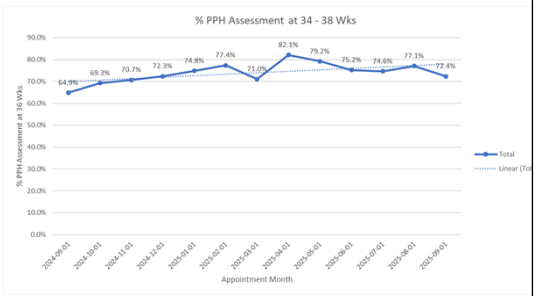
<u>General risk assessment at Booking</u>

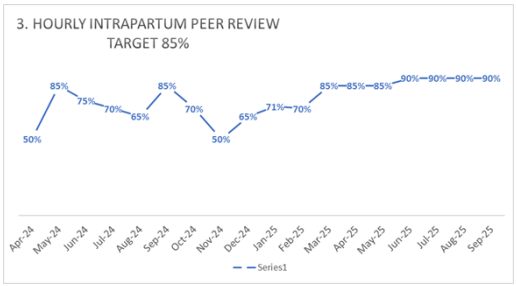
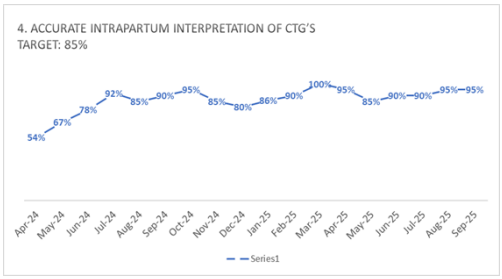
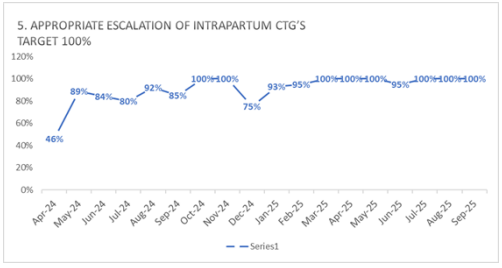
The general risk assessment at booking covers all the risk factors for PPH and completion rates are 99.7% - 100%.

<table>
<tr><th>Booking Month</th><th>GHT Bookings</th><th>Risk Assessment at Booking</th><th>Sum of %</th></tr>
<tr><td>2025-05-01</td><td>490</td><td>490</td><td>100.0%</td></tr>
<tr><td>2025-06-01</td><td>505</td><td>505</td><td>100.0%</td></tr>
<tr><td>2025-07-01</td><td>564</td><td>564</td><td>100.0%</td></tr>
<tr><td>2025-08-01</td><td>500</td><td>500</td><td>100.0%</td></tr>
<tr><td>2025-09-01</td><td>553</td><td>553</td><td>100.0%</td></tr>
<tr><td>2025-10-01</td><td>563</td><td>563</td><td>100.0%</td></tr>
<tr><td>Grand Total</td><td>3175</td><td>3175</td><td>100.0%</td></tr>
</table>

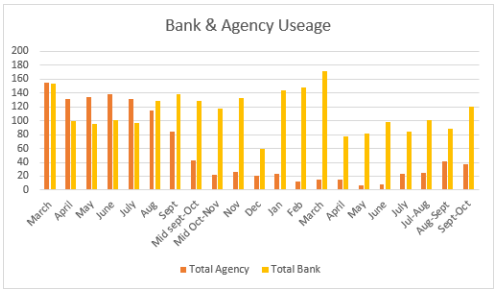
<u>PPH risk assessment at Booking</u>

Our completion rates for booking PPH risk assessment is 81.6%</td></tr>
</table>

Condition	Condition description	Met/ not met	Focus
			(target 85-90%). This form contains fields that cannot be completed at booking.  <u>36/40</u> This data demonstrates a 72.4% completion rate (target 85-90%). We will review barriers to completion with clinicians.  <u>On admission</u> The on-admission risk assessment average is >90% (target 90%). **Management of PPH** REDUCE checklist completion is 85% (rolling average over the last 3 months) (target 85-90%). **Next steps** - Meeting with the senior leaders to discuss and agree the measurement of the booking and 36/40 risk assessments (booking is part of general risk

Condition	Condition description	Met/ not met	Focus
			assessment and we are 99% compliant). - Continue focus in obstetric theatres - Introduction of hot debriefs - Improving thematic analysis with the support of Business Information.
2.	Ensure maternity staff at Gloucestershire Royal Hospital complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in line with national guidance.	Met and sustained for 6 months	Target sustained 
3	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **interpret fetal monitoring traces accurately** and **escalate** in line with Trust guidance to ensure all women and birthing people and their babies are cared for in a safe and effective manner in line with national guidance.	Met and sustained for 6 months	Targets sustained  
4.	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **complete and escalate maternity early obstetric warning score (MEOWS) charts** in line with national	Met and sustained	Current compliance for "Act on Amber" sustained within 90-95% range for all clinical areas (intrapartum and postnatal). We have reviewed MEOWs completion (all parameter complete) at the initial assessment in Triage

Condition	Condition description	Met/ not met	Focus
	guidance during intrapartum and postnatal care.		and this is currently 88% (target 90%).  **Next steps** Continue to make improvements to Triage MEOWs completion. New national maternal early warning score system being implemented in March 2026 and this is being planned for.
5.	Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.	Met and now sustained	Data provided to CQC as part of Inspection data request 30 September 2025. Guideline discussed at clinical effectiveness and awaiting haematology review (Policy VTE M2014) Nov 2025. **Next steps** Plan to move to oversight audits with BI pulling the data directly from Badgernet and discussions in progress.

Condition	Condition description	Met/ not met	Focus
6.	Implement an effective system for ensuring agency midwifery staff have a comprehensive induction to the unit, are able to access the maternity electronic records system and Trust policies, as well as enter and exit the unit without delay.	Met	We have implemented an effective system for ensuring agency staff have an induction. We have also reduced our agency usage. A 6 monthly Perinatal Workforce Report has been received by the Perinatal Oversight and Assurance Committee in October 2025. 
7 & 8	Monthly reports (to include PPH and Fetal Monitoring QI plan) Perinatal dashboard	Met	Monthly reports have been submitted to CQC, Trust Board, PDG and Q&P with the Perinatal dashboard demonstrating compliance. Progress is reported within the Division in the Perinatal Quality Surveillance Report.

Report to Board of Directors			
Agenda item:		**Enclosure Number:**	
Date	13 November 2025		
Title	Perinatal Quality Surveillance Report Q2 July- September 2025/26		
Author /Sponsoring Director/Presenter	Perinatal Quality and Governance Lead – Sarah Ashwood (Supported by the Director of Quality Governance) Chief Nurse and Director of Quality - Matt Holdaway		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	✓
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report

Our perinatal quality surveillance report aims to ensure consistent and methodical oversight of maternity and neonatal services, identify potential issues early, and drive improvements in care quality and safety. It provides our framework for monitoring, analysing, and acting on data related to perinatal care, ultimately contributing to better outcomes for mothers and babies.

The report has been reviewed in detail at the Perinatal Oversight and Assurance meeting and Divisional Board. It is scheduled to be presented and discussed in detail at the Perinatal Delivery Group (PDG) on the 12th November 2025.

In summary, the report contains the following information:

Independent perinatal mortality reviews

- Both the external neonatal death review and maternal death review action plans continue to progress, with oversight provided by the Trust Safety and Experience Review Group (SERG).

Data alerts

- During Q2 there were 16 babies **born before arrival** (BBA) to the maternity unit. BBA refers to a birth that occurs outside of the planned birth location prior to the arrival of midwifery/obstetric staff. The Trust are currently flagging above the national average for the number of BBA's at around 1% of births, compared to the national rate of 0.5%. A table-top review (structured discussion) was undertaken by the senior midwifery team to understand any themes, and to see if these any of the BBAs were avoidable. There was 1 case which was potentially avoidable, and this has been reviewed as a previous safety

incident. There were no themes identified that could have avoided the BBAs. The maternity department will continue to monitor the data for themes and trends and any safety incidents.

- For the month of July, the maternity unit flagged as an outlier on the National Clinical Quality Improvement Metrics (CQIM) data for **neonatal readmissions**. A thematic review has been undertaken showing that most readmissions were related to issues with infant feeding, including weight loss and jaundice. Infant feeding has now been added as a risk on the risk register, and the Director for Maternity Improvement has now met with the infant feeding leads to formulate a improvement action plan. We will continue to monitor rates monthly to have oversight of the effectiveness of the actions.

Learning from deaths – perinatal mortality review tool (PMRT)

- During Q2 there were 7 perinatal deaths. There were 6 antepartum stillbirths, and 1 neonatal death. All cases have received a multi-disciplinary review to identify any potential safety concerns, and all cases have been presented through Patient Safety Review Panel. Professional duty of candour has been completed, and all cases will be reviewed using the Perinatal Mortality Review Tool (PMRT). Cases are highlighted in more detail with learning identified and actions undertaken, within slides 10 and 11 and actions are being taken to improve timeliness of reviews (*Maternity Incentive Scheme Safety Action 1- as a Trust we are using the PMRT to review deaths to the required standard).*

Speciality specific training

- Multi-disciplinary speciality specific training compliance is detailed within slide16. There has been a reduction in both obstetric and anaesthetic compliance due to a recent rotation. The Maternity Incentive Scheme (MIS) supports a 6-month window (from their start date) to achieve compliance, and this is supported by the action plan that has been put into place and is included within slide 17. Compliance with MIS safety action 8 is expected to be achieved, however this is reliant on all staff booked onto training days, attending. (*Maternity Incentive Scheme Safety Action 8 – multiprofessional training compliance)*

Perinatal safety champions

- The Maternity and Neonatal safety champions continue to meet bi-monthly, supported by the Board safety champions. The Board safety champions continue to meet with the Perinatal Quad and this is detailed within slide 29 (*Maternity Incentive Scheme Safety Action 9 – clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues).*

Maternity and neonatal cultural improvement plan

- The perinatal culture improvement work continues, and an update has been provided

within slide 29.

Claims scorecard

- The maternity team have now received the updated claims scorecard for years 2015-2025. A triangulation exercise has been undertaken and is detailed within slides 19-25. There was a total of 61 obstetric claims during the specified time frame. This represents 13% of all Trust claims, but 70% of Trust claims by value.

Neonatal safer staffing standards

- The Board are asked to note the compliance with British Association of Perinatal Medicine (BAPM) standards in relation to neonatal nursing and neonatal medical standards within slide 28.

NHS Resolution Maternity Incentive Scheme

- The Maternity Incentive Scheme Year 7 update has been included within the slide set as our current position. We are currently non-complaint with Safety Action 1 (PMRT) due to our compliance with publishing reports within the 6-month timeframe, and Safety Action 4, due to our compliance with the locum obstetrician audit which is at 94% (must achieve 100%). Safety Action 8 is at risk (MDT training), and as noted above, compliance will be dependent on booked attendance.

Transitional Care (TC)

- We can demonstrate that we have TC services in place and we are undertaking quality improvement.

Recommendations

Safety action 1

1.We recommend that the Board note the PMRT report for quarter 2 (slide 10-11) and note that these reports have been discussed with the Board Safety Champions at the Perinatal Delivery Group on an ongoing basis (please note that there was an omission and that the Q4 PQS Report was not presented to the Board). Actions are being taken to improve timeliness of reviews.

Safety action 4

2. We recommend that Board please note and approve the action plan for rotational medical staffing (slide 17).

3. We recommend that the Board formally record in the minutes that we meet compliance with BAPM standards in relation to neonatal medical workforce and neonatal nursing workforce standards.

Safety action 9

4. We recommend that the Board are asked to note and confirm with the Board safety champions that they continue to meet with the Perinatal Leadership Team (Quad) (at least bi - onthly) and Maternity and Neonatal Voices Partnership (MNVP) (slide 29). 5. We recommend that the Board note the progress with the perinatal culture improvement work (slide 29). 6. We recommend that the Board note the Claims Scorecard and that it has been reviewed and the data triangulated with incident and claims data.
Enclosures
Perinatal Quality Surveillance (PQS) Report Q2

Gloucestershire Hospitals
NHS Foundation Trust

Perinatal Quality Report

Quarter 2, July- September 2025/26

the Best Care for Everyone
care / listen / excel

Quality Dashboard

Quality measure	Regional benchmark if applicable	National Benchmark if applicable	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
After event Review (AER)	N/A	N/A	2	1	1	2	0	0	0	0
Patient Safety Incident Investigation (PSII) commissioned	N/A	N/A	0	0	0	1	3	1	0	0
Quality Summit (QS)	N/A	N/A	0	0	0	0	0	0	0	0
NEW MNSI referrals	N/A	N/A	0	0	0	0	0	0	0	2
Direct maternal death	0 per 100,000	13 per 100,000	0	0	0	0	0	0	0	0
Stillbirths (24 weeks gestation and above)	2.8 per 1000	3.4 per 1000 births	0	0	2 (4.5 per 1000)	0	2	2	4	0
Neonatal Deaths (> 24 weeks gestation)		1.6 per 1000 births	2 (5.2 per 1000)	1	0	0	0	1	0	0
Babies born at < 27 weeks gestation at GHNHSFT	3.6 per 1000	4.1 per 1000	0	1	0	2 (twins)	0	0	0	1
Term admissions into the neonatal unit (ATAIN)	/	5% (50 per 1000 births)	4.47% (45.7 per 1000)	3.84% (38.4 per 1000)	4.46% (44.6 per 1000)	2.74% (27.4 per 1000)	4.1% (40.1 per 1000)	2.3% (23.4 per 1000)	3.7% (37.7 per 1000)	3.15% (31.5 per 1000)
Coroner Regulation 28 made directly to the Trust	/	/	0	0	0	0	0	0	0	0

Operational Activity Quarter 2

Births

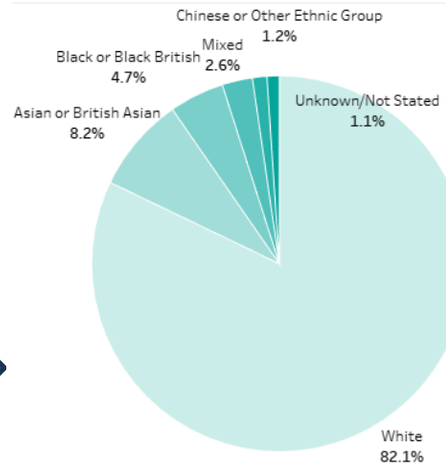
Location

Total Births (Registerable)

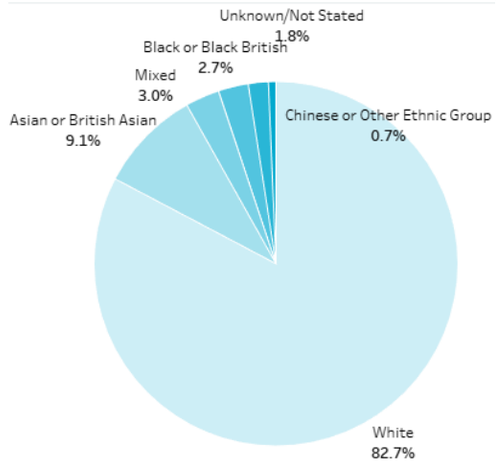
1,348

Delivery Suite Gloucester	Birth Unit Gloucester	Planned home birth	Birth Centre Stroud	BBA	Triage Gloucester
1,131	164	9	22	16	1

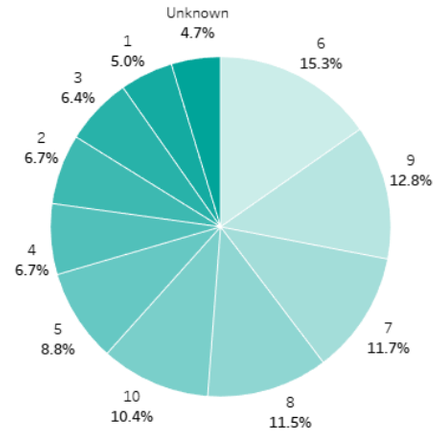
Bookings by Ethnicity



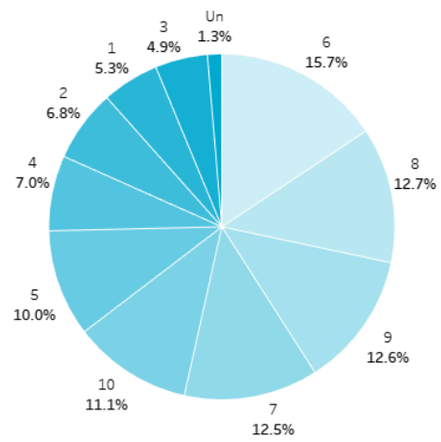
Births by Ethnicity



Bookings by Deprivation



Births by Deprivation

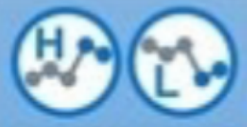


Births

Ethnicity

Deprivation

SPC Chart Guidance

Variation			Assurance		
					
Common Cause No significant change	Special Cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special Cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates consistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

Operational Activity

Above Standard Deviation | Within Standard Deviation | Below Standard Deviation

C-sections

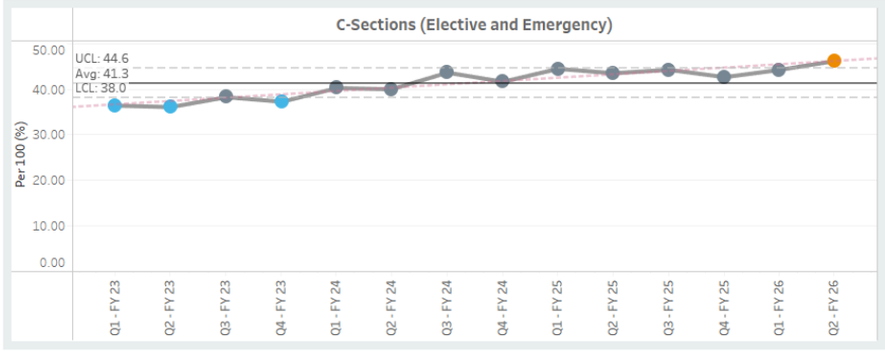
Latest Month

Metric ⓘ

Metric:	C-Sections (Elective and Emergency)
Rate of:	C-Section Births (Registerable)
Per 100 (%):	Registerable Births

46.1

Trend



Notes

There has been a steady increase in the number of caesarean sections, whilst this is not a quality metric, it is important to monitor from a provision perspective. There is an ongoing QI with a focus on caesarean section provision

Induction of Labour

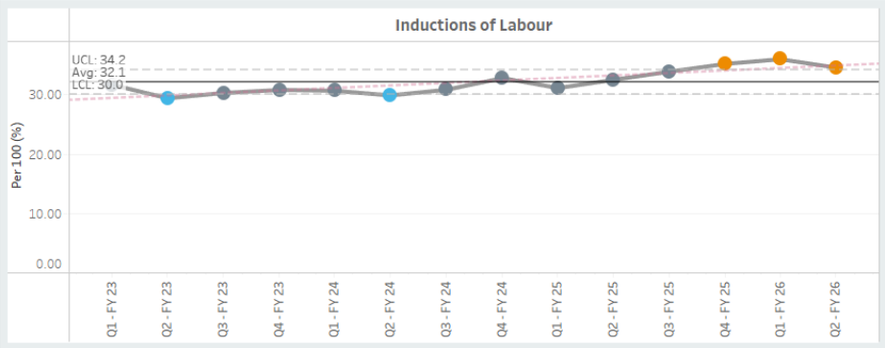
Latest Month

Metric ⓘ

Metric:	Inductions of Labour
Rate of:	Induced Deliveries (Registerable)
Per 100 (%):	Registerable Deliveries

34.6

Trend



Notes

We have seen an increase in our induction of labour rate over the past 12 months. This is in line with the national picture but is also reflective of policy change within maternity, for example a refreshed fetal movements guideline

Instrumental Births

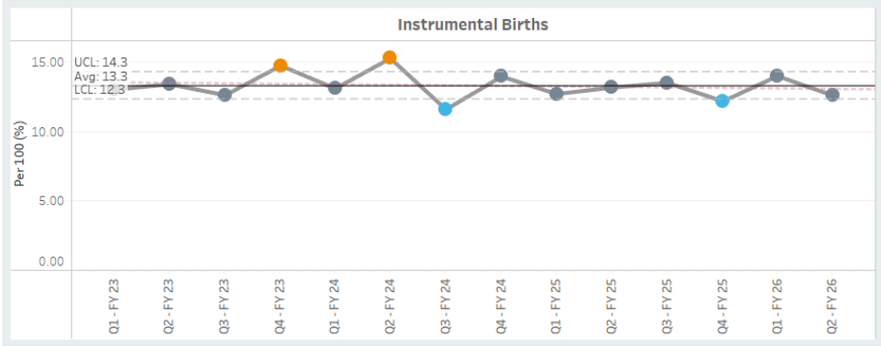
Latest Month

Metric ⓘ

Metric:	Instrumental Births
Rate of:	Ventouse and Forceps Births (Registerable)
Per 100 (%):	Registerable Births

12.6

Trend



Notes

Our instrumental births or assisted vaginal deliveries include both forceps and ventouse births. Instrumental births have fluctuated slightly over the past 3 quarters. There are no concerns regarding the current instrumental birth metric. National figures sit between 11-16% of all births.

SVB

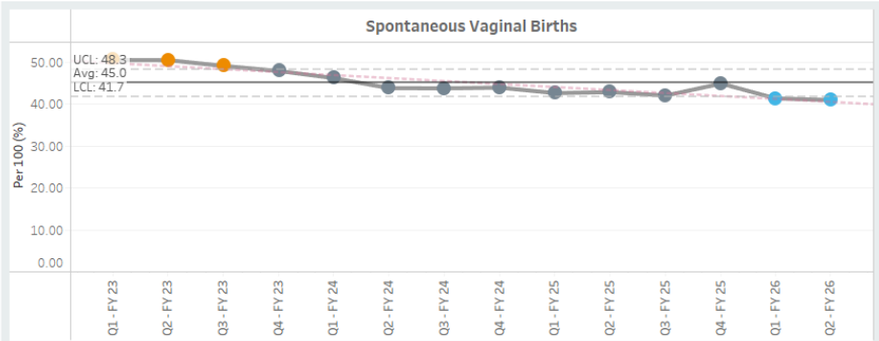
Latest Month

Metric ⓘ

Metric:	Spontaneous Vaginal Births
Rate of:	Spontaneous Vaginal Births (Registerable)
Per 100 (%):	Registerable Births

40.9

Trend



Notes

The number of spontaneous vaginal births have reduced over the past 2 quarters, and this is in line with the increase in caesarean sections

Gloucestershire Hospitals NHS Foundation Trust Perinatal Quality Surveillance Reporting

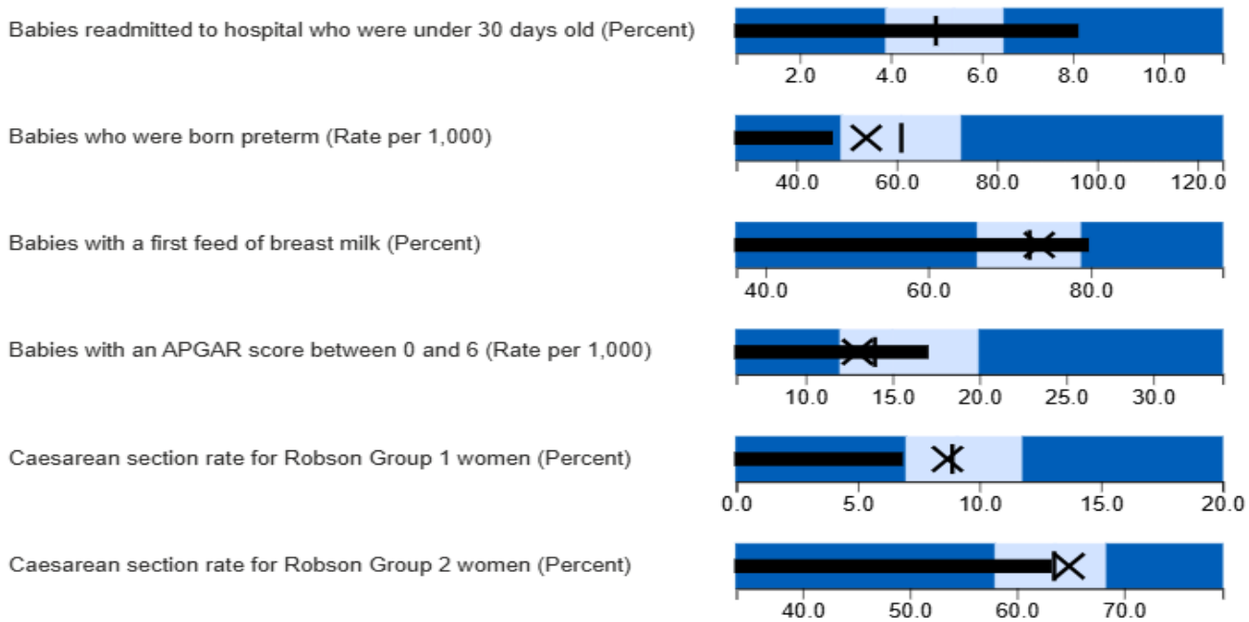
Month: Q2 2025/26	Gloucestershire Hospitals NHS Trust Perinatal Quality Surveillance Reporting					
CQC Maternity Ratings: GRH	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Not rated	Inadequate	Not rated	Not rated	Inadequate	Not rated
CQC Maternity Ratings: Stroud Maternity Unit	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Not rated	Requires Improvement	Not rated	Not rated	Requires Improvement	Not rated
Maternity Safety Support Programme	Yes		Support: Amy Stubbs			

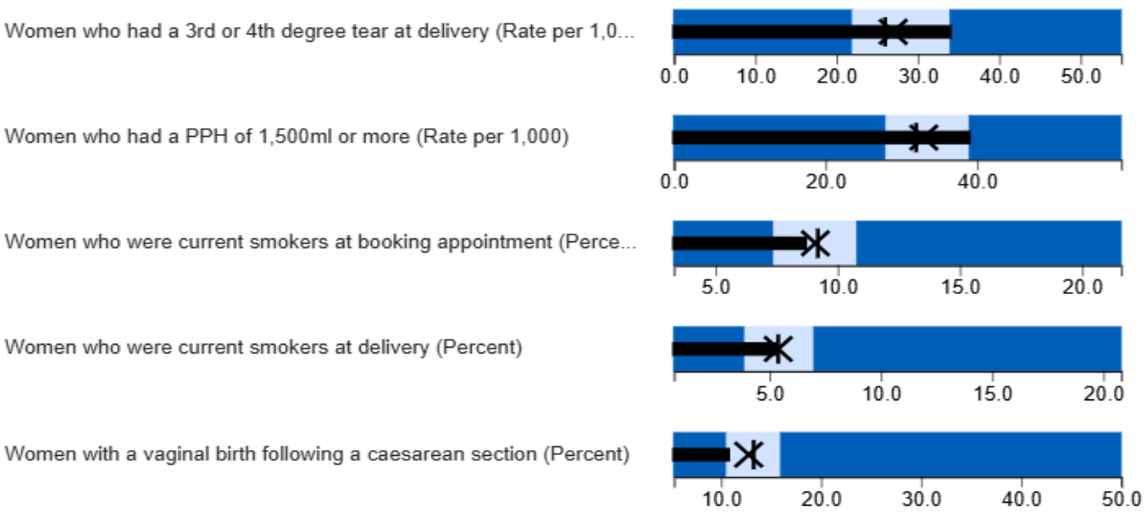
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust	1 concern raised by the CQC in relation to triage wait times	No	No	No	No	No	No	No
Coroner Regulation 28 made directly to the Trust	No	No	No	No	No	No	No	No
Progress in achievement with MIS Year 7	We are in reporting period for year 7 which with the relevant time period for reporting as April 2nd 2025 to November 30th 2025. The perinatal delivery group receives a monthly update on MIS year 7 progress							
Number of incidents reported as moderate harm or above			0	4 2 historic neonatal death cases as part of external review (both PSII's) Baby transferred to tertiary unit and fits criteria for MNSI due to seizures HDU care required	3 2 historic neonatal death cases as part of external review (both PSII's) Antepartum stillbirth	6 Return to theatre for bowel obstruction Non-accidental injury Antenatal stillbirth Wound dehiscence Preterm c/section, rapid progress, no steroids or Mag sulphate	7 Massive obstetric haemorrhage x 2 Unplanned admission to DCC Violence and aggression incident from patient to staff Delayed x-ray review of mother with possible paralytic ileus Inappropriate staff behaviour Massive	12 Thematic stillbirth review ITU admission with suspected sepsis Baby sent for therapeutic cooling Baby admitted to tertiary unit for further care Increased activity in triage leading to BSOTS breaches Retained placenta and PPH 3rd degree tear following forceps Preterm birth at 25+3 Failure to follow up hypertensive mother postnatally PPH

National Clinical Quality Improvement Metrics (CQIMS) data – Q2

Baby readmissions < 30 days

We have recognised that we are flagging as an outlier for babies readmitted under 30 days of age. We had 22 readmissions during the month of July. We have conducted a thematic review of all 22 cases. Of the 22 cases, 12 were readmitted for weight loss > 12%, 5 for jaundice, 1 for possible infection, 1 baby for a renal review by a neonatal consultant and 3 for SBR rechecks. The thematic review will be presented through the October POAC. Data collection was complicated due to the use of 2 digital systems being in use. This will feed into the current digital improvement workstream. More support is required in the infant feeding space, with parents asking for more support and information to be provided on breastfeeding. Infant feeding has now been reported as a risk on the risk register. The Director for Maternity Improvement has now met with the infant feeding team to support the improvement plans.





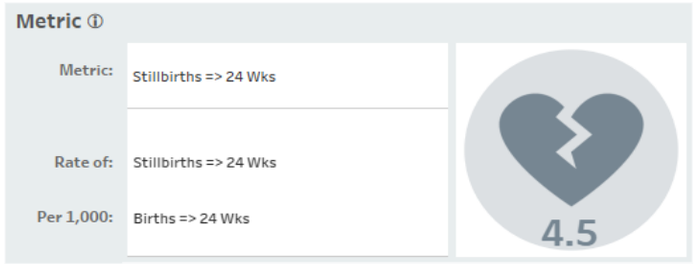
3rd and 4th degree tears (Obstetric Anal Sphincter Injury, OASI)

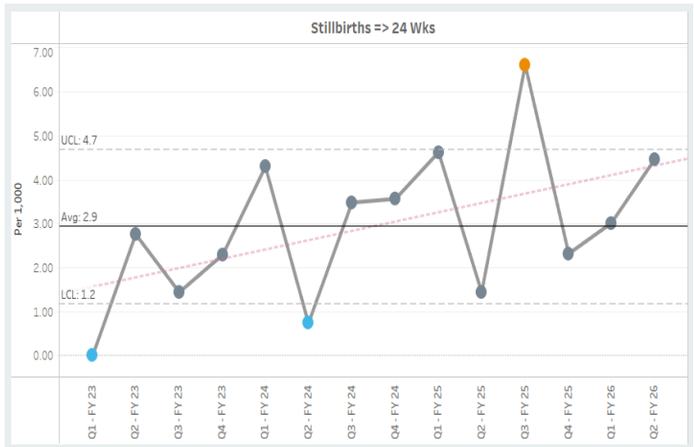
We are now sat just below outlier status for 3rd and 4th degree tears during July within our national CQIMS data. The 3rd and 4th degree tears during August show improvements within the instrumental delivery category. The overall 3rd and 4th degree tear rate, and those sustained following a spontaneous vaginal delivery have increased slightly during August. The OASI leads have been asked to review the slight increase during August to identify any contributing factors.

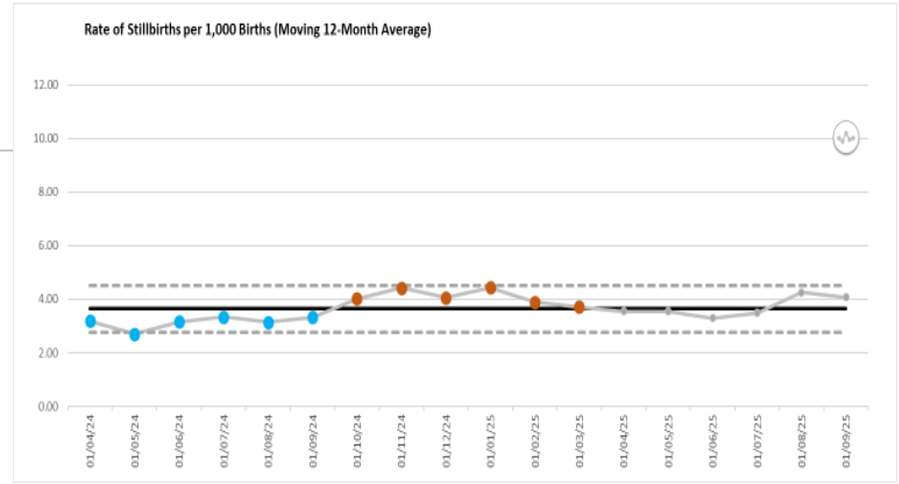
Learning from Deaths

PERINATAL MORTALITY REPORT

Quarter 2		
Type of loss	**Number over quarter**	**Rate per 1000 births across the quarter**
Stillbirth > 24 weeks	6	4.5 per 1000
Neonatal death	1	2.2 per 1000
Maternal Death	0	0.0 per 1000







MBRRACE-UK Saving Lives, Improving Mothers' Care, State of the Nation report – we have reviewed the national publication, and the key findings are as follows:

- There was a statistically non-significant decrease in the overall maternal death rate in the UK between 2020-22 and 2021-23
- Thrombosis and thromboembolism was the leading cause of maternal death during or up to six weeks after the end of pregnancy
- Rates for late maternal deaths occurring between six weeks and 1 year after the end of pregnancy continued to increase
- Suicide was the leading cause, with deaths from psychiatric causes accounting for 34%
- The rate for women from black ethnic backgrounds continued to decrease
- The report contained several recommendations, and these were a call at national level to:

➢ Set up an urgent referral pathway in early pregnancy for women with high-risk medical conditions or complex social circumstances to ensure they receive early triage for senior or specialised consultation
➢ Develop guidance for information-sharing within maternity services, and across health services and other agencies, in the event of safeguarding concerns

What is the intelligence telling us?

Stillbirths

- During Q2 there were a total of 6 stillbirths.
- All 6 stillbirths occurred in the antenatal period (0 intrapartum), with a gestation ranging from 24 weeks gestation up to 37 weeks' gestation
- All cases have undergone a multi-disciplinary scoping to identify any immediate safety concerns and have been presented at Patient Safety Review Panel to ensure that additional PSIRF learning responses are considered
- None of the cases during Q2 have had an additional PSIRF learning response commissioned
- All cases have or will be reviewed through the Perinatal Mortality Review Tool (PMRT) process
- The themes and learning from Q2 cases have been included in the PMRT update on slide 9

Neonatal Deaths

- During Q2 there was 1 neonatal death

Maternal Deaths

- There were no direct maternal deaths during Q2.

The new lead bereavement midwife commenced post mid-October. An improvement action plan will be formulated by the lead bereavement midwife and the lead obstetrician for bereavement

Baby loss Awareness Week was held between the 9th and the 15th October. The maternity team supported both families and staff during the week with displays, ribbon tying, lighting the maternity entrance and remembrance garden, and a special service of remembrance in Cheltenham.

Perinatal Mortality Review Tool update Q2

During Q2 there were a total of 7 perinatal deaths. There were 6 antenatal stillbirths above 24 weeks gestation, and 1 neonatal death above 22 weeks' gestation (MBRRACE criteria). We have not met the standard for publishing of PMRT reports within 6 months. The target is 75% of reports and we are currently at 43%. This is due to a high number of PSII investigations that have been undertaken on perinatal deaths within the timeframe, which has led to delays in finalising the PMRT. We have also seen a cluster of cases within the MIS reporting period which has created a delay in reviews. The request for additional PMRT meetings has not been facilitated due to obstetric PA time and availability. For the next reporting period, we have increased perinatal governance hours and support within the PMRT space to ensure we have robust oversight. The aim is to review all PMRT within their reporting quarter as this is not currently being achieved at present.

Grading of Care for PMRT:

A – there were no care issues identified
B – there were care issues that did not impact on the outcome for the baby/mother
C – there were care issues that may have impacted on the outcome for the baby/mother
D – there were care issues that were likely to have impacted on the outcome for the baby/mother

Type of perinatal death	Immediate learning identified	Action taken	PSIRF learning response commissioned	Reported to MBRRACE within 7 working days	Parents informed of PMRT process	PMRT review commenced within 2 months	Grading of care if PMRT review completed	Was an external panel member present at PMRT review
Antenatal stillbirth	Concerns highlighted surrounding the diagnosis of an intrauterine death and subsequent management. Did not impact the outcome but has impacted on patient experience	Escalation to obstetric specialty director, individual learning, and locum no longer working for us	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken
Antenatal stillbirth	Badgernet leaflets not accessed in pregnancy (not related to outcome)	To be actioned through monthly digital workstream	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken
Antenatal stillbirth	CO not completed at every appointment (not contributory)	Monitored through Saving Babies Lives audits	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken

Type of perinatal death	Immediate learning identified	Action taken	PSIRF learning response commissioned	Reported to MBRRACE within 7 working days	Parents informed of PMRT process	PMRT review commenced within 2 months	Grading of care if PMRT review completed	Was an external panel member present at PMRT review
Antenatal stillbirth	Learning identified relating to triage and advice given over the telephone.	For review through PMRT and to feed into Triage QI Learning shared with triage around having a low threshold for inviting women to attend for assessment when reporting pain	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken
Antenatal stillbirth	Delayed diagnosis of gestational diabetes due to incorrect interpretation of GTT results (not felt to be contributory)	Diabetes risk now raised, guideline currently under review, QI needs escalation	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken
Antenatal stillbirth	No documented obstetric review when attended with hypertension at 26 weeks	Learning shared through Triage QI	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken
Neonatal death	No obvious care issues identified	To undertake PMRT with neonates	No additional learning response	Yes	Yes	Yes	Not yet undertaken	Not yet undertaken

Perinatal Patient Safety Key Performance Indicators

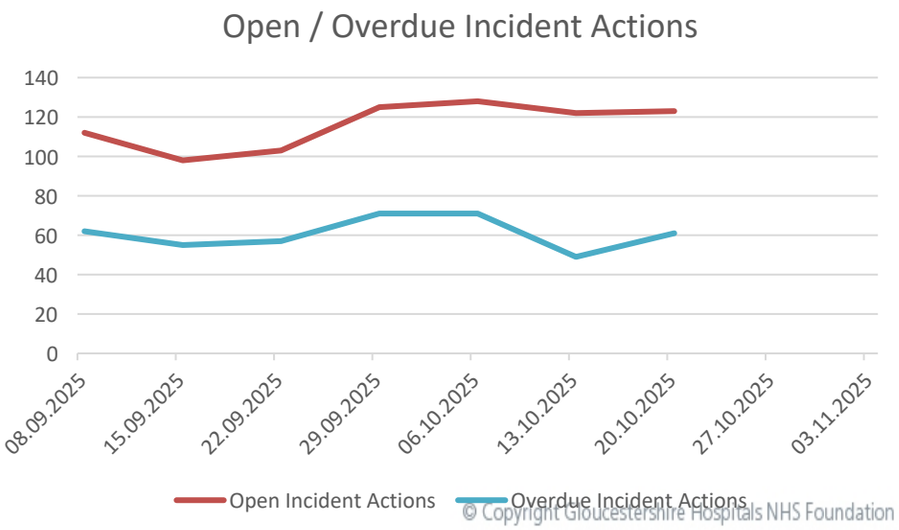
	July	August	September
Open Datix	218	224	251
Overdue Datix	104	107	40 (excluding PSII, MNSI, AER, PMRT)
MPR due	8	10	6
Open incident actions	/	112	125
Overdue incident actions	/	62	71
New MNSI cases	0	0	2
Open MNSI	2	2	4
Open PSII	8	7	7
Open ATAIN	70	27	22
Overdue ATAIN	56	18	1 (awaiting notes)

External Action Plans reported through SERG September 2025

Action Plan	INC-Number	Number of Actions	Update on actions
Maternal death cluster review. Presented at SERG 03.10.25	INC-34492	5 actions within this action plan	1 open action- in date 4 closed actions
Neonatal death review, Presented at SERG 03.10.25	INC-31171	22 actions within this action plan	20 open actions – in date 2 closed actions.
MIA stillbirth action plan. Presented at SERG 04.09.2025	INC-30053	12 actions within this action plan	7 open actions – 7 open actions in date. 5 closed actions

There are currently 4 open MNSI cases. All families have been provided with information regarding MNSI and have given their consent. Where applicable, families have been informed of and referred to NHS Resolution. Statutory duty of candour has been undertaken in all cases.

The team have addressed the number of overdue Datix and ATAIN cases, across Q2. The number of overdue actions includes all open actions plans. All PSIRF learning response action plans are monitored through SERG. All other actions plans are monitored weekly through the maternity patient safety meeting. As an updated position, during October there were 61 overdue actions



MNSI themes – Q2

Learning	Actions
Case 1 – • Ketones had not been tested during admissions to triage when presenting unwell with vomiting on multiple occasions in the antenatal period • Missed Community Midwife (CMW) appt at 16/40 as seen in diabetic clinic • Maternal hypoglycaemic treatment should have been commenced following the initial hypoglycaemia following admission to triage • CTG evident of hypoxia from commencing. Cord gases venous 7.18 arterial 7.12 were not documented on BadgerNet • Insulin pump had been removed in theatre- this should not have been removed, - unclear who had removed the pump. The theatre team had not been informed of this removal, and it was then a number of hours before this was known about and actioned. The mother was not having a sliding scale as per protocol for a type 1 diabetic mother • Baby was reluctant to feed and did not have feed within 1 hour as per high-risk baby requirements (wasn't fed until 3 hours 41 mins) • No antenatal colostrum harvesting • Delayed identification of hypoglycaemia in the baby, and delayed treatment • Training needs identified in relation to CFM monitoring for doctors and nurses	• Diabetes guidelines currently under review to align with national guidance • Diabetes risk score raised on the risk register • Learning from case has been circulated by the diabetes lead midwife to all staff • Babies at risk of hypoglycaemia are to be fed within 1 hour of birth, guideline updated • Diabetes midwife to support women with colostrum harvesting when attending antenatal clinic appointments. Community leads to discuss supporting colostrum harvesting in the community • Infant feeding team have shared a hypoglycaemia bulletin as shared learning • Learning has been shared regarding cord gases and documentation by the fetal wellbeing leads • November is diabetes awareness month with month long training planned by the PD and diabetes team • Neonatal practice development lead has launched formal CFM training
Case 2 - • No hot debrief offered for staff • Possible delay in transfer to theatre • High acuity, obstetric team unable to complete formal handover due to emergencies	• Cold debrief undertaken with staff involved for learning and support • Obstetric staffing currently on the risk register and under mandated support

Risk Management

Maternity are now being supported by the Trust risk team, and have recently welcomed a band 7 risk, health and safety advisor into the Women's Health division.

A monthly maternity risk meeting has now been scheduled and will support with the oversight of maternity risks and escalation up to Divisional Board and Risk Management Group.

Top 5 Risks

Risk ID	Risk Title	Current Scoring	Risk Owner	Next steps
922	The risk of women presenting with persistent reduced fetal movements from 28/40 not having a Ultrasound scan with liquor volume and umbilical dopplers within 24hrs of next working day	20	CT	To review current risk score at maternity risk meeting 14th November following introduction of external provider starting
746	The risk of failure to provide a safe and high-quality maternity service due to inadequate number of Consultant Obstetricians	16	CE	Requires escalation through RMG to the Trust Risk Register
490	The risk of delayed review, identification and treatment for pregnant women attending triage, in addition inability to adequately meet required standards of care	16	CT	Trust level risk
751	The risk of failure to provide a safe and high quality maternity ultrasound service	16	AH	Trust level risk
1060	The risk of poor outcomes and harm to women and babies as a result of the current diabetes management and guidelines during pregnancy, labour and post-birth	16	AW	Newly added risk, to be presented through forums, maternity risk meeting, divisional board and RMG

New Risks added during Q2

Risk ID	Risk Title	Current Scoring	Risk Owner
1106	The risk of non-compliance with the Maternity Incentive Scheme Year 7	9	JC/LS
1100	There is a risk of potential poor outcomes for babies due to poor compliance with intermittent auscultation in line with NICE guidance	12	JC
1105	The risk of not adequately listening and acting on safety and quality concerns raised by women and families due to the lack of a Maternity and Neonatal Voices Partnership lead for Gloucestershire	6	JC
1118	There is a risk of a poor quality training and education programme within maternity	9	CS
1117	Lack of medicines reconciliation service within maternity	8	LS/RS
1116	There is a risk of poor data quality within the maternity service	12	JW
1124	There is a risk of poor outcomes for babies and poor patient experience for mothers due to the current infant feeding service	12	AL

	Benchmark	Jul-25	Aug-25	Sep-25
Perinatal Mandatory Midwives	90%	86%	86%	86%
Perinatal Mandatory MCA's/MSW's	90%	81%	83%	82%
PROMPT Midwives	90%	87%	90%	92%
PROMPT MCA's/MSW's	90%	82%	85%	89%
PROMPT Total Obstetricians	90%	100%	75%	78%
PROMPT Obstetric Consultants	90%	100%	100%	100%
PROMPT Obstetric Registrars	90%	100%	92%	78%
PROMPT Obstetric ST1/2	90%	100%	NA	100%
PROMPT GP Trainee/FY	90%	100%	33%	46%
PROMPT Anaesthetic Trainees (90)	90%	90%	90%	90%
PROMPT Anaesthetic SAS/Consultants (90)	90%	83%	83%	79%
Fetal Monitoring Midwives	90%	87%	86%	90%
Fetal Monitoring Total Obstetricians	90%	94%	92%	89%
Fetal Monitoring Obstetric Consultants	90%	83%	93%	87%
Fetal Monitoring Obstetric Registrars	90%	100%	91%	91%
Fetal Monitoring Obstetric ST1/2	90%	100%	NA	NA
Neonatal Life Support Midwives	90%	86%	86%	86%
NLU Nurses	90%	100%	91%	93%
NLU ANNP	90%	100%		
NLU Consultants	90%	100%		

What is the intelligence telling us?

- With the new rotation of obstetric and anaesthetic doctors, we have seen a predicted fall in compliance – action plan on slide 17 with training projections on slide 18

What is going well?

- Projections completed for MiS compliance – projected to be >90% compliant across all staff groups except rotational medical staff
- MDT SiM planning continues. Date of SiM – 28/11
- Latest MBRRACE (2021-2023) integrated into training schedule

Focus for the next period?

- Additional dates across Perinatal (NLS) and PROMPT study dates planned earlier in year to mitigate against lack of compliance, high volume of training
- MDT SiM planned 28/11 (MiS SA8)
- Continued planning for 2026 training
- Continuation of Black Maternity Matters short course

Where do we want to be?

- Assurance for MiS compliance
- Fully recruited to team
- Finalised plan for 2026 full perinatal training
- Fully recruited to Black Maternity Matters (short course)

Patient and Staff experience

- Patient experience – meeting held in July to review and plan co-design following CQC Maternity survey results with focus on personalised care
- Continued attendance at patient experience meeting to draw themes and integrate into training
- Continued links with MNVP interim lead on 2026 program planning
- Staff experience: reviewed following study days and utilised for upcoming and planning

Risks & Resources

- Fall in compliance across rotational staff groups
- Administrative support removed 14/07/25 affecting the organisation of bookings
- PDM capacity reduced by 1WTE due to vacancy and family leave
- Additional ANNP support needed for NIPE Study day 14/12
- Operational support needed in ensuring attendance for last of mandatory training during compliance period
- Team leaders & matron team contacted prior to training to support attendance and rostering
- HDU training – currently 72% of CDS core – on risk register, increased from 53%, additional date Q1 2026 planned
- Unable to report NLS data from all NLU team

Training Action Plan for Rotational Staff

Safety action 8 of Maternity Incentive scheme states that all staff working in maternity should attend annual training. A 90% minimum compliance is required for every staff group by the end of the MIS year 7 period (30 November 2025).

For rotational medical staff that commenced work on or after 1 July 2025; a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. 90% of attendance in each relevant staff group required for:

1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal resuscitation training

Action plan:

- All rotational staff starting after 1st July 2025 with an identified training gap to be booked onto a course within 6 months of their start date
- Attendance at the required training will be closely monitored. Any non-attendance will be aim to be rebooked within the 6-month deadline.
- 100% compliance is anticipated to be achieved within 6 month of start date.

Rotational staff training plan

Item	Task description	Status	Timeline
Book staff onto training	All rotational staff starting after 1st July 2025 with an identified training gap must be booked onto a course within 6 months of their start date	Complete with assurance	Aug 1, '25 - Jan 30, '26
Monitor attendance and compliance	Attendance at the required training to be monitored monthly. Any non-attendance will be aim to be rebooked within the 6-month deadline.	On Track	Aug 1, '25 - Jan 30, '26
+ Add item			
			Aug 1, '25 - Jan 30, '26

Training Projections Rotational Staff

Staff Group	PROMPT current training compliance	PROMPT projected training compliance (6 months from start date)
Consultants	100%	100%
Registrars (pre-July 2025)	100%	100%
Registrars (new starters Aug 2025)	56%	100%
Total Registrar compliance	*81%*	*100%*
SHOs	86%	100%

Staff Group	Fetal monitoring current training compliance	Fetal Monitoring projected training compliance (6 months from start date)
Consultants	100%	100%
Registrars (pre-July 2025)	100%	100%
Registrars (new starters Aug 2025)	67%	100%
Total Registrar compliance	*86%*	*100%*

Claims Scorecard – Q2

CNST MIS – Year 7 – Safety Action 9

Process

- Review of Litigation Claims/Maternity element of the NHS Resolution (NHSR) Scorecard

- Themes from Complaints/Compliments/Friends and Family (FFT)

- Themes from PSII's/PMRT/External reviews (Ockenden, CQC)

- Top Themes from Moderate Harm > Incidents Reported

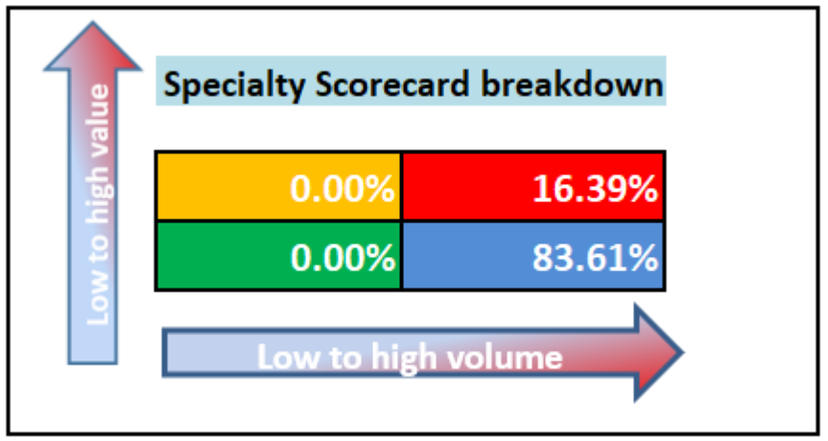
- National Reviews of themes/MNSI Safety Recommendations and Publications /MBRRACE/National Reports/CDOP

2015 – 2025 Claims Scorecard

Within obstetrics, between 1/4/2015 and 31/3/2025 there were a total of 61 claims with a total value of £116,178,058. This represents 13% of the Trusts clinical claims by volume, and 70% of the Trusts clinical claims by value.

The average cost of an obstetric claim is £1,904,558. Whilst this is a reduction on the average claim cost from the previous scorecard, the obstetric average claim cost is 528% of the average claim cost across the Trust.

As a specialty breakdown, 16.39% of claims fell into the red zone, high value, high volume, and 83.61% fell into the blue zone, low value, low volume.



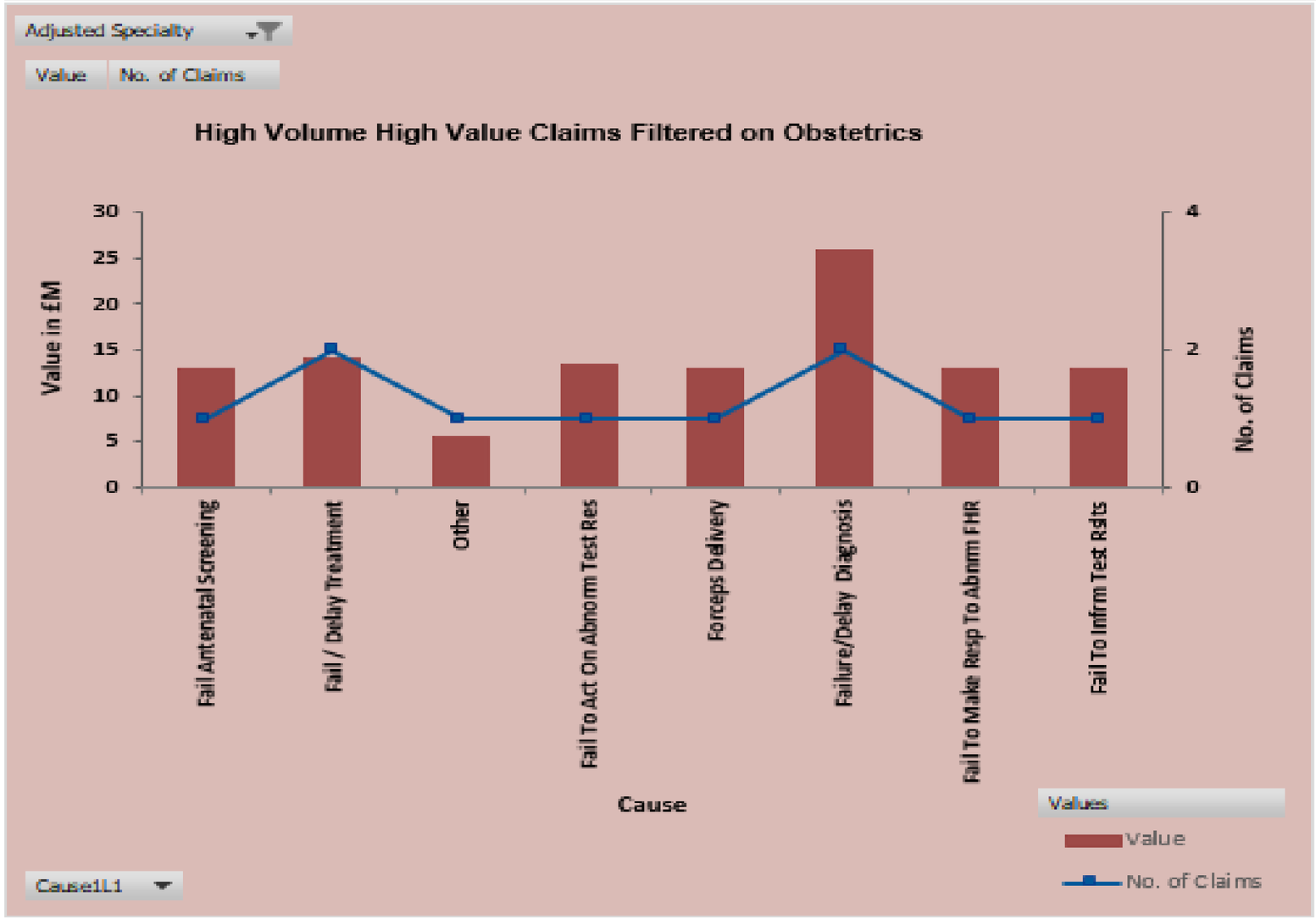
Red Zone Claims

– High Volume, High Value Claims for Obstetrics

16.39%

Claims are coded by the NHS Resolution team. There are often duplicate codes for similar conditions, for example cerebral palsy and brain damage.

Injury	Value	No. of Claims
Cerebral Palsy	£12,910,000.00	1
Erb's Palsy	£5,598,923.00	1
Brain Damage	£90,807,305.00	7
Fatality	£1,210,102.00	1
Grand Total	£110,526,330.00	10



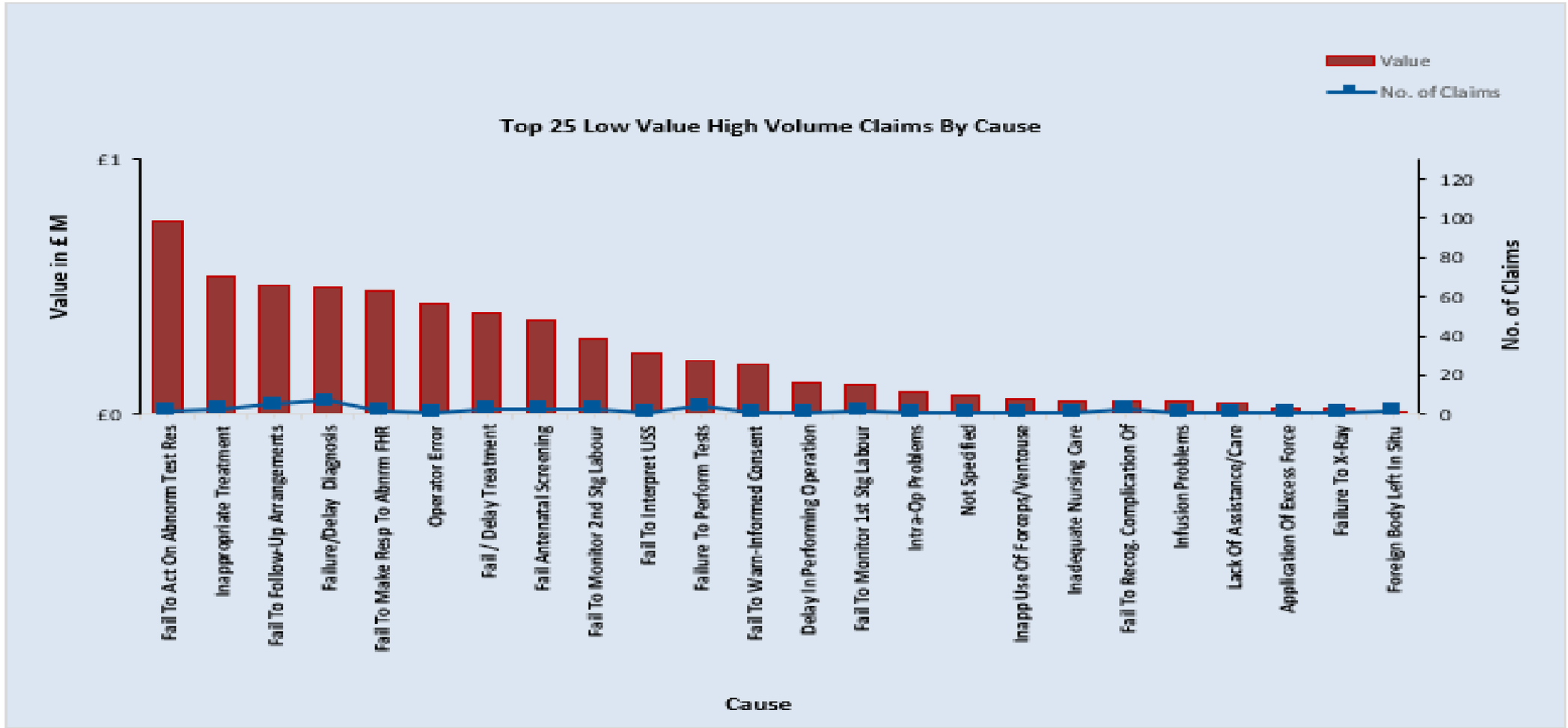
Data correct as of the 30/6/2025

Blue Zone Claims

– High Volume Low, Value Claims for Obstetrics

83.61%

Cause	Value	No. of Clain
Fail To Act On Abnorm Tes	£758,885	2
Inappropriate Treatment	£540,427	3
Fail To Follow-Up Arrangen	£506,352	5
Failure/Delay Diagnosis	£497,599	7
Fail To Make Resp To Abnr	£487,115	2
Operator Error	£436,002	1
Fail / Delay Treatment	£398,774	3
Fail Antenatal Screening	£366,926	3
Fail To Monitor 2nd Stg Lat	£293,673	3
Fail To Interpret USS	£238,326	1
Failure To Perform Tests	£209,264	4
Fail To Warn-Informed Con	£198,108	1
Delay In Performing Operat	£127,166	1
Fail To Monitor 1st Stg Labi	£117,417	2
Intra-Op Problems	£87,205	1
Not Specified	£74,083	1
Inapp Use Of Forceps/Vent	£63,000	1
Inadequate Nursing Care	£52,044	1
Fail To Recog. Complicatio	£51,775	3
Infusion Problems	£50,494	1
Lack Of Assistance/Care	£46,842	1
Application Of Excess Forc	£25,250	1
Failure To X-Ray	£24,250	1
Foreign Body Left In Situ	£750	2
Grand Total	########	51



Claims Themes 2015 - 2025

Top 5 injuries in Obstetrics by volume:	Top 5 causes in Obstetrics by volume:	Top 5 injuries in Obstetrics by value:	Top 5 causes in Obstetrics by value
1. Stillbirth 2. Brain Damage 3. Unnecessary operations 4. Fatality 5. Unnecessary pain	1. Failure/Delay in diagnosis 2. Failure/Delay in treatment 3. Fail to follow up arrangements 4. Fail antenatal screening 5. Failure to perform tests	1. Brain Damage 2. Cerebral Palsy 3. Erb's Palsy 4. Fatality 5. Stillbirth	1. Failure/Delay in diagnosis 2. Fail/Delay in treatment 3. Failure to act on abnormal tests results 4. Failure to make a response to abnormal fetal heart rate 5. Fail antenatal screening

Triangulation

There were no clear themes when comparing the updated claims scorecard and Q2 incidents and complaints

Themes from Clinical Incidents for Q2

- Diabetes management in pregnancy
- Hypoglycaemic management in newborns
- Prolonged second stage and MOH
- Infant feeding

Themes from PMRT for Q2

- Diabetes management in pregnancy
- Abdominal pain and triage admission

Themes from Complaints/FFT for Q2

- Clinical treatment concerns
- Communication
- Staff attitudes
- Appointment issues

Action taken and Next Steps

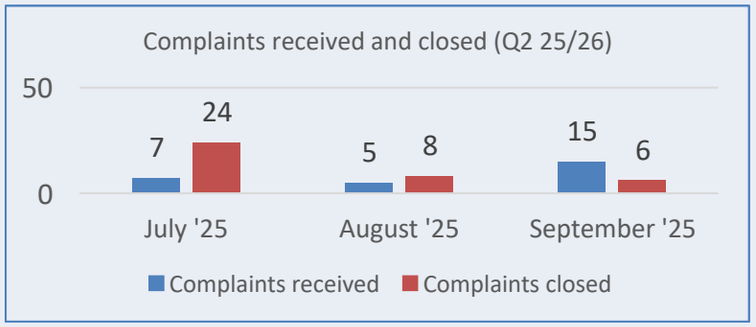
- Diabetes risk raised on the register, action plan in progress
- Infant feeding guideline currently under review
- Neonatal hypoglycaemia guideline has been updated in line with BAPM standards
- All women who call triage with abdominal pain are now invited to attend for review and assessment
- Prolonged second stage is being actioned with PD and intrapartum leads
- Ongoing triage QI
- Infant feeding action plan and risk now on the risk register

Patient Experience

Complaints figures

During Quarter 2, 27 complaints were received, and 38 closed.

Quarter 2 ended with 39 open complaints.



Complaints: Key Themes

Clinical Treatment Concerns
Many complaints relate to poor clinical outcomes, including mismanagement of labour, stillbirth, inadequate pain management, and post-treatment complications.

Staff Attitudes and Professionalism
Patients report poor attitudes, lack of compassion, and unprofessional conduct from staff including midwives, medical staff, and sonographers.

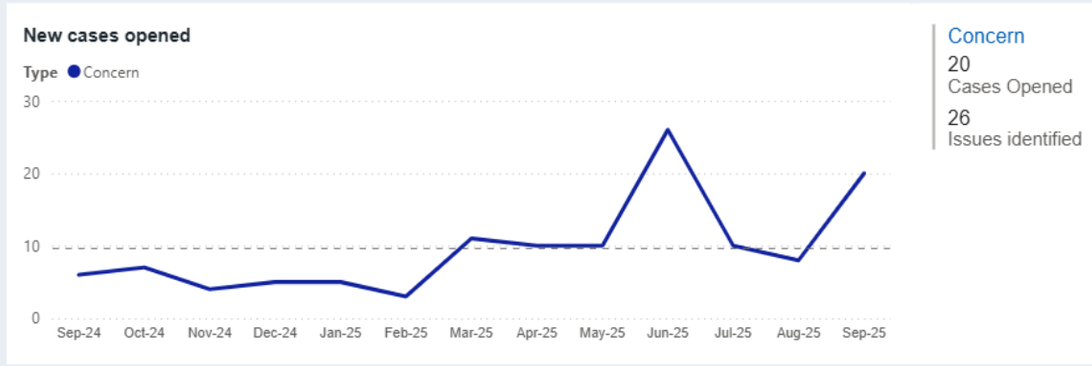
Communication Failures
Patients report not being listened to, receiving insufficient or unclear information, and poor communication with relatives.

Appointments and Access Issues
Complaints include delays, cancellations, and lack of appointment availability.

Policy and Administrative Decisions
Some complaints relate to policy enforcement and administrative decisions, such as visitor restrictions.

PALS Concerns figures

During Quarter 2, a total of 38 concerns were raised through PALS.
July: 10
August: 8
September: 20



PALS Concerns: Key themes

Birth Debrief Requests
Numerous cases involve patients requesting a birth debrief / birth reflection. This includes requests for meetings or information following the external neonatal and maternal reviews.

Staff Conduct and Behaviour
Concerns about staff attitude, inappropriate behaviour, and safeguarding issues.

Communication Failures
Patients report not being listened to, receiving insufficient information, or experiencing delays in communication.

Clinical Treatment Concerns
Patients raise issues about mismanagement of labour, delays in treatment, and lack of follow-up.

Appointments and Follow-Up Failures
Missed or delayed follow-up appointments, especially for debriefs.

Shared themes between complaints and concerns

Issue / Sub-issue	Recurrence
Communication with patient	25
Attitude of staff	21
Mismanagement of labour	13
Communication with relatives/carers	9
Treatment/test delays	6
Patient not listened to	6
Insufficent information	4

Actions and Learning from Complaints received in Q2

Following on from their complaint, most families have been offered the opportunity to meet and discuss their concerns with senior clinical staff face-to-face. For many of those that accepted this offer, this meeting sufficiently met their needs and the complaint was closed without a formal written response.
Learning has been cascaded to staff teams and individuals where necessary, especially with regards to compassionate and informative communication with patients and relatives.

Other specific actions and projects that have been implemented in response to feedback include:

- A buddy system between support workers and midwives on the maternity ward

- Work with the Tissue Viability team to deliver targeted training on the maternity ward

- Infant Feeding Team is launching a QI project to review and strengthen the support available on the ward.

- A second drug trolley to improve the efficiency of drug rounds and reduce delays.

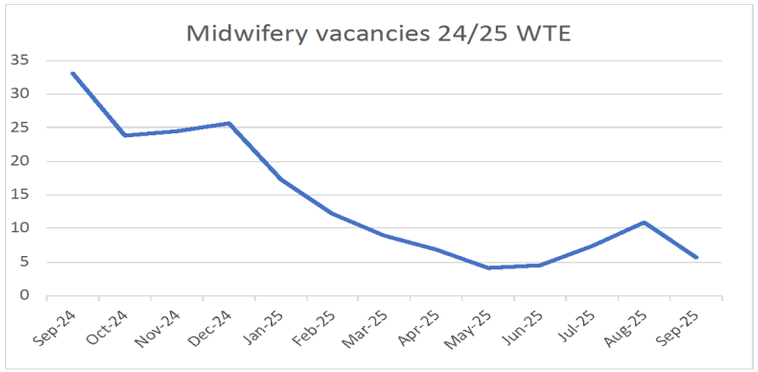
- Additional chairs purchased to improve comfort for partners and visitors.

- Fetal Medicine direct contact number listed on the Trust Maternity internet page. An information leaflet is also being designed specifically for the Fetal Medicine Department, containing key information and contacts.

Escalation

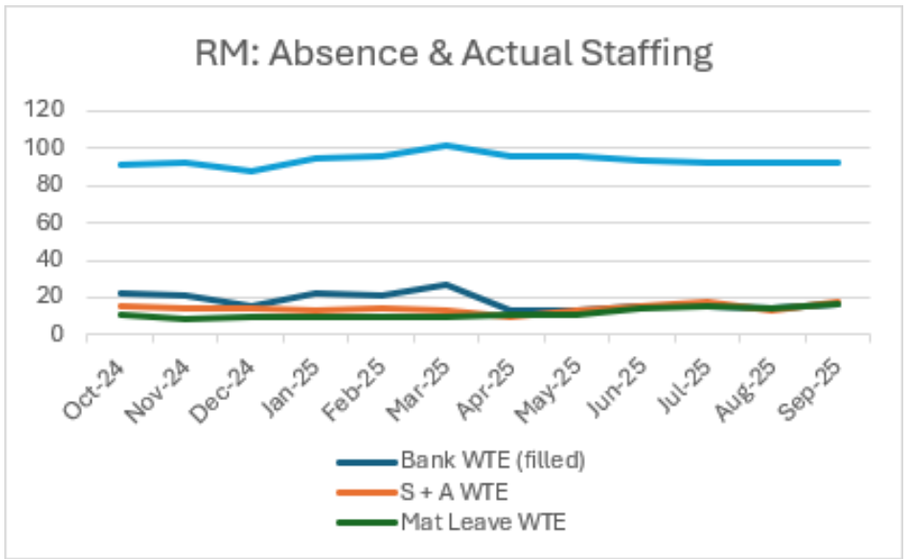
There are currently 40 debriefs awaiting allocation. This is impacting on complaint responses.

Perinatal Workforce



Month	1:1 care in labour compliance
Apr 25	98%
May 25	98%
Jun 25	99%
Jul 25	98%
Aug 25	100%
Sept 25	100%
YTD	98.8 % (av)

Midwifery Absence and Fill rates Apr 25 – Sep 25



Maternity Service Fill rate April to Sept 2025 Source: Health Roster

	Day qualified %	Night Qualified %
Apr 25	99	94
May 25	95	97
Jun 25	95	95
Jul 25	92	93
Aug 25	96	91
Sept 25	94	88

Neonatal Staffing

September 25 nurse staffing figures demonstrate a gap of 18.45 WTE. This is comprised largely of maternity leave (6.6 WTE), many vacancies (10.12 WTE) in the band 5 line, this is due to internal promotion to band 6 and review of staffing template increasing our numbers. Vacancies control requests made for 1.8 WTE band 6 and 5 band 5. Maternity leave is only predicted to slightly decrease from its current level. The impact is equally spread across both QIS and non-QIS nursing staff. Actions to mitigate have included attempts to boost the neonatal nurse bank, efforts to boost support services (admin and clerical roles, housekeeping and Band 4 nursery nurses) to reduce non-nursing tasks being carried out by nursing staff, and liaison with bank office to source and manage temporary staffing options to fill gaps. There are no current vacancies in band 2/3/4/ roles.

BAPM standards being met for both NN medical and NN nursing must be recoded in minutes.

Obstetric Staffing

There were 29 middle grade rota gaps during September due to sickness and vacancy. All gaps were covered by doctors working locum shifts.
There were a total of 5 obstetric consultant rota gaps due to vacancy. These gaps were covered by existing consultants working locum shifts.
The current sickness rate amongst the obstetric workforce is 7%.

Staff Experience

Safety Champions - Central Delivery Suite

Staff feedback from walkabout

Theatres - It was recognised during the walkabout that there had been increased activity within theatres on the day of the walkabout and that there had been excellent communication with the teams, and Hot Debriefs had been utilised effectively

Bereavement – during a review of the environment in the bereavement rooms it was noted that the carpet in the bereavement family room required a review by IPC. Soundproofing was also raised as a concern with families reporting that they can sometimes hear the scanner in the room next door. A risk has been added to the risk register regarding bereavement service improvements

Service User Engagement - a discussion was undertaken on communicating with service users about their expectations regarding bereavement care and facilities, and how we sensitively prepare women and families that they may possibly her sounds from the next room

Information Governance – liaison required with the Digital Executive/Associate Chief Nurse regarding the uploading of documents to Badgernet. This has been escalated for action to the executive team.

Perinatal Culture Update

- Korn Ferry have delivered their penultimate workshop on sustaining cultural improvements for the MDT (obstetricians and senior midwifery)
- The Wellbeing Collective have consulted with the OD team and midwifery leadership and submitted a plan for the cultural work with midwives and that is just waiting to be signed off so the work can begin.
- The Divisional Cultural Roadmap has been agreed at Divisional Board
- Maternity Triage have met with OD to begin planning the cultural work that will take place within the team

Safety Concerns Raised by Staff during Q2

There have been no specific safety concerns raised by staff during Q2

The Board Safety Champions continue to meeti with the perinatal Quad leadership team and meetings occurred on the 29th April, 3rd June and 30th September. No additional support was identified. Ongoing support being provided through mandated support where required.

Maternity Incentive Scheme Y7 (October 2025)

MIS Safety Action	BRAG Rating	Update
1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 Dec 2024 to 30 Nov 2025 to required standard?	Non-compliant	The requirement of additional monthly PMRT review meetings with consultant presence has been regularly escalated by the Patient Safety Team; however, re-review of the cases compliant with standard c) "*Were 75% of all reports completed and published within 6 months of death?"* is 43%. A review of the outstanding PMRT workload in line with current planned meeting capacity (2 scheduled meetings) took place in early October and indicated a compliance trajectory of 55% by the end of the reporting period (30th November 2025) but results in **non- compliance** with the standard. Increase in PMRT meetings with consultant presence is still to be arranged. We omitted to present the 24/25 Q4 paper to Trust Board which has resulted in **non-compliance** with standard d) "Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024."
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		Final July dashboard data shows 100% compliance for birthweight (target 80%) and 98.3 for ethnicity (target 90%).
3. Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies? Drawing on insights from themes identified form any term admission to the NNU, undertake QI initiative to decrease admission/length of stay.		• **TC action plan:** Revised final action plan progress with timescales for implementation of 34+0 babies on TC submitted to Neonatal ODN on behalf of LMNS in October 2025 and will be presented through to LMNS and Trust board in November. • **QI on LOS:** Presented the required update to LMNS via PQS workstream in October and at the Safety Champions meeting in October.
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	Non-compliant	• 6-month audit on short-term locums: Compliance of short-term locum doctors working within the Obstetric & Gynaecology service on tier 2 or 3 (middle grade) rota's between April and September 2025 was 94% (target 100%) resulting in **non-compliance** with the standard. A process review has taken place to ensure 100% compliance going forwards. • Compliance with RCOG guidance for the engagement of Long-term locums for the same period was 100% (target 100%). • Compliance with having a duty anaesthetist immediately available for the obstetric unit 24 hours a day during the same period was 100% • Compliance with consultant attendance in person to applicable clinical situations between June and August 2025 was 85.1% (target 80%) • Compliance with BAPM standards for neonatal medical and nursing staff have been met. • Data will be presented via the Q2 workforce paper.
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?		• Midwifery staffing is reported in the Q2 Workforce paper which outlines planned versus actual staffing levels and evidence of mitigation and the midwife to birth ratio. It can be demonstrated that the midwifery staffing budget reflects establishment in line with Birth rate plus. • Compliance with supernumerary labour ward co-ordinator on duty at the start of every shift between April and September is 100% (target 100%) • Compliance with the provision of one-to-one care in active labour is now 100% following an action plan however, given the average over the period has been 98.8% (target 100%), the action plan to continue to monitor is included in the workforce paper for approval. • Data will be presented via the Q2 workforce paper.

Maternity Incentive Scheme Y7 (October 2025)

MIS Safety Action	BRAG Rating	Update
6. Can you demonstrate that you are on track to comply with all elements of the Saving Babies' Lives Care bundle Version Three?		• While not fully implemented; we have an agreed local trajectory signed off by the ICB which is being monitored through the quarterly assurance meetings which will enable us to meet compliance. • The final quarterly assurance meeting took place in October with a further meeting anticipated before the end of the MIS reporting period. • Q2 SBL report to be presented in November. .
7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users.		• CQC Maternity Survey action plan: Action plan has been further developed from themes into actions and will be shared with the LMNS and Safety Champions before the end of the MIS reporting period. • Evidence of an MNVP commissioned and functioning as per national guidance unobtainable: Escalation route is being followed locally and to regional level via the LMNS. The lack of a functioning MNVP as per guidance is on both the Trust and the LMNS Risk Registers and the action plan for the ICB to monitor progress was shared at Perinatal Delivery Group in October 2025.
8. Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? (Target 90% compliance)		Compliance trajectories indicate 90% threshold can be met before the end of the reporting period if all staff attend booked training. Current areas of concern from September compliance data: • PROMPT for Obstetricians (78%), Obstetric registrars (78%) and GP Trainee / FY (46%). Mitigation for rotational medical staff completing training within 6 months of start date can be evidenced with an action plan agreed with QPC and is included in the October PQS Paper. • Anaesthetic consultant (excluding non-obstetric consultants) compliance is currently at 83% but expected to reach 92% by the end of the reporting period. MCA's / MSW's has risen to 89% currently. • Fetal Monitoring has fallen for Obstetricians (89%) and Obstetric Consultants (87%). • NLS training for midwives (86%). Data for ANNP and NLU consultants has been outstanding since August. This has been escalated with the neonatal team as no assurance of MIS compliance can be provided at this time. Data is expected by 7th November 2025. Additional NLS and PROMPT training sessions have been arranged, however the Education and Training team have experienced staffing shortages since July 2025 causing difficulties with managing the high volume of training. A VCP has been agreed for admin support but has reduced the ability to fail safe training bookings. **Advise: cancellations from training will result in non-compliance.**
9. Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		• Monthly and quarterly PQS reports demonstrating requirements of the Perinatal Quality Surveillance Model are being submitted to Quality and Performance Committee and quarterly to Trust Board within SA9 reporting period of 2 April to 30 November 2025. • A joint evidence review exercise with our MIA and Director of Maternity Improvement of the PQS content was anticipated for October, now being planned for 11th November 2025.
10. Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?		• 2 new referrals currently being reviewed for submission eligibility. All other referrals meet 100% compliance across all elements of safety action 10. • Migration to the new reporting system (SPEN) happened on 6th October and one case has been submitted successfully. • Once case which was unable to be reported to the claims reporting wizard (CMS) has now been rectified and validated by NHSR.

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Transitional Care (TC) update

Transitional care update:

Standard
- Community neonatal outreach services should be available seven days per week, with out-of-hours support to families available when required.

Current position
- We have outreach services support 5 days/week office hours only.
- The Band 6 fixed term contract post is due to end Dec 2025.
- Leaflet for emergency care is being given on discharge

Next steps
- Awaiting a meeting with General Manager to discuss the feasibility of utilising funding from existing Neonatal Unit to support outreach
- Evidence of 'NNU/TC discharge to community services'
- Wider user feedback to be sought
- Compliance with 'core team dedicated to discharge planning and outreach evidence'
- Badgernet training for all staff – launching with NEWT2
- Parent awareness training – leaflet launched, meeting to review any other actions

Outstanding actions/progress for supporting babies from 34 weeks gestation on the Maternity Ward:

Gloucestershire Hospitals NHS Foundation Trust

- Standard Operating Procedures (SOP) for TC care to include 34/40 babies
- Meeting w/c 4 November to agree potential start date.

SOP/Guideline:

- TC guideline to be updated to reflect changes – 'Keeping babies & mothers..'
- Action card for TC caring for babies to be agreed at Postnatal Forum (PNF) in November 2025

November Actions:

- Agree new date for 34/40
- Joint meeting with Maternity ward and TC staff to be undertaken
- Develop and update training for midwives and nurses caring for babies 34/40 gestation
- Parents should be signposted to relevant local and national organisations, both for condition specific and emotional and/or financial support.
- Communication to go out to Division about plan for 34/40
- Create TC display board

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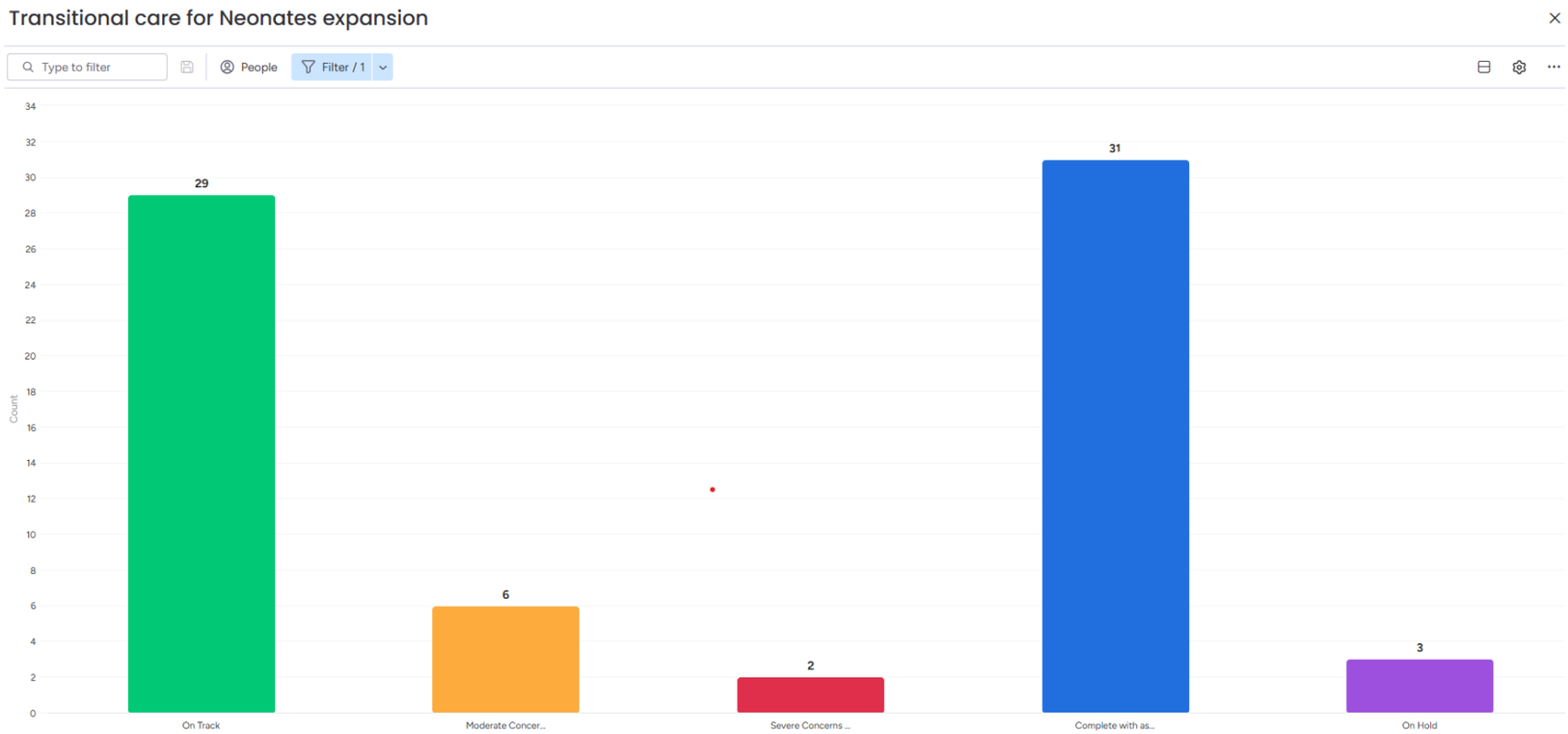
TC Action plan summary update

There are a total of 70 actions to complete – in summary 29 are on track (green), 6 moderate concern to be delivered on time (orange) , 2 red severe concern to be delivered on time (red), 31 complete with assurance and 3 actions on hold (purple).



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KEY ISSUES AND ASSURANCE REPORT Audit and Assurance Committee September 2025		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Risk Report	High number of out-of-date Trust policies	Report to be brought to November Audit Committee meeting
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Internal Audit	<u>Progress Report</u> Delayed submission of the final version Audit Report for Conflicts of Interests/Fit and Proper Person Audit due to capacity issues within the Trust's Recruitment team. <u>Received Audit Reports</u> The Committee received a report on **Patient Deterioration processes** with limited assurance as to design effectiveness with two high priority recommendations. Areas of specific concern were (i) Trust policy did not align with Royal College of Physicians guidance in two key areas (escalation and documentation) and (ii)significant non-compliance with frequency of NEWS2 observations. Of particular concern was the ability of clinical staff to backdate observation times with consequent artificial inflation of compliance rates The Committee received an Audit Report for the **PSIRF processes**, a year after introduction. Moderate design/moderate effectiveness. Areas of concern included significant delays in meeting investigation deadlines, inadequate recording of actions and evidence in Datix and varying compliance rates with PSIRF training.	Report will be before the November meeting of the Committee Actions agreed by Management. Report to be considered by the Deteriorating Patient Committee, Quality Delivery Group and an action plan created with future oversight by Quality and Performance Committee Medical Director confirmed remedial actions in place for the procedure for closing actions and that anticipated breaches of the deadline had to be brought to Medical Director for review.
Counter-Fraud	The Committee received a Report as to the effectiveness of the Trust's Secondary Employment Policy and Audit based on National Fraud Initiative data. Issues of concern identified were: • Policy out of date and inadequately communicated to staff and line-managers with consequent low levels of declarations.	HR senior manager to attend November Audit Committee meeting. HR work programme to achieve necessary actions.
Risk Report	It was identified that the Trust's Risk Appetite Statement was significantly out of date.	Board Development Session (October 2025) would be focused on risk, risk appetite and strategic

		risks to align with Trust's new Strategy and reflect feedback from the Well-Led Review. New Risk Appetite Statement and Board Assurance Framework by December 2025
Annual Cyber Security Report	The committee received a comprehensive report setting out the progress that the Trust had made in addressing cyber-security risk. It was reassured by the high level of benchmarking for critical areas such as Microsoft Defender Endpoint. However, some key areas of risk remain. In particular, the Trust has a number of systems that have reached their end of life and are no longer supported and thus vulnerable to attack. In addition, a key mitigation, the rolling out of Multi-Factor Authentication (MFA), remains challenging.	An internal audit report on cyber security will report to the February meeting of the Committee. It should report on progress addressing unsupported systems and putting in place key mitigations. Future reports to the Committee should also draw on the results of external penetration testing.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Good quality papers distributed in sufficient time to allow adequate preparation.		

Items not Rated			

Investments			
Case	**Comments**	**Approval**	**Actions**

Impact on Board Assurance Framework (BAF)

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

Report to Board of Directors			
Date	13 November 2025		
Title	Strategic and Operational Risk Report: Risk Appetite, Board Assurance Framework & Trust Risk Register.		
Author and Sponsoring Director	Lee Troake, Head of Corporate Risk, Health & Safety and Sarah Favell, Trust Secretary Kerry Rogers, Director of Integrated Governance		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	
Regulatory requirement	✓	To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Definition and Scope

The **Board Assurance Framework** (BAF) provides a structure and process which enables the Board of Directors to focus on the principal risks which might compromise the achievement of the Trust's strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and the sources of assurance available to the Board regarding the effectiveness of the controls. The BAF is received by the Board at least four times a year (most recently in September 2025).

The Board also receives at the same time a report on the **Trust Risk Register** (TRR) to provide additional assurance that key operational risks are being effectively managed.

Board assurance committees review both the BAF and the TRR risks assigned to them at each meeting. The BAF risks are refreshed frequently in line with that reporting structure by the lead Executive for each risk and then reviewed by the Risk Oversight Committee.

The Risk Management Group and Trust Leadership Team meetings oversee operational risks and the system of risk management.

Following two dedicated Board development sessions after the launch of our new Trust strategy, we have agreed a refreshed **Risk Appetite Statement** that reflects our strategic ambitions and commitment to safe, sustainable care. This statement sets out the level of risk the Board is willing to accept in pursuit of its objectives and provides a clear framework for decision-making and assurance.

It is essential that this approach is embedded across the organisation for the next six months to test its practical application and ensure alignment with operational and strategic priorities. The Risk Appetite Statement will be directly linked to the Board Assurance Framework, enabling the Board to monitor whether risks are being managed within agreed tolerances and to identify areas where assurance is strong or requires strengthening. After this implementation period, the Board will review its utility, effectiveness, and any adjustments needed to support informed risk-based governance.

Risk Appetite Statement

The new risk appetite gives clarity to the risk the Trust is willing to accept in pursuit of its goals. This refresh has included:

- Strategic Alignment: Twelve strategic objectives now form risk categories.
- Appetite Statements: Tailored per category; e.g., higher tolerance for digital innovation, lower for cyber security.
- Appetite levels: Significant → Seek → Open → Cautious → Avoid
- Realigned TRR thresholds: Significant (25), Seek (20), Open (16), Cautious (15), Avoid (12)

Implementation Plan for the Risk Appetite

- **Communication**: Share updates via Risk Management Group, divisional meetings, and staff briefings.
- **Integration**:
  - Reclassify 700+ risks under new categories.
  - Update risk registers, escalation processes, and decision-making frameworks.
  - Provide updated risk appetite matrix and revise Risk Management Policy.
- **Monitoring**: Review effectiveness April 2026; use audits and KPIs for assurance.

Current Trust Risk Register Profile

- **TRR**: 40 risks (highest in recent years); 63% extreme (15+) and 37% high (10+).
- **Highlighted Risks**: Fire safety (#363, #674), asbestos (#368), window safety (#1042), radiology workforce (#841, #135), ED overcrowding (#426).
- **Trend**: Risk exposure decreased over summer; slight increase in Sept–Oct.

Risk Management System Assurance

- **Level**: Reasonable Assurance
  - Some medium-risk weaknesses identified.
  - Isolated high-risk issues under resolution.

Next Steps:
Apply new risk appetite in December 2025; adjust TRR profile; maintain Board oversight through monthly reviews.

Board Assurance Framework: 'business as usual' reviews

The Board Assurance Framework provides details of strategic risks, the primary control framework, the assurances provided, and the actions underway to mitigate uncertainty relating the Trust's strategic objectives.

Over the past six months, the Board Assurance Framework (BAF) has been maintained in its existing form, pending the approval of the new Trust strategy. During this period, the focus has been on ensuring continuity and stability in risk oversight, rather than undertaking significant changes or improvements to the Board Assurance Framework. This approach was taken to ensure that any enhancements to the framework would be fully aligned with the strategic direction set by the Board.

Since the last BAF report to Board (September 2025) the following risks have been reviewed by the responsible Executive Director and further reviewed by the Board Committees according to their respective remits. The Board can be confident that the Board's Committees each with

responsibility for risk within their remit, have continued to oversee the management of risks in accordance with existing custom and practice.

Finance and Resource Committee (2 meetings during relevant period):
SR 9: Failure to deliver recurrent financial sustainability (Red rated) 5 x 5 = 25
SR 10: Poor Estate and maintenance backlog (Red rated) 4 x 4 = 16
SR 12: Failure to detect and control risk to cyber security (Red/Amber rated) 3 x 5=15
SR 13: Inability to maximise digital systems functionality (Red rated) 4 x 5=20
SR14: Failure to invest in research (Amber rated) 3 x 4 = 12

None of the above strategic risks had any alteration to the current or target score. Updates were provided to the descriptors, controls and gaps in controls as well as the actions and relevant action timelines.

People and Organisational Development Committee (1 meeting):
SR 17: Recruitment and attraction (Red rated) 4 x4 – 16
SR 16: 16 (Culture and Retention) (Red rated) 4x4 =16.

Quality & Performance Committee (2 meetings)
SR 1 Failure to effectively deliver urgent and emergency care. (Red rated) 4 x4 =16
SR 2: Failure to successfully embed the quality governance framework (Amber rated) 3 x4 =12

Strategic risks not reviewed during this period.

- SR 5 (Failure to implement effective improvement approaches) and SR 6 (Individual and organisational priorities are not aligned to deliver integrated care) are suspended from Committee Review pending the realignment of strategic risks post implementation of the Trust's strategy (2025-2030). Revised strategic risks will be considered by Board in December 2025 and by board committee from January 2026.
- SR 7 (Failure to engage and ensure participation with public, patients and communities) is suspended from Committee Review since June 2025 pending the realignment of strategic risks post implementation of the Trust's strategy (2025-2030). Revised strategic risks will be considered by the Board in December 2025 and be monitored by board committee from January 2026.

The Board can be confident that the Board's Committees each with responsibility for risk within their remit, have continued to oversee the management of risks in accordance with existing custom and practice.

Board Assurance Framework: Realignment of strategic risks
With the new strategy now being finalised, we have commenced a comprehensive refresh of the strategic risk profile and the Board Assurance Framework (BAF), to include a new BAF format that will aid its utility. Additionally, the current Key Issues of Assurance Report (KIAR) format will be replaced by the Alert, Advise, Assure Model, as recommended previously by the Good Governance Institute and more recently by the Well-Led review undertaken by Aqua and commissioned by the Trust.

The templates were considered at the Board seminars in October 2025 and will be implemented with the roll out of the confirmed realigned strategic risks from January 2026.

The refresh programme will ensure that our principal risks, controls, and assurances are fully

mapped to the Trust's updated objectives and priorities. Initial work has been undertaken (as set out within this report) to determine the risk Trust's risk appetite in the context of the approved Trust Strategy. That work will now be utilised by the responsible Executive Directors to fundamentally review the strategic risks within their portfolio. That review will be led by the responsible directors, supported by the Trust Secretary and will focus on updating the relevant risk descriptors.

The initial work undertaken by the Board at the relevant seminars in October 2025 confirmed that the Trust's strategic risks currently in place were consistent with key areas of strategic risk identified for all good and outstanding NHS Trusts and were in alignment with the most recent PWC report on strategic risk in the NHS.

It is anticipated that the core strategic risk themes will remain substantially the same with work focusing on the descriptor of the strategic risks to ensure alignment to the Trust's key strategic aims, golden threads and enablers, as set out in the Trust's new strategy. The other primary area of focus will be on the effectiveness of the control environments relied upon to provide assurance the risks are being mitigated within tolerances and the Trust's refreshed risk appetite.

This focus will then be reinforced in the refreshed training on strategic risk management to be provided to the Board Committees during Q4 2025/2026.

Risks or Concerns

N/A

Financial Implications

N/A

Equality, Diversity, Inclusion and Workforce Implications

None

Sustainability (Environmental) Implications

None

Recommendation

The Board is invited to:

1. Receive assurance on adequacy of risk management systems and the ongoing improvements following the launch of the new strategy, and challenge where assurance is weak
2. Formally approve the new Risk Appetite Statement, tolerance levels, thresholds (Appendix 1) with a review in 6 months to test its application and any need for adjustment
3. Note the implementation plan for the new Risk Appetite
4. Note the revised Risk Scoring Matrix (Appendix 2) to align with the new Risk Appetite
5. Note the Trust Risk Register profile (Appendix 3)
6. Note the system performance matters in divisions (Appendix 4)

Enclosures

BAF Summary (November 2025) (Appendix 5)
Risk Incident and Assurance Report
Appendix 1: Risk Appetite Statement, tolerance levels, thresholds.
Appendix 2: Updated Risk Rating Scoring Guide.

Appendix 3: TRR Summary.
Appendix 4: KPI Performance (Oct 2025).
Appendix 5: BAF Summary (Nov 2025)

RISK ASSURANCE REPORT

BOARD OF DIRECTORS

NOVEMBER 2025

1. Risk Appetite

Risk appetite defines the amount and type of risk that an organisation is willing to accept in pursuit of its objectives. It is a cornerstone of risk management and governance, guiding decision-making at all levels.

The **risk appetite cycle** (see diagram) illustrates best practice for annual review.

The Board undertook steps 4 and 5 at two recent development sessions, making the following decisions:

- **Strategic Alignment**

To align with the organisation's mission, values, and strategic goals, the Board considered the twelve objectives, enablers and golden threads as key elements driving its risk appetite.

- **Risk Categories**

The Board considered the existing risk types (categories) and their relevance to the twelve elements of the new Strategy. Definitions will balance actual and perceived risk to prioritise those with the greatest impact on long-term goals. It was agreed that the twelve elements would form the new risk categories.

- **Expression of Appetite – Appetite Statement**

For each risk category, a risk statement was agreed that reflected the level of risk the Trust was willing to take to achieve the goals outlined in the Trust Strategy. Sub-categories were agreed where the Trust appetite differed depending on the type of risk e.g., Digital risks: greater risk is accepted to achieve digital enhancement, but less risks is acceptable in relation to cyber security and data protection.

- **Tolerance levels**

Appetite statements were assigned tolerance levels:

Significant → Seek → Open → Cautious → Avoid

These influence decision-making, resource allocation, and compliance with NHS expectations.

- **Risk Threshold**

It was agreed that the Trust's thresholds were currently lower than required and invited a disproportionate number of risks on the Trust Risk Register. Threshold scores were realigned to reduce distraction from lower-level risks:

Tolerance level	Reaches TRR threshold at
Significant	25
Seek	20
Open	16
Cautious	15
Avoid	12

Other factors, such as divisional ability to mitigate risks, will also be considered before escalation to the Trust Risk Register (TRR).

Appendix 1 contains the Risk Appetite Statement, tolerance level and threshold score which is presented for final approval.

2. Implementing the New Risk Appetite

Communicate Widely

- Communicate to divisional leaders and senior managers via Risk Management Group and to divisional risk owners via the divisional risk meetings.
- Ensure all staff understand what the risk appetite means for their roles and decisions.

Integrate into Risk Management Processes

- Update risk all 700+ risks including assigned a new category and sub-category.
- Ensure risk registers, and escalation procedures align with the appetite levels.
- Embed into decision-making frameworks (e.g. risk strategy, business cases).
- Provide updated risk appetite matrix tool to support risk scoring – Appendix 2
- Review and update the Risk Management Strategy and Policy

Monitor and Review

- Review effectiveness in 6 months' time (e.g. April 2026) and adjust as needed.
- Continue to use internal audits, KPIs or assurance reviews to test effectiveness.

3. Current Risk Profile

Trust Risk Register Profile

Reports to the Trust Leadership Team (TLT) provide an overview of the Trust Risk Register profile to ensure that senior leaders maintain visibility of the changing landscape of risks. This process is designed to support the Trust Leadership Team oversight of significant risks that may impact operational priorities. The Trust Leadership Team is required to consider the system of risk management to ensure it has confidence teams are managing risk in accordance with policy.

The currently Trust Risk Register houses 40 risks and currently sits at one of the highest number of risks on this register in recent years. This includes 25 extreme risks scoring 15+ (63%) and 15 high risks scoring 10+ (37%).

The profile will adjust to reflect the new risk appetite once this applied in December 2025. This should support a broader picture of the key risks relevant to our new Trust goals. The Executive Review process which delivers monthly oversight of Divisional performance metrics will see closer scrutiny of areas of risk management that would benefit from particular focus.

Highlighted Risks

The following risks are highlighted as high-profile risks either due to the current level of risk associated with the subject matter or scrutiny in areas of the trust by a regulator e.g., CQC, HSE etc.

- **Fire Risks**

The previous 19 fire risks were amalgamated and reviewed, resulting in four headline fire risks:

Risk #363 - This risk was accepted onto the Trust Risk Register in June with a score of 20. The risk of statutory intervention became an imminent issue following receipt

of a fire enforcement notice with a deadline of 31 July 2025. The Trust submitted an early interim response, with final document, a primary (whole building) risk assessment, being submitted by the deadline. In August, the Trust received confirmation that the Enforcement Notice has been discharged.

By way of reassurance, a manual fire watch program is in place to check for fires, the fire alarm is operating, a costed plan is also in place to address a significant proportion of the compartmentation issues outside of Building Standards Regulations. Areas have been prioritised according to the patient profile and environmental risk. However, there will remain evident and prosecutable breaches until all primary fire risk assessments are completed, the new fire alarm is installed and the compartmentation issues resolved over the next few years. For these reasons, the risk is likely to remain high.

Risk #674 - This risk was accepted onto the Trust Risk Register in June with a score of 16. The fire evacuation risk demonstrates the complexity of delivering a robust interim evacuation plan should a fire occur today. An evacuation procedure to provide clear direction for horizontal and vertical evacuation is under development. This risk reflects the possibility of serious harm related to an ineffective evacuation. Evacuation procedures, training and equipment were tested in a live scenario on 4 November during a fire incident on ward 8a when all patients were successfully evacuated.

Risk #87 - the likelihood of a fire starting is captured in the fire loading risk (e.g. hazards that lead to a fire). This risk does not currently have a Trust Risk Register score and remains a safety risk.

Risk #374 - A further fire risk which relates to thermal run off in lithium batteries (used to power ward based mobile computers) also appears on the Trust Risk Register and has been on the register with a score of 15 since 2022. Trust Leadership Team was advised that a focussed effort is required to resolve this risk either by use of fire compartments or fire cabinets in August 2025. A thermal run-off event on 4 November saw this risk materialise with significant disruption to the Trust and harm to staff.

- **Asbestos risks**

Risk #368 – the Asbestos Management risk has been increased in score to 16 following the RIDDOR incidents earlier this year and the audit findings in relation to compliance. This risk was accepted onto the Trust Risk Register in June. Progress has been made with the publication on the new Asbestos Policy, an asbestos survey across both sites and a revised Asbestos Management Plan. All areas with identified or suspected asbestos are now strictly controlled using a permit to work system. A plan is in place to encapsulate or remove asbestos from high-risk areas. However, renewed effort is required to reinstate regular asbestos management meetings within the Trust.

- **Window risk**

Risk #1042 – the risk of a fall from height from a Tower Block window in Gloucestershire Royal Hospital has been escalated following two near misses. An internal investigation identified potential weaknesses in the integral window restrictors which can be overcome by a determine and / or vulnerable patient and which do not meet the standard recommended in the relevant Healthcare Technical Memorandum. An expert has been commissioned to support a suitable solution and attended site in late July, September and October to examine the windows. Several rooms were identified by the clinical teams which have had the window opener / handle removed to lock the window shut. These rooms will accommodate high risk patients until a viable and practicable solution is identified by the expert for all windows. The expert report is expected imminently.

- **Radiology risks**

Risk #841 – this risk refers to an inability to deliver acute and cancer patient care due to a critical shortage of Interventional Radiologists. This risk was opened in June 2024, scoring 20 and is on the Trust Risk Register. Up to date evidence is provided on the risk in support of the current grading. Additional controls were approved through Trust Leadership Team in May 2025 to recruit an additional IR consultant, and to align the demand and capacity for IGIS for phase 0-1. An update on the progress with recruitment will be added to the risk, with successful recruitment the score may then reduce. At present the pressure on the small service remains significant due to maternity leave.

Risk #135 - The risk of delays in patient pathways, due to insufficient consultant radiologists. The risk scores 20 and is on the Trust Risk Register. This is one of Diagnostics &Specialities' Division oldest risk dating back to 2015, which was reviewed by the Division and presented at Risk Management Group on 6 August. The Division has provided evidence of the scoring which reflects the impact of workforce issues on the quality of the service. Additional controls have been approved through Trust Leadership Team to recruit an additional consultant to year one of the business case and carry out a strategic review of the reporting capacity. An update on the progress with recruitment will be added to the risk and the score reviewed when appropriate.

- **ED risk**

Risk #426 -The risk to patients within the Minors Area of the Emergency Department due to overcrowding and staffing. The risk scores 20 and is on the Trust Risk Register. All actions on the risk are complete and listed within the controls. Further actions may be needed to address the gaps in controls. At the last review, the score of 20 was still considered appropriate.

4. Risk Monitoring

It is important for Risk Management Group to ensure effort and focus is being proportionately targeted on reducing Trust Risk Register risks. A number of Trust Risk

Register risks have not progressed in terms of reducing the level of risk and have remained at their current score for several years. This suggests either remedial actions are not successful, or controls have not been implemented. If the Trust is prepared to tolerate the level of risk on these longer-term risks, and there are no new significant actions that can be taken to reduce them further, consideration should be given to whether they merit retention on the Trust Risk Register at all and have, in fact, already reached the lowest level of risk reasonably practicable (e.g., achieved a reasonable target).

The Risk Management Group has now embedded a process through which each division is required to review and present its oldest and highest risks for scrutiny. This has already successfully led to renewed attention on these risks.

5. Trust Risk Register (TRR) Update

Nine risks have been escalated to the Trust Risk Register between April and October 2025.

- #1042 Risk of a fall from height from a Tower Block window in Gloucestershire Royal Hospital leading to serious or fatal harm to patients, in particular those without capacity or with mental health conditions
- #368 - The risk of statutory intervention as a result of a failure to manage asbestos in our buildings in line with the Control of Asbestos Regulations 2012, leading to harm
- #850 - The risk of increased workplace stress due to an imbalance of workforce against workload
- #722 - The risk that the Trust is unable to retain members of the substantive workforce (risk replaced #236 below)
- #1012 - The risk of critical disruption to operational and clinical services, due to decreased sustainability and delays in development of digital services, systems and infrastructure caused by strategic and tactical workforce constraints
- #363 The risk of statutory intervention due to non-compliant fire safety infrastructure including an obsolete fire alarm at GRH, poor compartmentation / fire doors and insufficient break-glass points; leading to harm to patients, visitors and staff
- #674 - The risk of harm affecting patient and staff safety due to the inefficient evacuation of a hospital building in the event of fire due to poor uptake in evacuation drills and training and a clear evacuation plan
- #911 - The risk of significantly reduced quality of patient care and management caused by insufficient general anaesthetic workforce to manage the clinical demands upon service
- #293 - The inability to provide a Pharmacy Manufacturing Service due to the closure of the department.

Three risks have been downgraded from the Trust Risk Register between April and October 2025:

- #499 - The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.
- #236 - The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention (risk superseded by #722 above)
- #538 – The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of the early warning scoring system which may result in a failure to recognise, plan and deliver appropriate urgent care needs.
- #281 - The risk of not being able to provide a pharmacy manufacturing service due to staff shortage.

One risk has been closed:

- #385 The risk of reduced quality of care for dying patients due being unable to discharge to a place of their choice and dying within hospital

A summary of the Trust Risk Register is provided in Appendix 3.

6. Risk Management System Effectiveness (KPIs)

An overall level of assurance is provided below for the system as a whole:

Assurance Level	Description
Reasonable Assurance	• Some medium risk rated weaknesses identified • Isolated high risk rated weaknesses identified which is not systemic and / or has resolution in progress

Level of Organisational Risk

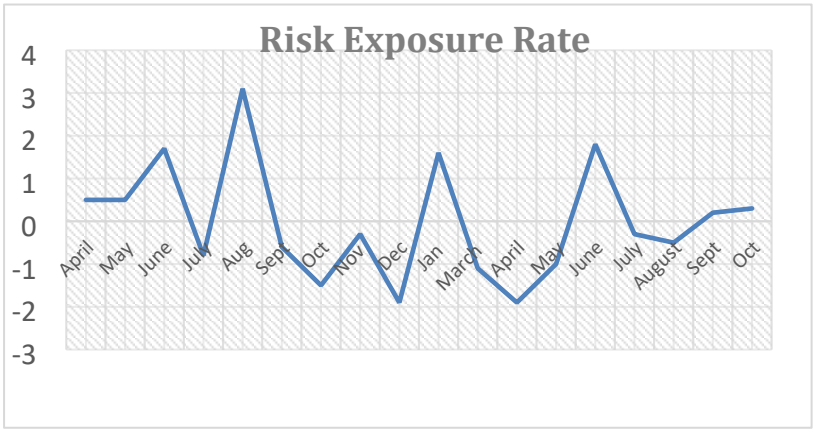
Across all registers, there were 586 active risks as of 31 October 2025. Of these, 63% of risks are scored as high-risk, and a further 8% are scored as extreme risk. This reflects a risk profile that is heavily weighted toward high risk and demonstrates the prevalence of risk within the organisation's day-to-day activities. The level of high risk also represents the day-to-day uncertainty at any one time.

Consequence	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	0	24	8	5	0
Likely	3	31	79	24	2
Possible	1	54	165	42	8
Unlikely	2	18	67	25	4
Rare	0	1	8	13	3

Likelihood

Risk Exposure Rate

The Trust experienced a general decrease in exposure to risk during the summer months, with a steady but slight increase in September and October 2025. However, the overarching benefit of the active reduction of risk is being eroded by the consistent identification of new ones.



Appendix 4 - Outlines the KPI performance for October 2025

Appendix 1 - Risk Appetite Statement

Category: Patient experience and voice	Statement	Appetite	TRR Thres-hold score
Patient Voice, Engagement & Co-production	We have a **significant** appetite for co-production with patients and carers, including the involvement of experts by experience in service design. Risks associated with innovation in engagement methods (e.g. digital platforms, community outreach) are accepted where they enhance inclusivity and representation. We prioritise robust, ethical, and transparent methods for gathering patient experience data linked to the NHS Oversight Framework and NHS 10-year Plan and will accept risk where new approaches may yield richer insights as long as due diligence is in place.	**Significant**	**25**
Category: People, culture and leadership	**Statement**	**Appetite**	**TRR Thres-hold score**
Staff Experience, Development and Culture	The Trust maintains an open appetite for initiatives that enhance staff experience and embed a compassionate, inclusive culture. We accept moderate risk where new approaches (e.g. flexible working, wellbeing, leadership and development) are designed to improve engagement and competency, provided they are supported by evidence and feedback. We support a learning culture, including open reporting, constructive challenge, and continuous improvement. We accept workforce management risks where changes improve efficiency, equity, or responsiveness, provided that staff safety, wellbeing, and regulatory compliance are maintained	**Open**	**16**
Workforce Sustainability	We adopt a **cautious** appetite for workforce sustainability risks. While we aim to innovate in recruitment and retention (e.g. international recruitment, career pathways), we maintain a low tolerance for risks that could lead to critical staffing gaps or compromise service delivery. Strategic workforce planning and system-wide collaboration are essential mitigations.	**Cautious**	**15**
Category: Quality, Safety & Delivery	**Statement**	**Appetite**	**TRR Thres-**

			hold score
Safety (Patient Safety, Staff Safety)	The Trust maintains a **cautious** appetite for risks that could compromise safety. We prioritise the prevention of avoidable harm and ensure that all clinical and non-clinical activities are underpinned by robust safety systems, incident reporting, and continuous learning. Risks may only be accepted where there is clear evidence of mitigation and oversight.	**Cautious**	**15**
Clinical Effectiveness	We adopt a **cautious** appetite for risks associated with clinical effectiveness. The Trust supports evidence-based practice, clinical audit, and innovation where it improves outcomes. Risks are accepted where new models of care or treatments are supported by strong governance and evaluation frameworks.	**Cautious**	**15**
Experience	The Trust holds an **open** appetite for risks related to service responsiveness, including access, flow, inadequate equipment and timeliness of care. We accept moderate risk where changes to pathways or digital solutions improve patient experience and reduce delays, provided safety and quality are not compromised.	**Open**	**16**
Operational Models	We adopt an **open** appetite for risks linked to testing new operational models, including integrated care, remote services, and automation. Operational transformation, including pathway redesign, digital optimisation, and productivity initiatives are welcomed. Risks are accepted where pilots are well-governed, and outcomes are measurable.	**Open**	**16**
Business Continuity	The Trust maintains a **cautious** appetite for risks that could disrupt core service delivery, patient access, or medium to long-term performance against national targets. We accept limited risk only where temporary disruption is necessary for long-term improvement, and where mitigation plans are in place.	**Cautious**	**15**
Category: Digital First	**Statement**	**Appetite**	**TRR Thres-hold score**
Infrastructure & Stability	We adopt a **cautious** approach to core infrastructure, software investments, upgrades, and maintenance, recognising the strategic value of scalable, secure, and reliable platforms. Risks will be accepted where mitigated by supplier assurance and business continuity planning.	**Cautious**	**15**

Data Integrity, Quality & Cyber Security	Our appetite is **cautious** in relation to cybersecurity and patient-identifiable data. We maintain a low tolerance for risks that could compromise confidentiality, integrity, or availability of critical systems. All digital solutions must comply with NHS DSP Toolkit, UK GDPR, and national cyber standards.	**Cautious**	**15**
Data Sharing & Governance	Data sharing is supported in the spirit of improving the delivery of healthcare for better outcomes - with demonstration of good control and in the context of our approach over data integrity, quality, and security. We maintain an **open** appetite for information partnerships, ensuring third-party providers meet NHS standards and contractual obligations. Due diligence and risk assessments are mandatory.	**Open**	**16**
Digital & Service Transformation, capability, capacity	With a willingness to take decisions that allow innovation, the Trust has a **Seek** appetite for digital innovation, where pilots are well-governed, risk assessed, and ethical considerations are addressed. We encourage innovation that improves care pathways, provided risks are monitored and evaluated. We are receptive to risk to gain measurable improvements in our digital transformation programme and digital capability.	**Seek**	**20**
Category: Living within our Means	**Statement**	**Appetite**	**TRR Thres-hold score**
Operational financial management	We maintain a **cautious** appetite for risks that could result in unplanned deficits, breaches of statutory financial duties, or loss of public confidence. Financial decisions must be underpinned by robust forecasting, cost control, and assurance mechanisms. They must be in line with our Financial Sustainability Plan (FSP) / Medium Term Plan (MTP).	**Cautious**	**15**
Strategic Financial Decisions and Transformation	The Trust holds an **open** appetite for financial risks associated with strategic financial decisions, including digital infrastructure, estates modernisation, and workforce development. Risks are accepted where there is a clear benefit to investment and alignment with strategic goals	**Open**	**16**
System Collaboration and ICS Financial Balance	We adopt an **open** appetite for financial risks arising from system-wide collaboration and Integrated Care System (ICS) financial arrangements. Risks are accepted where they support population health outcomes and shared efficiencies /benefits, provided governance and accountability are clear.	**Open**	**16**

Category: Estates and Facilities	Statement	Appetite	TRR Thres-hold score
Estates Modernisation and Capital Development	The Trust adopts an **open** appetite for risks associated with capital development and estate modernisation. We accept moderate risk where investment in infrastructure supports improved patient care, operational efficiency, staff experience and sustainability, provided robust project governance, risk assessment, due diligence and assurance mechanisms are in place.	**Open**	**16**
Facilities Management Operational Delivery	The Trust holds a **cautious** appetite for risks in day-to-day facilities management, including cleaning, catering, maintenance, and security. We prioritise reliability, safety, and compliance with statutory standards including HTMs, HBNs, and CQC standards, accepting limited risk only where service innovation improves quality or efficiency	**Cautious**	**15**
Category: Research and Innovation	**Statement**	**Appetite**	**TRR Thres-hold score**
Clinical Research & Trials	The Trust adopts am **open** appetite for risks associated with clinical research and trials. Risks are accepted provided safety and governance standards are upheld and where research is ethically approved and contributes to improved patient outcomes or scientific advancement.	**Open**	**16**
Category: Partnerships with Purpose	**Statement**	**Appetite**	**TRR Thres-hold score**
Partnerships and Strategic Collaboration	The Trust adopts an **open** appetite for risks associated with strategic partnerships, including those within the Integrated Care System (ICS), academic institutions, and voluntary sector. Risks are accepted where partnerships align with our strategic goals, shared values and deliver measurable benefits for patients and communities. Risks may arise from co-developing innovative solutions with partners, including digital platforms, shared services, and joint ventures. Risks are accepted where innovation is well-governed and supports transformation. All partnerships must be underpinned by robust	**Seek**	**20**

	contracts, due diligence, and contract management agreements.		
Category: Health Inequalities	**Statement**	**Appetite**	**TRR Thres-hold score**
Strategic Programmes to Reduce Inequalities	The Trust adopts an **open** appetite for risks associated with strategic programmes aimed at reducing health inequalities. We accept moderate risk where initiatives are designed to improve access, outcomes, and experience for underserved populations, provided they are evidence-informed and ethically governed.	**Open**	**16**
Category: Continuous Improvement	**Statement**	**Appetite**	**TRR Thres-hold score**
Quality Improvement and Service Redesign	The Trust adopts a **seeking** appetite for risks associated with quality improvement initiatives (e.g. PDSA cycles, Lean, Model for Improvement) to test new ideas, models, or technologies through structured improvement methodologies. We accept risk where improvement projects are well-governed, evidence-informed, and designed to enhance patient outcomes, staff experience, or operational efficiency. Risks are accepted where they time-bound, and subject to evaluation.	**Seek**	**20**
Category: Brilliant Basics	**Statement**	**Appetite**	**TRR Thres-hold score**
Compliance	We maintain a **cautious** appetite for risks that could compromise compliance with legislation or key 'must do' standards	**Cautious**	**15**
Well-led	We adopt a **cautious** appetite for risks that could undermine strategic governance, including misalignment between plans and operational delivery. We accept risk where change initiatives are well-led, inclusive, and designed to improve outcomes, efficiency, or resilience. Risks are accepted where they improve oversight efficiency, foster transparency and strengthen governance maturity.	**Cautious**	**15**

Category: Green Sustainability	Statement	Appetite	TRR Thres-hold score
Sustainability, Biodiversity and Climate Adaptation	We maintain an **open** appetite for sustainability-related risks, including risks associated with energy efficiency upgrades, green / renewable technologies, carbon reduction initiatives, sustainable transport, logistics optimisation and waste reduction. Risks are accepted where they align with the NHS Net Zero strategy and our Green Plan, and where long-term benefits outweigh short-term disruption. We accept risk for initiatives that where green measures protect health and reduce environmental impact, provided safety, due diligence and equity are maintained.	**Open**	**20**

Risk Rating Score Guide

Instructions:

1. Select the most appropriate **category** – patient voice, workforce sustainability and staff experience, safety, quality and service delivery, digital first, brilliant basics, estates and facilities, living within our means, research and innovation, health inequalities [link to appetite]
2. Select the most appropriate **sub-category** – see tables below
3. Select the **consequence score** that best matches the severity of the outcome of your risk should it materialise even with your controls in place (consider the evidence to support this) e.g. minor = 2 *[see pages 1-12]*
4. Select a **likelihood score** *[page12]* that reflects description, probability or frequency that your consequence could happen e.g. likely = 4
5. Multiple the two scores to get your **risk rating** 2 x 4 = 8 *[see page13]*
6. Look at the table *[page14]* to **check which risk register** your risk should be escalated to, based on the appetite threshold score for your subcategory
7. Your risk needs to be **approved onto each level of the risk register in turn** (e.g., specialty, then divisional, then Trust), use the escalate function on Datix to get your risk approved at each level.

Category: Patient Voice	Consequence Score	Definition	Examples Consequences
Sub-category: Patient Voice, Engagement & Co-production	**1 – Negligible**	Significant co-production transforms services and sets new standards. Patient is given voice.	Co-production leads to national recognition and /or adoption of best practices in several areas of the Trust.
	2 - Minor	Active co-production with patients/carers and experts by experience, influencing core service design and delivery. Minor areas for improvement in engagement.	Co-produced redesign of a clinical service results in improved outcomes, reduced complaints, or enhanced safety.
	3 – Moderate	Some involvement in specific areas of service design, with measurable impact on service quality or experience. Some strong areas of community engagement with areas for improvement.	Patients/carers contribute to minor service improvements (e.g., signage, waiting room layout) but are not involved in strategic decisions. Feedback is collected but not always considered
	4 - Major	No meaningful impact on critical service design or delivery. Very limited involvement or influence on non-critical aspects of service design, with evidence the service re-design has failed as a result. Wide-spread community disengagement.	Patients/carers rarely contribute to any service improvements and are not involved in strategic decisions. Feedback is not collected. Patients/carers are invited to meetings but not given a voice.
	5 – Catastrophic	Systemic lack of co-production or engagement leading to serious service failures, harm or reputational damage.	Failure to involve patients/carers results in unsafe service design.

Risk Rating Score Guide

Category: Workforce Sustainability & Staff Experience	Consequence Score	Definition	Examples Consequences
Sub-category: Workforce Sustainability	**1 – Negligible**	Minor, short-term staffing issues with no discernible impact on service delivery or patient care. Easily resolved through routine operational adjustments.	Temporary vacancy in a non-critical role; internal cover available without disruption to bridge gap.
	2 - Minor	Localised staffing pressures causing slight delays or increased workload, but manageable within existing resources or additional controls.	Delayed non-urgent appointments; increased reliance on bank staff in one department.
	3 – Moderate	Notable workforce gaps affecting service efficiency and staff wellbeing. Requires targeted interventions (e.g. recruitment drives, temporary reallocation).	Difficulty filling specialist roles; rising turnover in key teams; staff burnout indicators, increased patient complaints; moderate reliance on costly agency cover.
	4 - Major	Significant and sustained critical staffing shortages impacting staff wellbeing, service quality, safety, or access. Strategic workforce planning and system-wide collaboration required.	Inability to maintain safe staffing levels in critical services; failure to meet statutory staffing requirements; reputational damage or enforcement action. High-level and long-term reliance on costly agency cover
	5 – Catastrophic	Critical workforce failure leading to service closure, patient harm, or regulatory intervention. Immediate executive-level response required.	Closure of essential services due to lack of staff; failure to meet statutory staffing requirements; reputational damage or enforcement action.
Sub-category: Staff Experience, Development and Culture	**1 – Negligible**	Exemplary initiatives in place transform organisational culture and become sector leading. Some areas for improvement but these do not fundamentally affect staff experience.	Co-designed staff support programme leads to sustained improvements in morale, reduced absenteeism, and increased diversity in leadership roles.
	2 - Minor	Initiatives significantly enhance organisational culture, staff wellbeing, and retention. Constructive challenge and equality are embedded in practice. Some areas for improvement but these have localised or low-level impact on staff experience.	Staff retention in affected area remains stable. Introduction of inclusive leadership training results in improved staff survey scores and reduced turnover in targeted departments.
	3 – Moderate	Initiative improves staff experience in specific areas, with measurable benefits in engagement, retention, or inclusivity but could go some way further. Some evidence of retention issue or dissatisfaction emerging through incidents, surveys, staff complaints, grievances, speaking-up concerns, related-sickness and turnover data.	A new staff mechanism is introduced but only used by a few teams; only moderate improvements in local team dynamics. Some evidence of bullying or discrimination
	4 - Major	Staff experience initiatives lead to some improvements in staff morale or inclusivity, but limited reach or sustainability. Wide-spread poor staff experience, where initiatives have had no measurable change in engagement, retention, or inclusivity, culture. Clear evidence of broader long-term dissatisfaction	A staff wellbeing campaign is launched but poorly communicated or not sustained, leading to negligible uptake. Evidence of systemic adverse behaviours in a service line/ directorate or division including bullying or discrimination

		emerging in a service line/ directorate or division through incidents, surveys, staff complaints, grievances, speaking-up concerns, related-sickness and turnover data.	
	5 – Catastrophic	Systemic failure across the Trust to embed compassionate, inclusive culture leads to serious consequences. Mass staff burnout, high turnover, widespread poor behaviours that are unchecked, uncontrolled related-sickness, extremely poor performance in national survey results, reputational damage.	Systemic failure to address bullying or discrimination results in whistleblowing or regulatory intervention; or, a culture change programme becomes a national exemplar for compassionate leadership.

Category: Quality, Safety & Delivery	Consequence Score	Definition	Examples Consequences
Sub-category: Safety (patient, staff and public)	**1 – Negligible**	Near misses or negligible injury requiring no intervention or treatment or where treatment is limited to self-care by the application of basic first aid. near miss. Safety systems function as intended. No discernible impact on patient/staff wellbeing.	Superficial cuts, minor bruising, cat 1 pressure ulcer.
	2 - Minor	Low-level incident or near miss with minimal impact. No or minor harm where treatment is limited to self-care or minimal medical intervention. Learning opportunity identified. Increased hospital stay of 1-3 days. Staff time off work / light duties for 1-7 days	Fracture of a digit / toe, first-degree (superficial) burns, minor sprains / hematoma, cat 2 pressure ulcer, extended period of neurological observations following inpatient fall.
	3 – Moderate	Incident resulting in short-term moderate harm, requiring medical intervention and follow-up appointments. Requires formal investigation and remedial action. Staff injury requiring short-term absence or light duties over 7 days / RIDDOR reportable. Increase in length of hospital stay by 4-15 days - patient is expected to recover within 12 weeks.	Fractures - reasonable recovery expected, moderate strains, Cat 3 pressure ulcer, hospital / occupational acquired infection with increased length of stay, brief loss of consciousness / seizure, resuscitation, psychological harm impacts on daily life for a period, second-degree burns (partial thickness)
	4 - Major	Serious incident causing significant / major harm, leading to medium to long-term incapacity, disability, or recovery beyond 12 weeks. May trigger external intervention and oversight.	Permanent loss of function, cat 4 pressure ulcer, chronic pain, internal organ damage, serious penetration injury, hospital / occupational acquired infection - permanent impact on health, permanent vessels or nerves damage, long term psychological harm, third-degree (full thickness) burns
	5 – Catastrophic	Critical safety failure resulting in death, permanent serious harm, progressive conditions without curative treatment options. irreversible health effects that will limit life expectancy or quality of life, susceptibility to health complications. An event which impacts on many people. Immediate executive and regulatory response required.	Critical harm or loss of life, mass harm to patient / staff harm, spinal cord injuries, traumatic brain injury, irreversible organ failure, miscarriage, permanent blindness or deafness, fourth-degree burns, life limiting harm.

Risk Rating Score Guide

Sub-category: Clinical effectiveness	**1 – Negligible**	Minor deviation from clinical guidelines and best practice with no notable impact on patient outcomes or quality of service. Easily corrected through routine clinical governance.	Outdated clinical guideline used in a non-critical context; minor documentation error.
	2 - Minor	Localised or short-term reduction in clinical effectiveness with minimal impact on care quality or patient experience.	Delay in updating protocols; inconsistent application of evidence-based practice in localised team.
	3 – Moderate	Noticeable gaps in clinical effectiveness affecting care consistency, staff confidence, or patient outcomes. Requires targeted improvement actions.	Variation in treatment approaches across departments; identified non-compliance with NICE guidance.
	4 - Major	Sustained or widespread failure to deliver evidence-based care, impacting patient safety, outcomes, or service reputation. Major deviation from clinical guidelines. Requires strategic intervention.	Systemic failure to implement clinical standards; increased adverse events; poor benchmarking performance.
	5 – Catastrophic	Critical breakdown in clinical effectiveness leading to patient harm, regulatory breach, or loss of public trust. Immediate executive-level response required.	Serious non-adherence to clinical guidelines; external investigation; reputational damage or enforcement action.
Sub-category: Patient Experience	**1 – Negligible**	Minor delays, access issues with no impact on patient satisfaction or outcomes. Easily resolved through routine operational adjustments.	Slight delay in appointment booking; short wait times within acceptable limits.
	2 - Minor	Localised or short-term issues affecting patient convenience or experience, but not care quality or safety.	Longer-than-expected waiting times in one clinic; minor delays in discharge process.
	3 – Moderate	Noticeable delays or access barriers affecting patient satisfaction, flow, or continuity of care. Patient does not feel listened to or needs not well met. Requires targeted service improvement.	Repeated cancellations or rescheduling; delays in diagnostics or referrals; patient complaints increase.
	4 - Major	Sustained or widespread issues in access, flow, quality of care, or timeliness that impact patient outcomes, equity, or trust in services. Strategic intervention required.	Long waits for urgent care; bottlenecks in patient flow across departments; reduced access for vulnerable groups.
	5 – Catastrophic	Critical failure in service responsiveness leading to high risk of patient harm, serious incidents, or reputational damage. Immediate executive-level response required.	Patients unable to access care when needed; missed diagnoses due to delays; regulatory breach or media scrutiny.
Sub-category: Operational Models & Business Continuity	**1 – Negligible**	Minor operational inefficiencies or delays during testing new pathways with no or negligible impact on service delivery, patient care, staff workload, or service continuity. Easily resolved with minimal intervention. Brief outage of services such as IT, power, water, heat etc with no discernible clinical impact	Slight delays in rollout or functioning of a a service; minor technical glitches resolved quickly.
	2 - Minor	Localised or short-term disruption with limited impact on service delivery or user experience. Easily mitigated through operational adjustments or routine business contingency measures.	Temporary loss of access to one facility; minor supply chain delay; short-term system downtime. Temporary drop in productivity during event or transition to new process.

	3 – Moderate	Noticeable impact on service flow, staff workload, or patient experience. Requires coordinated mitigation response / management.	Partial service suspension; delays in diagnostics or treatment; increased reliance on manual processes for up to a week. Delays in integrated care coordination
	4 - Major	Sustained or widespread disruption impacting multiple services, patient safety, or operational capacity. Requires activation of formal Trust wide business continuity plans. Strategic intervention and system-wide collaboration required	Failure of remote service platform; breakdown in cross-organisational care pathways. Extended system failure over several weeks (IT, power, water etc) prolonged evacuation of site.
	5 – Catastrophic	Critical failure resulting in service closure, patient harm, or regulatory breach. Immediate executive-level response and external coordination required.	Total loss of a hospital site; prolonged outage of critical systems; emergency service diversion; reputational damage or enforcement action.

Category: Digital	Consequence Score	Definition	Examples Consequences
Sub-category: Digital Infrastructure & Stability	**1 – Negligible**	Minor technical issue or delay with no impact on system performance, data security, or service delivery. Easily resolved through routine support.	Brief system slowdown; minor bug in non-critical software; no data exposure. A brief network issue during off-peak hours.
	2 - Minor	Localised disruption or low-level data breach with limited operational impact. No breach of confidentiality or service interruption. Minor security incident, no data loss or Incomplete data shared, minor inconvenience. Small-scale resistance to change in technology. Limited expertise in some areas	Delay in software upgrade; temporary access issue; minor data entry error. A non-critical server goes offline for short time, no impact on patient care.
	3 – Moderate	Partial system outage affects some services; delayed access to clinical or corporate systems required for daily function. Noticeable impact on system availability, data integrity, or user access. May affect service flow or staff productivity. Requires coordinated response.	A key system (e.g., patient record access) is intermittently unavailable for a few hours.
	4 - Major	Significant compromise of critical systems or patient-identifiable data and sensitive data. Extended outage, significant operational impact on service delivery, patient safety, or regulatory compliance.	Extended failure of core infrastructure during peak operations. Hospital-wide system outage delays in diagnostics and treatment.
	5 – Catastrophic	Complete infrastructure failure or critical services failure of digital infrastructure Results in patient harm, regulatory enforcement, or reputational damage. Immediate executive and external response required.	Prolonged outage of national systems (e.g. EPR, ESR, PAS). Total infrastructure failure during a critical incident (e.g., major trauma event), emergency services disrupted
Sub-category:	**1 – Negligible**	Minor data entry error, easily corrected. Isolated quality issue, no security impact	A typo in a non-clinical report. A phishing email is received but not clicked.

Risk Rating Score Guide

Data Integrity, Quality & Cyber Security	**2 - Minor**	Small-scale data corruption, limited scope. Minor security incident, no data loss	Incorrect patient demographic data entered, quickly corrected. Malware detected and quarantined before spreading.
	3 – Moderate	Data loss or inaccuracy affecting reporting or decision-making. Quality issue affecting service delivery, phishing attempt.	Lab results mismatched with patient records, causing treatment delays. Unauthorised access to a small number of non-sensitive records.
	4 - Major	Widespread data corruption, regulatory impact. Security breach with data exposure, service compromise. Cyberattack affecting clinical systems, significant operational impact.	Corrupted patient data across multiple systems, impacting clinical decisions. Ransomware attack encrypts clinical systems, backup recovery required.
	5 – Catastrophic	Critical data loss, legal/regulatory breach, reputational damage. Major data breach of highly sensitive data. Results in patient harm, regulatory enforcement, or reputational damage. Immediate executive and external response required.	Ransomware attack disabling hospital systems; large-scale data breach involving patient records. Loss of entire patient database, legal action and regulatory ICO investigation triggered.
Sub-category: Data Sharing & Governance	**1 – Negligible**	Delay in data sharing, no impact	Delay in sharing non-urgent data with a partner organisation.
	2 - Minor	Incomplete data shared, minor inconvenience	Incomplete data shared with a research team, minor inconvenience.
	3 – Moderate	Unauthorised data sharing or access to sensitive data; data sharing error affecting collaboration. Isolated breach of policy, legislation or guidelines	incorrect data sharing within the organisation with another NHS Trust, requiring follow-up.
	4 - Major	Unauthorised sharing or access to large volumes of sensitive data; significant breach of policy, legislation or guidelines	Sensitive data shared without consent, breach of GDPR.
	5 – Catastrophic	Critical data leak, breach of confidentiality, legal consequences	Mass data leak to external parties
Sub-category: Digital & Service Transformation, capability, capacity	**1 – Negligible**	Minor delay in rollout, no impact. Minor skill gap easily addressed. Temporary resource shortage, no impact	Slight delay in rollout of a new scheduling tool. Temporary understaffing in IT support.
	2 - Minor	Small-scale resistance to change. Limited expertise in some areas. Minor delays due to limited capacity.	Staff resistance to using a new app, requiring extra training. Limited digital skills in a department, slowing adoption. Delays in responding to non-critical service requests.
	3 – Moderate	Project delays, moderate user adoption issues. Skills shortage affecting project delivery. Capacity issues affecting timelines	Delays in EPR implementation affecting workflow efficiency. Shortage of skilled staff delays project delivery. Project timelines extended due to resource constraints.
	4 - Major	Transformation failure, financial loss. Lack of capability impacting strategic goals. Inability to meet demand, service degradation	Failure of a major digital programme, financial loss and strategic setback. Lack of expertise leads to failed implementation of a critical system. Inability to meet service demand during peak periods.
	5 – Catastrophic	Systemic failure in transformation, major financial impact. Critical capability gap, failure to deliver core services. Severe capacity shortfall, reputational/legal consequences	Collapse of transformation strategy, loss of funding, leadership change. Organisation-wide capability gap, unable

			to meet strategic objectives. Systemic failure due to chronic under-resourcing, patient or staff safety compromised.

Category: Living within our means	Score	Definition	Examples Consequences
Sub-category: Operational financial management	**1 – Negligible**	Minor financial variance with no impact on statutory duties, service delivery, or stakeholder confidence. Easily managed within existing budgets.	Small overspend in a non-critical area; minor forecasting error corrected in-year.
	2 - Minor	Localised or short-term financial pressure requiring internal reallocation or minor corrective action. No breach of financial duties.	Delay in achieving savings target; temporary cash flow issue resolved without external support.
	3 – Moderate	Noticeable financial risk affecting budgetary control or delivery of planned initiatives. Requires formal mitigation and oversight.	Emerging deficit in a key service area; risk to achieving control total; increased scrutiny from ICS partners.
	4 - Major	Significant financial shortfall or breach of financial planning assumptions. Potential risk to statutory duties or strategic objectives.	Unplanned deficit requiring external support; failure to deliver cost improvement plans; concern among stakeholders.
	5 – Catastrophic	Critical financial failure resulting in breach of statutory duties, loss of public confidence, or regulatory intervention. Immediate executive and system-wide response required.	Breach of financial duty under NHS Act; external audit qualification; ICS-wide financial instability; media or political scrutiny.
Sub-category: Strategic Financial Decisions and Transformation	**1 - Insignificant**	Minor budget adjustment, no impact on services.	Reallocation of funds between non-clinical departments.
	2 - Minor	Small-scale financial inefficiency.	Slight overspend on a digital pilot project, easily absorbed.
	3 – Moderate	Delays or changes to planned transformation.	Delay in rolling out new critical system or process due to funding gap.
	4 - Major	Strategic programme failure. Cancellation of a major transformation initiative due to financial constraints	Major project aborted.
	5 – Catastrophic	Financial collapse of strategic plans	Multi-year transformation programme fails, leading to loss of external funding and leadership change.
Sub-category: System Collaboration and ICS Financial Balance	**1 – Negligible**	Minor disagreement between partners	Slight delay in agreeing shared procurement terms
	2 - Minor	Localised financial tension	One partner overspends, requiring minor ICS-level adjustment
	3 – Moderate	Disruption to joint initiatives	Disagreement over funding allocation delays shared workforce programme
	4 - Major	Breakdown in financial collaboration, service impact	ICS partners unable to agree on capital investment priorities, affecting service delivery

	5 – Catastrophic	ICS-wide financial failure	System-wide deficit leads to service cuts, regulatory intervention, and public scrutiny

Category: Estates & Facilities	Score	Definition	Examples Consequences
Sub-category: Estates Modernisation and Capital Development	**1 – Negligible**	Minor deterioration or delay in investment with no impact on safety, service delivery, or compliance. Easily managed through routine maintenance.	Small maintenance delay; minor wear and tear; non-critical equipment fault. Cosmetic wear and tear; minor backlog in non-critical repairs; low-priority upgrade deferred.
	2 - Minor	Localised disruption or delay in estate projects or facilities management. Minimal impact on patient/staff experience or statutory compliance.	Delay in refurbishing non-clinical areas; temporary failure of non-essential systems; minor deviation from HTM/HBN guidance.
	3 – Moderate	Noticeable impact on service flow, staff experience, or patient care due to estate or infrastructure issues. Requires targeted mitigation and oversight.	Delays in clinical space upgrades; ventilation or heating issues affecting comfort; backlog in statutory maintenance tasks.
	4 - Major	Significant disruption or failure in estate infrastructure affecting safety, compliance, or operational continuity. Strategic intervention required.	Failure to meet CQC environmental standards; disruption to clinical services due to infrastructure failure; non-compliance with HTMs/HBNs.
	5 – Catastrophic	Critical estate or infrastructure failure resulting in service closure, patient harm, or regulatory enforcement. Immediate executive-level response required.	Unsafe clinical environment causing closure of key facilities; enforcement action due to statutory breaches; reputational damage.
Sub-category: Facilities Management Operational Delivery	**1 – Negligible**	Minor facilities issues with no impact on service delivery, safety, or compliance. Easily resolved through routine facilities management.	Slight delay in non-clinical cleaning; minor maintenance backlog; brief catering supply issue.
	2 - Minor	Localised or short-term disruption with minimal impact on service quality or statutory standards. No safety risk.	Temporary failure of non-critical equipment; short-term staffing gap in facilities team; minor deviation from HTM/HBN guidance.
	3 – Moderate	Noticeable impact on service delivery, staff/patient experience, or compliance. Requires formal mitigation and oversight.	Repeated complaints about cleanliness; catering disruption affecting patient meals; delay in statutory maintenance tasks.
	4 - Major	Significant failure in facilities management affecting safety, regulatory compliance, or operational continuity. Strategic intervention required.	Non-compliance with CQC environmental standards; breakdown in security systems; disruption to clinical services due to infrastructure failure.
	5 – Catastrophic	Critical failure resulting in patient harm, service closure, or regulatory enforcement. Immediate executive-level response required.	Unsafe clinical environment due to poor maintenance; serious incident linked to facilities failure; enforcement action or reputational damage.

Risk Rating Score Guide

Category: Research & Innovation	Score	Definition	Examples Consequences
Sub-category: Clinical Research & Trials	**1 – Negligible**	Minor procedural deviation with no impact on participant safety, data integrity, or regulatory compliance. Easily corrected through routine governance.	Slight delay in ethics documentation; minor data entry error identified and resolved.
	2 - Minor	Localised or short-term issue affecting study timelines or administration, but no impact on safety or scientific validity.	Recruitment delays; minor protocol deviation; temporary staff capacity issue.
	3 – Moderate	Noticeable impact on research delivery, data quality, or participant experience. Requires formal review and corrective action.	Incomplete data collection; pronounced participant withdrawal due to unclear communication; audit findings requiring process change.
	4 - Major	Significant breach of research governance, ethical standards, or safety protocols. Potential impact on patient outcomes or organisational reputation.	Failure to follow approved protocol; adverse event not reported promptly; data integrity concerns.
	5 – Catastrophic	Critical failure resulting in participant harm, regulatory breach, or loss of public trust. Immediate executive and regulatory response required.	Serious adverse event due to protocol violation; suspension or termination of study; reputational damage or legal action.

Category: Partnership with Purpose	Score	Definition	Examples Consequences
Sub-category: Partnerships and Strategic Collaboration	**1 – Negligible**	Minor issue in partnership delivery with no impact on strategic goals, patient outcomes, or reputation. Easily resolved through routine contract management.	Slight delay in joint project milestones; minor miscommunication between partners.
	2 - Minor	Localised or short-term disruption in partnership activity. Minimal impact on service delivery or stakeholder confidence.	Delay in data sharing agreement; limited engagement from one partner; minor deviation from agreed scope.
	3 – Moderate	Noticeable impact on partnership outcomes, innovation delivery, or stakeholder relationships. Requires formal review and mitigation.	Underperformance in a joint venture; misalignment of priorities affecting project delivery; reputational concern among stakeholders.
	4 - Major	Significant breakdown in partnership governance, delivery, or strategic alignment. Risk to patient benefit, transformation goals, or public confidence.	Failure to deliver shared digital platform; contractual dispute; withdrawal of a key partner affecting service continuity.
	5 – Catastrophic	Critical failure of partnership resulting in harm, financial loss, or regulatory breach. Immediate executive-level response and external coordination required.	Collapse of a strategic alliance; breach of legal or ethical obligations; public or media scrutiny; impact on ICS-wide transformation programmes.

Risk Rating Score Guide

Category: Brilliant Basics	Score	Definition	Examples Consequences
Sub-category: Compliance & Well-led	**1 – Negligible**	Minor deviation from strategic plans or standards with no impact on compliance, service delivery, or reputation. Easily corrected through routine governance.	Slight delay in reporting; minor documentation error; localised misalignment between plan and delivery.
	2 - Minor	Localised or short-term non-compliance or governance issue with minimal impact. No breach of statutory duties or strategic objectives.	Missed internal deadline; temporary gap in oversight; minor audit recommendation.
	3 – Moderate	Noticeable misalignment or compliance risk affecting delivery of strategic priorities or assurance processes. Requires formal review and mitigation.	Incomplete implementation of a 'must-do' standard; gaps in assurance reporting; operational delivery not aligned with strategic goals.
	4 - Major	Significant breach of statutory or regulatory requirements, or failure in strategic governance. Risk to organisational performance or stakeholder confidence.	Non-compliance with NHS constitutional standards; failure to deliver key national priorities; external scrutiny or reputational concern.
	5 – Catastrophic	Critical failure resulting in breach of legal duties, regulatory enforcement, or loss of public trust. Immediate executive-level response required.	Breach of statutory financial or clinical duty; serious governance failure; regulatory intervention or media scrutiny.

Category: Green Sustainability	Score	Definition	Examples Consequences
Sub-category: Sustainability, Biodiversity and Climate Adaptation	**1 – Negligible**	Minor disruption or delay in sustainability initiative with no impact on safety, compliance, or service delivery. Easily resolved through routine project management.	Slight delay in installing LED lighting; minor adjustment to recycling processes.
	2 - Minor	Localised or short-term issue affecting implementation or stakeholder engagement. No breach of safety or environmental standards.	Temporary resistance to sustainable transport changes; minor cost overrun in green technology pilot.
	3 – Moderate	Noticeable impact on operational efficiency, staff experience, or environmental targets. Requires formal review and mitigation.	Delay in carbon reduction targets; underperformance of renewable energy system; disruption during infrastructure upgrade.
	4 - Major	Significant failure or delay in sustainability initiative affecting compliance, strategic goals, or public confidence. Strategic intervention required.	Non-compliance with NHS Net Zero milestones; failure to meet Green Plan commitments; reputational concern due to environmental impact.
	5 – Catastrophic	Critical failure resulting in breach of statutory environmental duties, safety risks, or reputational damage. Immediate executive-level response required.	Unsafe implementation of green technology; environmental incident; enforcement action or media scrutiny due to sustainability failure.

Risk Rating Score Guide

Category: Health Inequalities	Score	Definition	Examples Consequences
Sub-category: Strategic Programmes to Reduce Inequalities	**1 – Negligible**	Minor implementation issue with no impact on target populations or programme outcomes. Easily resolved through routine oversight.	Slight delay in community engagement activities; minor data collection gap.
	2 - Minor	Localised or short-term disruption in programme delivery. Minimal impact on access or experience for underserved groups.	Low uptake in one area; temporary staffing gap in outreach team; minor deviation from planned timeline.
	3 – Moderate	Noticeable impact on programme effectiveness or reach. Requires targeted mitigation to avoid missed opportunities for improvement.	Incomplete delivery of targeted interventions; delays in evaluating impact; reduced engagement from key stakeholders.
	4 - Major	Significant failure to deliver intended benefits, risking widening inequalities or loss of trust among communities. Strategic intervention required.	Breakdown in partnership delivery; failure to reach priority populations; reputational concern due to perceived inequity.
	5 – Catastrophic	Critical failure resulting in harm, exclusion, or systemic inequity. Immediate executive-level response and external scrutiny required.	Programme contributes to unintended disparities; breach of ethical standards; public or media criticism; loss of funding or regulatory action.

Category: Continuous Improvement	Score	Definition	Examples Consequences
Sub-category: Quality Improvement and Service Redesign	**1 – Negligible**	Minor deviation or delay in improvement activity with no impact on patient care, staff experience, or service delivery. Easily corrected within the cycle.	A PDSA test yields inconclusive results; minor data collection error; no change to current practice.
	2 - Minor	Localised disruption or unintended outcome following of improvement activities with minimal impact. Learning captured and used to refine future cycles.	Staff confusion over new process; temporary increase in workload; minor resistance to change.
	3 – Moderate	Noticeable impact on service flow, staff engagement, or patient experience as a result of improvement activities. Requires formal review and adjustment of the improvement approach.	A redesigned pathway causes delays; technology trial affects patient communication; staff feedback indicates dissatisfaction.
	4 - Major	Significant unintended consequences as a result of improvement activities affecting safety, quality, or operational performance. Requires escalation and strategic oversight.	New model leads to missed care steps; digital tool fails in clinical setting; patient complaints increase due to process change.
	5 – Catastrophic	Critical failure of improvement initiative resulting in patient harm, service disruption, or reputational damage. Immediate executive response required.	Unsafe care due to flawed redesign; breach of clinical standards; external scrutiny or withdrawal of improvement programme.

Risk Rating Score Guide

Likelihood Score Definitions

There are several ways of defining likelihood, for example, by probability of occurrence, onset time or frequency. Read the descriptions and the examples below to help you choose. You do not have to meet

Score - Level	Description	Example of probability of occurrence	Example of frequency
1- Rare	May occur only **in exceptional circumstances** or very slow onset which take place over years allowing a long time to identify and address.	There is a < 5% chance of it happening	The risk may materialise once every 1-5 years
2- Unlikely	**Could occur** at some time, but **not expected**. Has happened very occasionally in similar organisations; or emerges over 6 months or more allowing time for identification and mitigation to address it	There is a 5–20% chance of it happening	The risk may materialise every 6-12 months (bi-annually-annually)
3- Possible	**Just as likely to happen as not**; or might occur at some time. Has happened occasionally in similar settings or onset is over 3 months or more	There is a 21% to 50% chance of it happening	The risk may materialise every 3+ months (quarterly+)
4- Likely	Will probably **occur in most circumstances** or has occurred several times in the organisation; or onset may be identified only a matter of days to a few weeks and this is unlikely to provide reasonable time to address it;	There is 51% to 79% chance of it happening	The risk may materialise every 2-4 weeks (fortnightly-1+ month)
5- Almost Certain	Will **undoubtedly occur** or very rapid onset, little or no warning or will be instantaneous	There is a > 80% chance of it happening	The risk may materialise every few days or more (daily to one week)

Overall risk rating *multiply your consequence score with your likelihood score to get a risk rating

Consequence Score ⇩	Likelihood Score				
	1	**2**	**3**	**4**	**5**
5	**5** (C5 x L1)	**10** (C5 x 2)	**15** (C5 x L3)	**20** (C5 x L4)	**25** (C5 x L5)

Risk Rating Score Guide

4	**4** (C4 x L1)	**8** (C4 x L2)	**12** (C4 x L3)	**16** (C4 x L4)	**20** (C4 x L5)
3	**3** (C3 x L1)	**6** (C3 x L2)	**9** (C3 x L3)	**12** (C3 x L4)	**15** (C3 x L5)
2	**2** (C2 x L1)	**4** (C2 x L2)	**6** (C2 x L3)	**8** (C2 x L4)	**10** (C2 x L5)
1	**1** (C1 x L1)	**2** (C1 x L2)	**3** (C1 x L3)	**4** (C1 x L4)	**5** (C1 x L5)

See below for which register your risk should be escalated to for approval. *Risk must be approved onto each register in turn, not directly onto the highest register

Category	Sub-category	Appetite	Specialty	Division	Trust
Patient experience and voice	Patient Voice, Engagement & Co-production	**Significant**	**1-6**	**8+**	**25**
People, culture and leadership	Workforce Sustainability	**Cautious**	**1-6**	**8+**	**15**
	Staff Experience, Development and Culture	**Open**	**1-6**	**8+**	**16**
Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety), Clinical Effectiveness or Business Continuity	**Cautious**	**1-6**	**8+**	**15**
	Patient Experience or Operational Models	**Open**	**1-6**	**8+**	**16**
Digital First	Infrastructure & Stability / Data Integrity, Quality & Cyber Security	**Cautious**	**1-6**	**8+**	**15**

Risk Rating Score Guide

	Data Sharing & Governance	**Open**	**1-6**	**8+**	**16**
	Digital & Service Transformation, capability, capacity	**Seek**	**1-6**	**8+**	**20**
Living within our Means	Operational financial management	**Cautious**	**1-6**	**8+**	**15**
	Strategic Financial Decisions and Transformation / System Collaboration and ICS Financial Balance	**Open**	**1-6**	**8+**	**16**
Estates and Facilities	Estates Modernisation and Capital Development	**Open**	**1-6**	**8+**	**16**
	Facilities Management Operational Delivery	**Cautious**	**1-6**	**8+**	**15**
Research and Innovation	Clinical Research & Trials	**Open**	**1-6**	**8+**	**16**
Partnerships with Purpose	Partnerships and Strategic Collaboration	**Seek**	**1-6**	**8+**	**20**
Brilliant Basics	Compliance or well-led	**Cautious**	**1-6**	**8+**	**15**
Green Sustainability	Sustainability, Biodiversity and Climate Adaptation	**Open**	**1-6**	**8+**	**20**
Health Inequalities	Strategic Programmes to Reduce Inequalities	**Open**	**1-6**	**8+**	**16**
Continuous Improvement	Quality Improvement and Service Redesign	**Seek**	**1-6**	**8+**	**20**

ID	Risk Description	Risk Register	Division	Service	Type	Subtype	Initial rating	Current likeli-hood	Current conse-quence	Current rating	Target rating	Move-ment	Next Review Date
83	3550 The risk of physical or psychological harm to patients, relatives, public and staff during incidents involving challenging, aggressive, abusive, threatening and offensive behaviour or physical violence.	Trust Risk Register	Corporate	Risk, Health & Safety	Safety	Abuse, violence and aggression	10	4	3	12	6	↑	04/02/2025
93	3787 The risk of harm to patients due to clinical reports being lost and required clinical action omitted or delayed.	Trust Risk Register	Corporate	Medical Executive Office	Safety	Electronic patient record	15	3	4	12	6	↓	31/10/2025
96	3826 Risk of delays in managing formal employee relations cases due to limited investigating officer capacity.	Trust Risk Register	Corporate	People & OD (Human Resources)	Workforce	Staffing and competency	12	4	3	12	2	↔	17/12/2025
122	The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack	Trust Risk Register	Corporate	Information Governance	Business	Digital risk	20	3	5	15	2	↓	30/11/2025
135	The risk of delays in patient pathways, due to insufficient consultant radiologists	Trust Risk Register	Diagnostics and Specialties	Radiology	Quality	Delayed diagnosis or treatment	20	5	4	20	3	↔	13/01/2026
141	4007 The risk that substantive non-medical staff are not fully compliant with their appraisal requirements and they receive a low-quality appraisal experience	Trust Risk Register	Corporate	People & OD (Human Resources)	Workforce	Staffing and competency	16	4	3	12	8	↓	12/12/2025
154	4009 The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher	Trust Risk Register	Corporate	People & OD (Human Resources)	Workforce	Recruitment and retention	16	4	3	12	8	↓	31/10/2025

	levels of discrimination, leading to low morale, poor health and wellbeing												
160	1945 The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.	Trust Risk Register	Corporate	Nursing Management	Safety	Clinical assessment	9	4	3	12	6	↑	31/10/2025
161	2667 The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	Trust Risk Register	Corporate	Infection control	Safety	Infection control	16	3	4	12	6	↓	22/12/2025
162	2610 The risk of not adhering to numerous pieces of NICE guidance through the inadequate resourcing of specialist psychology services for cancer and palliative care patients.	Trust Risk Register	Diagnostics and Specialties	Health Psychology	Quality	Clinical Standards	12	5	3	15	1	↑	09/01/2026
233	2669 The risk of harm to patients as a result of inpatient falls	Trust Risk Register	Corporate	Nursing Management	Safety	Clinical assessment	15	3	4	12	12	↓	30/11/2025
264	2404 Risk harm as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Trust Risk Register	Diagnostics and Specialties	Clinical Haematology	Workforce	Recruitment and retention	9	4	4	16	6	↑	10/10/2025
266	3682 The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Trust Risk Register	Medical	Emergency Department	Statutory	Integrated care board risk	15	4	4	16	6	↑	30/01/2026
293	3879 The inability to provide a Pharmacy Manufacturing Service due to the closure of the department.	Trust Risk Register	Diagnostics and Specialties	Pharmacy	Quality	Delayed diagnosis or treatment	12	4	4	16	3	↑	31/10/2025

333	3968 Risk of a delay to follow-up appointments leading to significant reduction of vision due to insufficient resources to correctly prioritise patients on the waiting list.	Trust Risk Register	Surgical	Ophthalmology	Workforce	Staffing and competency	9	4	4	16	6	↑	28/11/2025
355	3941 The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal Hospitals	Trust Risk Register	Corporate	Strategy and Transformation – Estates and Facilities	Safety	Estates related	15	2	5	10	5	↑	31/12/2025
363	3371 The risk of statutory intervention due to non-compliant fire safety infrastructure including an obsolete fire alarm at GRH, poor compartmentation / fire doors and insufficient break-glass points; leading to harm to patients, visitors and staff.	Trust Risk Register	Corporate	Strategy and Transformation – Estates and Facilities	Statutory	Prosecution	15	4	5	20	6	↑	08/09/2025
368	3751 The risk of statutory intervention as a result of a failure to manage asbestos in our buildings in line with the Control of Asbestos Regulations 2012, leading to harm.	Trust Risk Register	Corporate	Strategy and Transformation – Estates and Facilities	Statutory	Breach of legislation	10	4	4	16	5	↑	31/10/2025
374	3930 The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Trust Risk Register	Corporate	Strategy and Transformation – Estates and Facilities	Statutory	Breach of legislation	10	3	5	15	5	↑	31/05/2025
397	The risk of clinicians not having access to information relating to requested pathology and radiology investigations and spending unnecessary time looking up pathology and radiology results not yet available - due to lack of order comms	Trust Risk Register	Corporate	Health Records	Workforce	Staffing and competency	12	4	3	12	1	→	02/01/2026

401	The risk of core IT infrastructure equipment failure and loss of access to business critical data as a result of environmental hazards, e.g. loss of essential service; power / AC, heatwave, floods water leaks and ingress etc.	Trust Risk Register	Corporate	IT Services	Business	Digital risk	9	5	4	20	3	↑	02/01/2026
425	2424 The risk of increased financial impact on theatres and the trust due to ageing and ineffective air handling units	Trust Risk Register	Surgical	Theatres	Business	Facilities related	4	4	4	16	6	↑	02/03/2025
426	2268 The risk to patients within the Minors Area of the Emergency Department due to overcrowding and staffing	Trust Risk Register	Medical	Emergency Department	Statutory	Integrated care board risk	16	5	4	20	4	↑	01/08/2025
458	3326 The risk to quality from an inadequate bed base, estate and facilities within the Department of Critical Care in Gloucestershire Royal Hospital (DCCG)	Trust Risk Register	Surgical	Critical Care	Quality	Estates – condition, space, housekeeping	12	4	4	16	1	↑	03/12/2025
472	3743 The risk of failing to deliver appropriate support to the Haematology Laboratory due to insufficient staffing levels and appropriate skill sets, leading to a delay to diagnosis or treatment and patient harm	Trust Risk Register	Diagnostics and Specialties	Clinical Haematology	Workforce	Recruitment and retention	15	4	3	12	4	↓	10/10/2025
534	2895 There is a risk the Integrated Care Board (ICS)/ Trust has insufficient capital due to the Capital departmental expenditure limit (CDEL) and/or is unable to secure additional borrowing to address critical digital, estate or equipment risks	Trust Risk Register	Corporate	Finance	Business	Service interruption	8	3	4	12	6	↑	19/12/2025
609	2976 The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Trust Risk Register	Surgical	Breast	Workforce	Recruitment and retention	15	5	3	15	4	→	28/11/2025

674	2719 The risk of harm affecting patient and staff safety due to the inefficient evacuation of a hospital building in the event of fire due to poor uptake in evacuation drills and training and a clear evacuation plan.	Trust Risk Register	Corporate	Strategy and Transformation – Estates and Facilities	Safety	Legal requirement	5	3	5	15	6	↑	03/09/2025
722	4006 The risk that the Trust is unable to retain members of the substantive workforce.	Trust Risk Register	Corporate	People & OD (Human Resources)	Workforce	Recruitment and retention	16	4	4	16	8	↔	31/12/2025
749	The risk of the vascular network becoming unviable due to the inability of the service to support elective and emergency work as a result of reduced consultant numbers.	Trust Risk Register	Surgical	Vascular	Workforce	Recruitment and retention	20	5	3	15	4	↓	10/12/2025
751	The risk of failure to provide a safe and high quality maternity ultrasound service due to a lack of current dedicated maternity scanning service	Trust Risk Register	Women's and Children's	Maternity	Quality	Clinical Standards	9	4	4	16	3	↑	31/10/2025
764	S2045 The risk of reduced quality of care in the fractured neck of femur (NOF) pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Roy	Trust Risk Register	Surgical	Theatres	Quality	Clinical Standards	6	4	4	16	8	↑	15/12/2025
813	The risk of harm to dermatology patients due to delays in minor operations impacting on cancer pathway	Trust Risk Register	Medical	Dermatology	Safety	Delayed diagnosis or treatment	16	3	4	12	6	↓	06/03/2026
841	The risk of being unable to deliver acute and cancer patient care due to a critical shortage of Interventional Radiologists	Trust Risk Register	Diagnostics and Specialties	Radiology	Workforce	Recruitment and retention	15	5	4	20	6	↑	31/10/2025

850	The risk of increased workplace stress in Oncology due to an imbalance of consultant workforce across Oncology against workload	Trust Risk Register	Diagnostics and Specialties	Oncology	Workforce	Staffing and competency	16	4	4	16	2	↔	31/10/2025
893	The risk to patient safety due to inappropriate insertion and management of indwelling urinary catheters	Trust Risk Register	Corporate	Infection control	Safety	Clinical Standards	12	4	3	12	9	↔	22/12/2025
911	The risk of significantly reduced quality of patient care and management caused by insufficient general anaesthetic workforce to manage the clinical demands upon service	Trust Risk Register	Surgical	Anaesthetics	Quality	High patient demand	12	4	4	16	4	↑	31/12/2025
970	The risk to patients and staff safety in East Block CGH OMF OPD due to inadequate and outdated estate and facilities for care delivery.	Trust Risk Register	Surgical	Oral Maxillo Facial (OMF)	Safety	Estates related	12	3	4	12	2	↔	31/12/2025
1012	The risk of critical disruption to operational and clinical services , due to decreased sustainability and delays in development of digital services, systems and infrastructure caused by strategic and tactical workforce constraints.	Trust Risk Register	Corporate	IT Services	Business	Digital risk	20	5	3	15	2	↓	27/10/2025
1042	Risk of a fall from height from a Tower Block window in Gloucestershire Royal Hospital leading to serious or fatal harm to patients, in particular those without capacity or with mental health conditions	Trust Risk Register	Corporate	Risk, Health & Safety	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	15	3	5	15	5	↔	30/12/2025
40													

Appendix 4 - KPI performance for October 2025

Risk Controls

All risks on the system have identified controls. This provides a **substantial level** of assurance for this element of the system. The Trust has performed consistently well against the identifications of controls. Risks that had previously progressed on a specialty register without identified controls are now captured at an earlier stage, and owners are actively focusing on including current risk reduction measures.

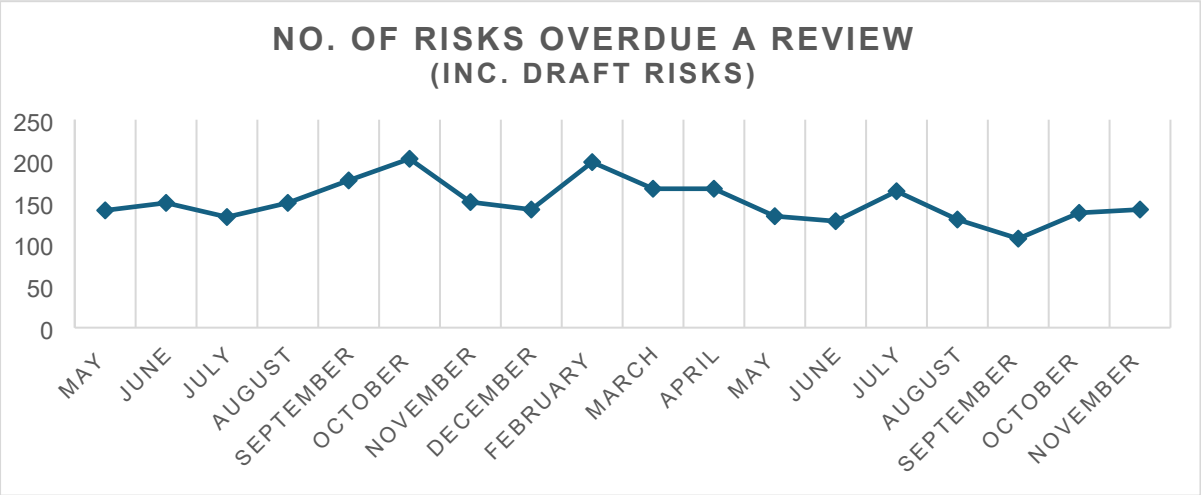
Actions to Mitigate Risks

1 risk (0.1%) has no identified recent active or completed actions designed to mitigate the risk. This provides a **substantial level** of assurance for this element of the system.

Risk Reviews

Since the opening of the new DATIX Cloud system in February 2024, risk review activity has increased, with over 100 risks reviewed each month.

However, 142 risks (24%) remain overdue. The Medical division has 50 overdue. This provides a **limited level** of assurance for this element of the system.



All divisions have received details of these on a monthly basis via divisional reports, and both the divisions and GMS are provided this information at RMG and are expected to address these. These are also highlighted to divisional leadership in the Executive Review data.

Actions

Of the 22nactions that remain open on Datix-Web, 21 of these (95%) are overdue.

Performance is similar on Datix-Cloud has improved but still requires further input from action owners, with 331 actions associated with risks and 289 actions associated with incidents overdue. All actions from 2023 have now been cleared via greater scrutiny at RMG, 68 actions date back to 2024 and are now the focus of RMG. This provides a **limited level** of assurance for this element of the system.

Key:

The evidence presented for each element of the system is used to form an assurance opinion for that part of the system based on the table below. A system-wide level of assurance is provided in the summary.

Assurance Level	Description
Substantial Assurance	• Isolated medium-risk rated weaknesses identified • Mainly only low weaknesses • No individual element is classed as limited or as no assurance
Reasonable Assurance	• Some medium-risk rated weaknesses identified • Isolated high-risk rated weaknesses identified that are not systemic and / or have resolution in progress
Limited Assurance	• Significant number of medium-risk rated weaknesses and /or • Several high-risk weaknesses • Internal audit has concerns about management approach
No Assurance	• Serious systemic weakness • Significant number of high-risk weaknesses

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges**								
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	July 2025	July 2025	CNO/ MD/C OO	QPC	4x3=12	5x5=25	4x4=16
SR2	Failure to successfully embed the quality governance framework	Dec 2022	Sept 2025	October 2025	CNO/ MD	QPC	3x3=9	5x4=20	3x4=12
2.	**We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**								
SR16	Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve. (Culture and Retention)	Jan 2023	Sept 2024	June 2025	DFP	PODC	3x4=12	N/A	4x4+16
SR17	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve (Recruitment and attraction)	May 2024	Sept 2025	Sept 2025	DFP	PODC	3x4=12 Mar 26	N/A	4x4+16
3.	**Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other**								
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	October 2024	November 2024	MD/C NO	QPC	2x3=6	N/A	4x4=16

				(awaiting review July 2025)					
4.	**We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners**								
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	April 2024	To be closed as part of the Strategy realignment	COO/ DST	QPC	2x3=6	N/A	4x3=12

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	May 2024	-	DID	QPC	1x3=3	3x3=9	**3x2=6**
7.	**We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources**								
SR9	Failure to deliver recurrent financial sustainability	July 2019	October 2025	October 2025	DOF	FRC	Mar 26:5x4=20 Mar 27:5x3=15 Mar 28:5x2=10 Mar 29:5x1:5	5x5+25	**5x5=25**
8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**								
SR10	The risk to patient safety, quality of care, reputational damage and contractual penalties as a result of the areas of poor estate and the scale of backlog maintenance.	July 2019	June 2025	Sept 2025	DID	FRC	4x4=16	N/A	**4x4=16**
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero	Dec 2022	January 2025	January 2025	DID	FRC	3x3=9	N/A	**3x4=12**

	carbon organisation by 2040								
9.	**We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care**								
SR12	Failure to detect and control risks to cyber security	Dec 2022	October 2024	July 2025	CDIO	FRC	3x4=12	N/A	3x5=15
SR13	Inability to maximise digital systems functionality	Dec 2022	October 2024	July 2025	CDIO	FRC	2x5=10	N/A	4x5=20
10.	**We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**								
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	Sept 2024	January 2025	MD	FRC	2x3=6	N/A	3x4=12

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

		Consequence				
Likelihood		**1**	**2**	**3**	**4**	**5**
	5	**5 Rating**	**10 Rating**	**15 Rating**	**20 Rating**	**25 Rating**
						SR 1
	4	**4 Rating**	**8 Rating**	**12 Rating**	**16 Rating**	**20 Rating**

				SR6	SR16, SR17 SR5 SR9 SR10	
	3	**3 Rating**	**6 Rating**	**9 Rating**	**12 Rating**	**15 Rating**
			SR7	SR11	SR2 SR13 SR14	SR12
	2	**2 Rating**	**4 Rating**	**6 Rating**	**8 Rating**	**10 Rating**
				SR7 Patient and Public Engagement		
	1	**1 Rating**	**2 Rating**	**3 Rating**	**4 Rating**	**5 Rating**

Report to Board of Directors			
Date	13 November 2025		
Title	NHS England self-certification of compliance with the NHS Provider Licence in 2024-25		
Author **Sponsoring Director**	Sarah Favell, Trust Secretary Kerry Rogers, Director of Integrated Governance		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	✓
Regulatory requirement	✓	To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

All Trusts are required to annually self-certify that they meet the obligations set out in the NHS Provider Licence. This includes requirements to comply with legislation and corporate governance standards

This paper provides information relating to the licence compliance requirements for the Trust and recommends that the Trust CONFIRM that the requirements of the relevant conditions are met.

Risks or Concerns

Ability to maintain our provider licence without condition.

Financial Implications

None

Equality, Diversity, Inclusion and Workforce Implications

Compliance with Fit and Proper Person requirements for Trust Leadership: Well-Led domain

Sustainability (Environmental) Implications

Recommendation

1. Receive ASSURANCE that the Trust is compliant with the NHS Provider Licence and confirm support for the source, robustness, and an appropriate degree of independence of the assurance;
2. To APPROVE the self-certification of 'confirmed' for each of the applicable Provider Licence Conditions.

Enclosures

1. Introduction

1.1 The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, with coherence across legislation, policy and regulatory frameworks

1.2 Compliance with the licence is routinely monitored through the Single Oversight Framework with segmentation ratings allocated by NHS England. For the relevant period the Trust was rated 2, reflecting that minimal support or intervention was required.

1.3 The Trust is required to self-certify its compliance with the following conditions after the financial year end (2024/2025):

- Condition G3: Fit and Proper Persons
- Condition G5: Systems for Compliance
- NHS 1 & 2: Good governance arrangements

2. Condition G3 – Fit and Proper Persons as Governors and Directors

2.1 Condition G3 states that Trusts must not have in place any person, as a Governor or Director, who is not fit and proper.

2.2 Governors must not be subject to undischarged bankruptcy, a moratorium period of a debt relief order, undischarged arrangements with creditors, or conviction for an imprisonable offence within the preceding five years. All Governors submit a fit and proper persons declaration on election or appointment and must declare any change in circumstances that occur during their tenure.

2.3 Directors are subject to similar conditions and additionally must meet the criteria of a fit and proper person under the NHS England Framework for board members. This Framework is incorporated within the recruitment and selection processes for all Board appointments and the Directors' appraisal process, including annual individual self-attestations and other required checks. Compliance is also reported annually to the Audit and Assurance Committee and Board.

2.4 The Trust's compliance with this requirement has been subject to an Internal Audit (September 2025) and identified as an area of strength the Fit and Proper Person Test Procedure with one area of improvement identified as to the secondary checks of qualifications and education.

2.5 It is proposed that the Trust confirms its compliance with this requirement.

3. Condition G5 – Systems for compliance with Licence conditions and related obligations

3.1 Condition G5 requires licensees to take all reasonable precautions against the risk of failure to comply with the licence conditions, legal requirements and stipulations of the NHS Constitution including the establishment, implementation, and regular review of processes and systems to identify and mitigate risk of non-compliance.

3.2 The Trust has a robust compliance framework in place as part of the system of internal controls, to maintain oversight and assurance. This includes reports to Board on the following items:

3.2.1 Board Assurance Framework. It is recognised that during the relevant period there was a need to align the Trust's risk appetite and strategic risks with the Trust Strategy (implementation post April 2025) but systems of review were maintained in respect of the current Strategic Risks with regular reviews by both responsible Executive Directors and the relevant Board Committees
3.2.2 Regulatory compliance assurance
3.2.3 Reservation of Powers, Schemes of Delegation, and Standing Financial Instructions Reviews
3.2.4 Board Committee Effectiveness and Terms of Reference Reviews (delayed report to Board to September 2025)
3.2.5 Committee Chair reports to Board detailing risks and issues that required escalation; and
3.2.6 An enhanced Integrated Performance Report, delivering a consolidated summary of critical metrics across quality, safety, people, performance and finance, further aiding Board Oversight.
3.2.7 Other specific reports on high-risk areas.

3.3 The Audit and Assurance Committee undertakes a regular review of risks to internal controls and reports assurance to the Board.

3.4 The Trust's Internal Auditors (currently BDO) undertake a number of specific risk-based internal control audits each year. Head of Internal Audit Opinion for 2024/2025 was Moderate, an improvement from the Limited opinion provided for 2023/2024.

3.5 Annual assurance is also provided through the Annual Report and Accounts process.

3.6 It is proposed that the Trust confirms its compliance with this requirement

4. Trust conditions – NHS1 and NHS2

4.1 Condition NHS1 requires Trusts to make available to NHSE written and electronic copies of the following (available on the Trust's website and were submitted to NHS England as required:

a. the Trust's Constitution.
b. the Trust's most recently published annual accounts and any report of the auditor on them, and
c. the Trust's most recently published annual report

4.2 Condition NHS2 outlines the governance arrangements that the Trust must adhere to, including, but not limited to, ensuring good corporate governance, addressing climate change and achieving net zero emissions, following NHS England guidance on digital maturity, fulfilling the duty to operate efficiently, economically, and effectively, and maintaining sufficient capability at Board level to provide effective organisational leadership in the quality of care delivered.

4.3 The Board is required to review annually their systems and processes to ensure good governance. There is no set approach for how NHS England expect this to be evidenced but would normally include a review of the effectiveness of board and committee structures,

reporting lines and performance and risk management systems.

4.4 The Board currently has five substantive committees with delegated authority for undertaking statutory duties and/or consideration of key strategi matters and risks, including those required under this Condition, each chaired by a Non-Executive Director.

4.4.1 Audit and Assurance Committee;
4.4.2 Finance and Resource Committee;
4.4.3 People and Organisational Development Committee.
4.4.4 Quality and Performance Committee
4.4.5 Appointments and Remuneration Committee.

4.5 The Board also has a Trust Leadership Team forum with delegated authority for operational aspects of the Trust's management, chaired by the Chief Executive Officer.

4.6 Each Committee provides regular Key Issues and Assurance Reports (KIAR) that are reviewed by the Board. These reports focus on issues requiring escalation and offer assurance on actions that aim to improve governance.

4.7 The Board Assurance Framework (BAF) serves as a structured tool to identify and manage strategic risks, helping ensure committees' activities align with the Trust's strategic goals.

4.8 The Trust's Annual Report (incorporating the Annual Governance Statement) includes commentary on committee performance and any gaps identified in effectiveness, promoting transparency in governance. The Trust's annual report provides several key areas where evidence of compliance with regulatory requirements and internal governance standards is presented:

i. Care Quality Commission (CQC) Compliance: The Trust is broadly compliant with CQC registration standards; however, certain areas, notably Maternity and Urgent and Emergency Care Services, have received warning notices. These notices have led to targeted quality improvement actions, with oversight by the Integrated Care Board, aimed at enhancing safety and service quality. In May 2024, the Trust received an enforcement notice from the CQC, which imposed specific reporting and operational conditions to drive improvements in quality and safety, particularly within maternity services. Key requirements of this enforcement action included enhanced quality oversight and strengthened incident learning processes. During the relevant period, regular progress reports were provided to both Board and Care Quality Commission.

ii. Workforce Compliance: Regular reporting on workforce metrics, including vacancy rates, staff turnover, and mandatory training completion, is overseen by the People and Organisational Development Committee

iii. Internal Audit and Governance: The Trust's governance structure includes an annual internal audit plan managed by the Audit and Assurance Committee.

iv. Board Assurance Framework (BAF): The BAF provides a structured approach for the Board to monitor and manage risks that could impact strategic objectives. This framework is part of the Trust's compliance with NHS Foundation Trust License Condition 4.

Within the Annual Governance Statement, risks to compliance and mitigations in place were detailed. This was considered by both the Audit and Assurance Committee and Board. The External Audit opinion following the Annual Audit of both financial statements and annual report was unmodified, subject to two identified significant weaknesses (reliance on non-recurrent savings and the continuing regulatory action by the Care Quality Commission). This was an improvement on the previous year when four significant weaknesses had been identified and the Audit Report noted the improvements during the relevant period.

4.7 The Trust's plans for achieving net zero carbon emissions are detailed in the Green Plan and relevant sections of the Annual Report, targeting a net-zero footprint by 2040 for emissions under their direct control. The Trust has implemented various initiatives, including:

i. Infrastructure Upgrades;
ii. Green Space Initiatives;
iii. Operational Changes;
iv. Sustainable Waste Management.

4.8 The Finance and Resources Committee, plays a key role in overseeing the Trust's financial performance. Its main responsibilities include:

i. Resource Management:
ii. Operational and Financial Reporting
iii. Investment approvals
iv. Digital Strategies and implementation
v. Managing Financial pressures**.**

4.9 It is proposed that the Trust confirms its compliance with this requirement

5. Conclusion

There is a good level of assurance that the Trust was compliant with the provider licence conditions without any imposed requirement for the financial year 2024/2025. This is also reflected in the Trust's segmentation rating of 2 under the NHS Oversight Framework. The Board's recent scrutiny of the new Provider Capability Assessment is further supporting evidence of the appropriateness of a self-certification of compliance 'confirmed'.

Recommendations
The Board is asked to 1. Receive ASSURANCE that the Trust is compliant with the NHS Provider Licence and confirm support for the source, robustness, and an appropriate degree of independence of the assurance; 2. To APPROVE the self-certification of 'confirmed' for each of the applicable Provider Licence Conditions.

Report to Board of Directors			
Date	13 November 2025		
Title	Gloucestershire Hospitals NHS Foundation Trust 2025-2030 Strategy		
Author / Presenter **Sponsoring Director**	Will Cleary-Gray, executive Director of Improvement and Delivery		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	**To obtain approval**	✓
Regulatory requirement	✓	**To highlight an emerging risk or issue**	
To canvas opinion	✓	**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report

The Trust current strategy expired in April 2024 signally a need for a refresh. Over 2024/25 work has been underway to inform the review and development of a new strategy including:

- an assessment of the current challenges and opportunities facing the trust and to be addressed in the strategy
- the progress made and benefit realised as a result of our previous strategy
- a deeper understanding of our population health needs by way of Strategic Health Needs Assessment
- a programme of engagement with staff, our communities and key stakeholders to understand what matters most to them to shape our strategy
- there has also been consideration of the draft strategy in light of the recently published NHS 10 Year Health Plan.

A draft of the strategy was presented to full board in July and September for further consideration and feedback given to inform and shape the final draft. The draft was positively received and key feedback given.

Over 2024/25 there has been extensive engagement with our staff to gain their views and insights to what matters to them most and to shape the strategy. More than 2000 individual staff shared their views supported by over 70 facilitated sessions. In addition, during January and February we joined forces with Gloucestershire Health and Care's Health Bus to engage with communities across each of our 6 districts to gain public views and insights about what matters most to them about their services at Gloucestershire Hospitals. 600 individuals shared their views with 200 completed surveys providing rich insights as to what matter most to our communities. We have also sought the views of our wider key stakeholders including our Council of Governors, Healthwatch and local partner organisation including sharing of our draft strategies at as execs to execs between GHC and ourselves.

This strategy is shaped by what our staff, public and key stakeholders have told us about what matters most to them as well as the key challenges the Trust needs to address.

Risks or Concerns

Approval of the strategy will inform a review of our Board Assurance Framework and Corporate Risks

Financial Implications

There are financial implications but the detail of this will be fully articulated through the Business Planning Process and the development key delivery plans and our Medium Term Planning.	
Approved by: Director of Finance / Director of Operational Finance	**Date:**
Equality, Diversity, Inclusion and Workforce Implications	
A Strategic Health Needs Assessment was undertaken to inform the development of the strategy supported by public health colleagues from Gloucestershire County Council.	
Sustainability (Environmental) Implications	
Recommendation	
The Board is asked to consider and approve the strategy.	
Enclosures	
Approval Draft of full Trust Strategy	

Gloucestershire Hospital NHS Foundation Trust Strategy 2025-2030

Purpose

1. The purpose of this paper is to present the final draft of our new Trust strategy 2025-2030 for Board approval.

Introduction and Background

2. The Trust previous strategy expired in 2024 and throughout 2024/25 work has been underway to inform the development of the new strategy including:

   - an assessment of the current challenges and opportunities facing the trust and to be addressed in the strategy
   - the progress made and benefit realised as a result of our previous strategy in particular from implementing service transformation
   - a deeper understanding of our population health needs by way of Strategic Health Needs Assessment
   - a programme of engagement with staff, our communities and key stakeholders to understand what matters most to them to shape our strategy
   - and more recently consideration of the NHS 10-Year Health Plan

   A summary of the development timeline can be found in **appendix, A.**
   A Summary of key challenges to address in the strategy can be seen in **Appendix, B**

3. There have been regular updates on progress and opportunities to further inform and shape the strategy through staff forum, Trust Leadership Team, Council of Governors, Board briefings and development sessions.

4. A draft of the strategy was presented to board in July and to confidential board in September for further consideration and feedback to inform and shape the final draft. The draft was positively for final approval pending changes from key feedback included:

   - Consideration about how the strategy directs and reflects the work of the Trust Group
   - Further consideration of our level ambition and balance with a focus on core services
   - Further consideration of the strategic framework and in particular enablers;
   - The prominence of patient experience and voice in our ambition and focus and how this influences and shapes services
   - Improved balance of strategic verses specificity especially around Goals and what will be different for patients and staff
   - Importance of review in light of the NHS 10 Year Health Plan, published in July 2025

- Strengthening our commitment to working in collaboration with key partners including primary, community mental health and VCSE sectors and our wider partners across the region
- The importance of our role in supporting the development of neighbourhood health with a focus on frailty and long-term conditions management

Summary of staff, public and stakeholder engagement approach and feedback

5. Over 2024/25 there has been extensive engagement with our staff to gain their views and insights to what matters to them most and to shape the strategy. Almost 2000 staff shared their views supported by over 70 facilitated sessions and wider service engagement.

6. In addition, during January and February we joined forces with our ICB and the NHS Information Bus to engage with communities across each of our six districts to gain public views and insights about what matters most to them about their services at Gloucestershire Hospitals. More than 600 people shared their views with 200 completed survey's providing rich insights as to what matter most to our communities

7. We have also sought the views of our wider key stakeholders including our Council of Governors, Healthwatch and local partner organisation including sharing of our draft strategies at as execs to execs between GHC and ourselves.

8. Feedback themes were developed and sentiment analysis used to establish a sense of feeling on what matter most which included:

    - Patients care being our main focus and delivery of safe and effective high-quality care;
    - Getting the basics right.
    - Improving access to care and support and reducing inequity and health inequalities.
    - Care be joined up across organisations and working collaboration;
    - Being a listening and learning organisation;
    - Making the best use of digital and technology both for staff and patients;
    - Improving the estate and facilities so that it provides a good environment to deliver and receive high quality care.

    A summary of our engagement can be seen in **Appendix, C**
    A summary of key themes from feedback which has shaped the strategy can be seen in **Appendix, D**

Alignment with national and local strategies and plans

9. Work has been undertaken to consider our strategy alongside key local plan including the published Interim Integrated Care Strategy and Joint forward plan.

10. There has also been consideration of our strategy in light of the recently published NHS 10 Year Health Plan. The plan sets out the government's commitment to secure the future of the NHS for the longer term and a case for change based on:

- an aging population with multiple long-term conditions
- long term conditions accounting for 65% of NHS spending which is not affordable
- higher public expectations and an NHS that has not moved with the times
- continuous increasing cost which are not delivering improved outcomes, experience, productivity or value for money

11. The plan focuses on 3 major shifts to achieve the vision:

From hospital to community with neighbour heath services bringing care into places where people live, supported by new models of care, contractual leavers and reallocation of funding away from hospital care to community and prevention

Analogue to digital with an ambition to make the English NHS the most digitally enabled system in the world. The NHS App as the main front door to the NHS and facilitating single patient record with a reduction in administrative burden of staff

Treatment to prevention with and ambition to half the gap in live expectancy between the rich and poor focusing on tobacco, obesity, alcohol, mental health, vaccination and screen. Through new genomic medicine predicting and preventing in health.

And is underpinned by 5 enablers:

A new operating model which includes the merging of NHSE and DHSE, with head count reduction. Changes to ICB to become strategic commissioners aligned with new strategic mayoral authorities, resetting of Foundation Trusts with earned autonomy, introduction of testing new Integrated Care organisations holding of population health budgets.

New transparency of care including new league tables of providers and patient experience being a major influencing factor, refreshed quality board, NHS App enabled transparency.

Workforce transformation, majorly supported and enabled through AI, expectation that the workforce will be smaller in the future, focus on development and accountability for most senior members.

Innovation and technology focus on use of data to inform insights, AI, genomic and predictive analysis, wearables and robotics with funding for

research to drive global leadership. Establishment of Regional Health Innovation Zones bringing together ICB, Providers and industry.

Finance and Productivity 2% productivity gains, phasing out of deficit funding, mutli-year budgets 3% for service transformation, patient power payments, new capital models to include private finance, pension fund and partnerships.

12. The 10-Year Health Plan signals a direction of travel in which:

- More care will take place out of hospital supporting local care in neighbourhoods
- Greater focus on prevention and supporting people to stay well in their own home and communities
- Hospitals are asked to focus on their core acute and specialist services and ensuring that these are high quality and effective with some significant transformation to services expected to achieve this
- The 10-year Health Plan places significant emphasis on digital innovation and sees the NHS App as the front door to the NHS where do we need to be to respond positively to this ambition?
- Genomics, predictive medicine are expected to reduce demand for acute / specialist services like ours – how will we work with wider partners to deliver this?
- An NHS workforce of the future will be smaller than had been predicted in the previously published NHS Long-Term plan owing to the impact of prevention

Trust strategy focus and strategic framework

13. We have taken a fresh look at our strategic framework, and this serves as the cornerstone of our strategy keeping us focussed on what matters most to deliver our vision. It is based on what our staff, patients and key stakeholder have told is in most important to them and the key challenges the trust needs to address in order to continue to provide high-quality acute services for the people of Gloucestershire and beyond.

The strategic Framework can be seen in **Appendix, E**

Vision and Values

14. Our vision is simple – we want the best care every day for everyone. We believe the best care happened when it is compassionate, inclusive and responsive and takes place with a strong governance and accountability framework.

15. Central to our vision is a refocus on our core services as an acute and specialist hospital and working as a good partner with other to deliver joined up care for our communities. This will be brought to live through the development of our clinical services underpinning deliver plan.

16. The way we go about our work is an important as what we do, guiding how we behave with each other our patients and our partners. We have reviewed and updated our values, which have been developed in partnership with our staff:

- **We are Caring -** always showing kindness and concern for others
- **We are Compassionate** – focusing on our relationships with others by listening, respecting and valuing their experiences
- **We are Inclusive** – ensuring everyone gets the care and support they need regardless of identity or background
- **We are Accountable** – taking personal responsibility for our actions, decisions and behaviours

17. These values sit alongside the wider NHS Values which all NHS employees are expected to uphold.

18. It's vital that all 9,000 of our staff volunteers can shape and influence our strategy. That's why, over the past year, we've focused on creating the right conditions to make this possible.

Strategic Aims, delivery plans and measuring our progress

Patient experience and Voice – our goal is to put patient experience and feedback as the main influencing factors drawn upon to shape and re-shape their services

People, culture and leadership – our goal is to enhance staff experience and sustainability in an organisation where everyone can flourish

Quality, safety and delivery – our goal is to provide timely and responsive, high-quality, safe and effective services always for everyone

Digital first – our goal is to support patients and staff to be supported by technology and an innovative culture

19. To support deliver of our strategy each of the priorities within our strategic framework will have a delivery plan. This will set out in detail how the goal will be achieved with specific objectives, benefits and milestones. A number of key delivery plans will be developed by the end of quarter 4, these include a clinical, digital, data and insights, estates and workforce.

Communication & Engagement for launching the new strategy

19. To support communicating our strategy the following actions and material will be developed:

- **Short Summary Version** - a concise, 10–12-page summary of the strategy -presented to board with the full version of the strategy.
- **Posters - Strategic Framework -** posters for staff areas, break rooms, and digital screens

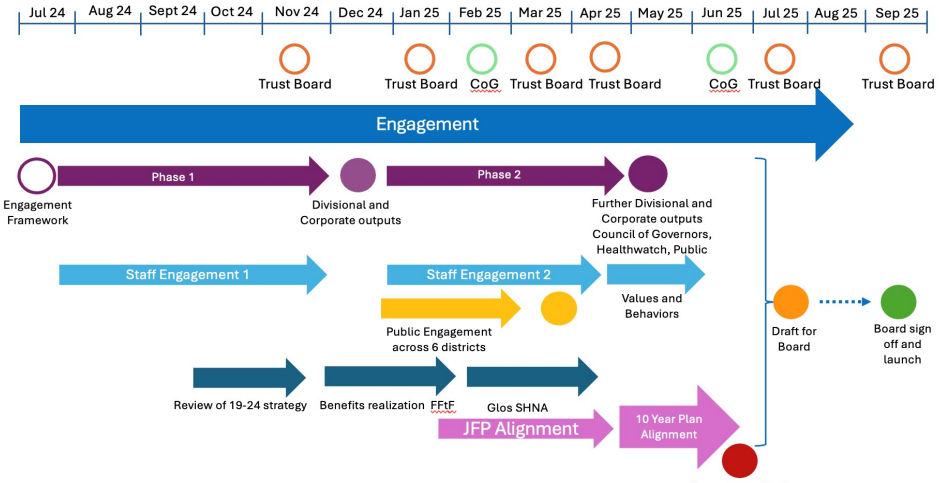
- **Senior Leadership Forum -** OD sessions for senior leaders to explain the strategy and next steps – and their role in engaging their teams
- **Sharing with Partner Organisations and Communities** - Brief for a wide range of stakeholders and partners on the new strategy and our vision for the next 5 years. Include within our community engagement programme
- **Dedicated Website and Intranet Pages** microsite to include - Strategy documents; FAQs; Video messages from leadership; Feedback
- **Staff Global -** Use weekly Global updates to share milestones, staff stories, and progress
- **Feedback –** Use National Quarterly Pulse Surveys and intranet to collect staff input and track engagement/awareness of new strategy
- **Vlogs and Video Briefings -** short videos from leaders and staff explaining the strategy and its importance
- **Staff Networks and Unions** – share with Staff Side and staff networks to ensure engagement across key groups

Recommendations

- The board is asked to consider the final draft strategy and give its approval.

Appendix, A

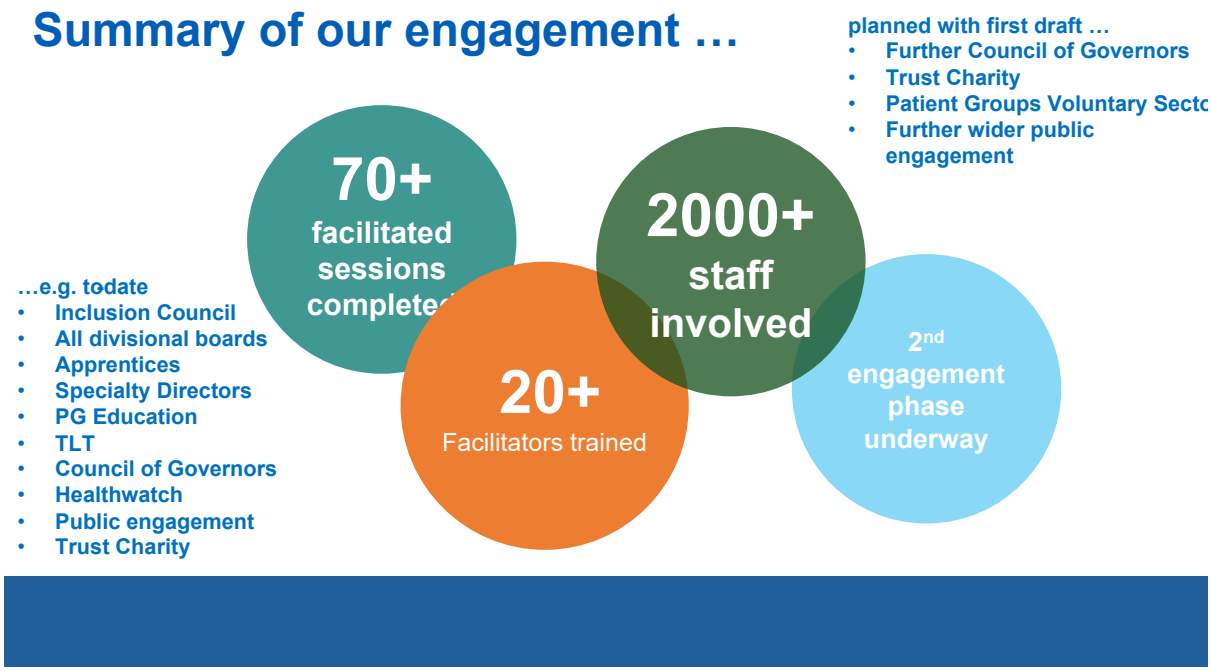
Strategy development, timeline and approach



Appendix, B

Key challenges to address in the strategy

Appendix, C



Appendix, D

Summary of key feedback themes

Clarity of Purpose	High Quality and Safe Care	Positive Working Environment	Getting the Basics right	Improved digital systems and data	Collaboration and Partnership Working
Sense of Pride	People and Patient Focused	Inclusive	Psychological Safety	Greater focus on Improvement	Focus on Prevention
Culture of Learning and development	Sense of Team	Valuing and Recognition Culture	Sort out the Estate and Environment	Greater focus on Health Inequalities	Consistent use of Digital Technology

Appendix, E

Our Strategic Framework

Gloucestershire Hospitals
NHS Foundation Trust

SUMMARY VERSION

Our five year strategy

2025 – 2030

Foreword

Our strategy defines who we are, what we do and most importantly, why we do it.

We want our patients, staff and the public to be proud of our hospitals and the care and support we deliver.

For our staff and our communities, we want their hospitals to be recognised as a place to receive high-quality care and support.

We also want to support primary care and help shape the future development of neighbourhood health services, with a focus on long term conditions and frailty.

In developing the strategy, staff and communities told us what matters most to them:

- What we do is shaped by feedback from patients, staff and our communities.
- We are known as a good place to work and receive care.
- We provide good care which is safe, effective, inclusive and responsive.
- We get the basics right by doing the simple things well and consistently.
- We live with in our means and deliver value for money in everything we do.
- We work together to improve our estates and facilities, providing a good place to work and receive care into the future.
- We deliver our core acute and specialist services well and support wider health and care provision.
- We work in a joined-up way to support people to get care more locally where needed and in hospital when necessary
- We build on our research and innovation to find the care for tomorrow's generation.
- Our digital systems are easy to use and connect patients to better manage their own health.

This strategy sets out our future vision, direction and strategic priorities for the next 5 years.

This is for Gloucestershire Hospitals, our wholly owned subsidiary Gloucestershire Managed Services and our trust charity, Cheltenham and Gloucester Hospitals Charity, which together make up our Hospital Group.

NHS Gloucestershire Hospitals NHS Foundation Trust

NHS Gloucestershire Managed Services

Cheltenham Gloucester Hospitals Charity

Introduction to our Strategy 2025–2030

Gloucestershire Hospitals NHS Foundation Trust's five-year strategy sets out a bold vision: to deliver the best care every day for everyone.

This strategy is rooted in the Trust's core values: Caring; Compassionate; Inclusive; Accountable; and reflects our deep commitment to listening to patients, staff, and communities. It is both a promise and a challenge. We want to change and save lives, to act with integrity, and to ensure fair access to care for all to good quality and safe care.

Our Trust serves a diverse population across Gloucestershire and beyond, with 9,000 staff and hundreds of volunteers working from our two main hospitals and within the communities. Together we deliver safe, effective, and compassionate care, working with partners to eliminate health inequalities and co-designing services that meet our local community needs. Our staff are at the heart of the organisation, and we are building a culture of kindness, accountability, and continuous improvement.

Understanding the changing health needs of the people we serve is critical in the way we are developing our services, delivering the right care whilst living within our means financially. While many residents enjoy good health, significant disparities continue, with an 11-year gap in healthy life expectancy between the most and least affluent areas. To meet this challenge in our role as an anchor institution, we must think beyond the four walls of our hospitals to address the wider determinants of health such as housing, employment, and education, and work with partners to create lasting change.

The strategy also acknowledges the challenges ahead: rising demand, workforce pressures, financial constraints, and the need to modernise our ageing estate.

There has been good progress made in our digital transformation and workforce development, but ongoing efforts are needed to go further, and to improve access, more joined-up care, and sustainability across our services.

Aligned with the national NHS 10 Year Plan, the Trust is embracing a shift toward community-based, digital, and preventative care. Through collaboration, innovation, and a focus on quality improvement, Gloucestershire Hospitals NHS Foundation Trust is committed to delivering the best care every day for everyone.

Deborah Evans,
Chair

Kevin McNamara,
Chief Executive

Our Trust in numbers

£2.3m
Average daily Trust spend

30k
patients admitted to a bed via our EDs per year

537
procedures performed by our 4 robots per year

155k
patients attending our Emergency Departments per year

2.3k
number of research participants per year

120
number of research studies per year

568k
Radiology images and scans per year

36
number of air ambulance arrivals per year

856
number of beds in our hospitals

177k
video and telephone appointments per year

791k
outpatient attendances per year

26k
cancer referrals per year

38
number of organs retrieved for transplants in 2025

3.1m
diagnostic tests per year

660k
population of Gloucestershire, 2023

5.3k
Average births per year

28k
Children seen by the Paediatric team per year

33
number of operating theatres in our hospitals

33k
patients treated in our SDEC units per year

900k
meals prepared for patients and staff

36k
Ambulance attendances per year

1.5m
items of post

33k
planned operations per year

Our vision

We have taken a fresh look at our vision and values. We believe the best care happens when it is compassionate, inclusive and responsive.

Our vision is simple, we want to:

Deliver the best care every day for everyone

Central to our vision is a refocus on delivery of our core services as an acute and specialist hospital provider and working as a good partner to deliver joined up care for the people of Gloucestershire.

We see getting the basics right across all our services as an essential part of achieving our vision.

Our values

The way we go about our work is as important as what we do. Our values guide our behaviour, whether with our patients, with one another or with wider stakeholders.

We have refreshed our values, which have been developed in partnership with our staff:

- **We are Caring** – always showing kindness and concern for others
- **We are Compassionate** – focusing on our relationships with others by listening, respecting and valuing their experiences
- **We are Inclusive** – ensuring everyone gets the care and support they need regardless of identity or background
- **We are Accountable** – taking personal responsibility for our actions, decisions and behaviours

These values sit alongside the wider NHS Values which all NHS employees are expected to uphold.

Our strategic framework

Our vision

To deliver the best care every day for everyone

Our values

we are **caring**
we are **compassionate**
we are **inclusive**
we are **accountable**

Strategic aims
Our top priorities

Patient experience and voice
What we do is shaped by feedback from patients, carers and our communities.

People, culture and leadership
Making our Trust somewhere everyone is proud of and would recommend as a place to work and receive care

Quality, safety and delivery
Provide good care which is safe, effective, inclusive and responsive

Digital first
Helping patients and staff work together using technology and new ideas to make care better

Golden threads
that runs through everything we do

Health inequalities
Working with our communities to prevent illness and tackle health gaps

Continuous improvement
Involving staff and patients to make innovation and improvement happen

Brilliant basics
Simple actions that when done well and consistently, make a difference to patients and staff

Green sustainability
Our actions must be green, fair, and affordable

Enablers of success
Supporting how we succeed

Living within our means
We live within our means and deliver value for money in everything we do

Estates and facilities
Improve our estates and facilities, providing a good place to work and receive care into the future

Research and innovation
We build on our research and innovation to find the care for tomorrow's generation

Partnerships with purpose
Work in a joined-up way to support people to get care they need

Our strategic aims

These are our four strategic aims to support our vision: to deliver the best care every day, for everyone

Patient experience and voice

What we do is shaped by feedback from patients, carers and our communities.

Better feedback systems, including digital platforms and streamlined complaints processes, ensure that what people tell us can lead to real change.

Digital transformation will support personalised care, with tools like the NHS App improving access and engagement. By putting patients at the heart of service delivery, the Trust aims to improve how we provide care that meets the needs of local people.

People, culture and leadership

We want to make our Trust somewhere everyone is proud of and would recommend as a place to work and receive care.

Our staff experience and culture is shaped through regular feedback, workforce planning, and recruitment and career development pathways.

We need to make sure everyone feels welcome and included in our workplace.

We support staff health and wellbeing, train leaders to manage well, and use digital tools and simple basics so everyone has what they need to give great care.

Quality, safety, and delivery

We want to provide good care which is safe, effective, inclusive and responsive for everyone.

Continuous improvement is driven by good processes and shared learning.

Acting on concerns and building a culture of safety build better health outcomes and ensure accountability.

Patient experience, safety, and clinical effectiveness are core priorities, with a focus on restoring national standards for planned, urgent, cancer, and maternity care.

Digital first

We want our digital systems to be easy to use for staff, and to connect patients to better manage their own health.

The Trust now uses digital systems instead of paper, making care safer and more connected. Staff have the tools and training they need, and patients can access records, book services, and get tailored information.

Strong digital foundations and leadership support better planning, teamwork, and data-driven improvements, so staff spend more time with patients and people can manage their own health.

Our golden threads

We have identified four golden threads that run through our strategy and all that we do.

Health inequalities

We are committed to reducing unfair health gaps that affect life expectancy, quality of life, and access to care – especially for deprived communities, ethnic minorities, people with disabilities, and other marginalised groups.

We know that even by providing the very best acute care, we will only influence around 20% of what drives good health, and we will work with partners to help improve access to jobs, education, housing and transport.

We'll improve data to find gaps and work with local partners on issues like housing and jobs.

Our goal is safe, high-quality care for all, a diverse workforce, and inclusive growth across Gloucestershire.

Continuous improvement

We are focused on always getting better. The Gloucestershire Safety and Quality Improvement Academy supports this by helping staff learn and share ideas.

Over the next five years we will align our improvement efforts with our strategic priorities and build a culture of shared learning and innovation.

Staff must be empowered to drive improvements in safety, quality, delivery, and productivity across all areas.

By listening to patients, staff, and partners, we aim to improve care, experience, and performance every year.

Brilliant basics

Our 'Brilliant Basics' are the everyday actions that make a big difference. For patients: a warm welcome, clear communication, respect, quick help, and clean spaces. For staff: being approachable, sharing information, showing appreciation, supporting wellbeing, and leading by example.

It also means addressing those things within our control that make a difference to good care and experience for patients and staff.

When a patient calls, it will be answered. We will have IT systems tat are resilient and an estate that supports good care.

Green sustainability

Sustainability is part of everything we do, covering the environment, people, and finances.

The Trust aims for an 80% reduction in carbon footprint by 2032 and net zero by 2040, with 90% of its fleet being low or ultra-low emission by 2028.

Key actions include decarbonising hospital sites, embedding sustainability in investments, supporting clinical teams to deliver sustainable care, and meeting new legislation.

Every staff member plays a role in achieving a greener, healthier Gloucestershire for future generations.

Our enablers

There are four key strategic enablers that are central to delivering our strategy.

Living within our means

Every part of the NHS and wider public sector is facing real challenges in living within their means, particularly post-COVID.

By 2030, we aim to be financially sustainable so we can invest more in staff, buildings, and equipment. Our plan is to strengthen core services, find growth opportunities, and save money by managing resources better. We'll improve finance systems, governance, and training so decisions are patient-focused and efficient. This will allow us to fund staff, infrastructure, and digital healthcare, with the finance team giving visible support and guidance.

Estates and facilities

Delivering care in the right environment is essential for patients and staff. Over the last five years we have invested over £101m into our hospitals. However, we still have significant challenges with an aging estate, backlog maintenance, and complex site navigation.

Our investments have modernised facilities, including new operating theatres, radiology, oncology departments, and emergency care units.

Over the next five years, we need a strong estates plan, meet fire safety rules, fix maintenance issues, and set a clear capital programme. This will make sure services are safe and effective now and in the future, improving experiences for patients and staff.

Research and innovation

Our research and innovation needs to be part of everyday clinical practice. The Research Innovation and Genomics (RIG) plan aligns with local health needs, making participation accessible for patients and staff.

The Trust supports targeted innovation through the Gloucestershire Advanced Research and Innovation Institute (GARII), rapidly adopting new solutions and measuring impact.

Through new training we want to expand our participation, and partnerships with academic institutions will help strengthen engagement.

Genomics is reshaping diagnosis and treatment, enabling personalised care. Financial sustainability is ensured by recovering study costs and reinvesting income, while upgraded infrastructure supports future research demands and quality improvement.

Partnership with purpose

We cannot change everything on our own. Only by building strong partnerships we can achieve our vision. We work with NHS organisations, councils, primary care, universities, and local communities to design joined-up services that are easy to access and tailored to local needs.

Patients, families, and community groups help co-design care, giving insights that improve outcomes, reduce inequalities, and make services that truly matter..

Delivering the strategy and measuring success

Our strategy provides a clear and ambitious vision for the next five years, shaping our future and responding to the challenges ahead. We are confident that by working with our partners, we can make it a reality.

We do not underestimate the scale of the challenge and have developed a delivery plan that sets the stages required achieve our ambitions.

Our approach to determining how we best work to achieve each of our objectives – and how we track and evaluate progress towards them – will build on the components we already have in place for business planning, quality improvement, governance and performance monitoring.

Priorities will be set through our annual planning cycle

To help us demonstrate progress against our strategy, we have developed key performance indicators and measures of success alongside our strategy. These will be tracked and monitored as part of our annual plan and will help us ensure that we are making progress against the things that are important to us.

Each of the priorities outlined in our Strategic Framework will have a delivery plan developed by the end of Q4 2025/26. This will set out the specific deliverables, key milestones and benefits to action the goal set out in the priority to deliver the best care every day for everyone.

Tangible differences

What will be different if we deliver our strategy by 2030.

What we do is shaped by feedback from patients, staff and our communities.

We are known as a good place to work and receive care.

We provide good care which is safe, effective, inclusive and responsive.

We get the basics right by doing the simple things well and that makes a difference to patients and staff.

We live with in our means and deliver value for money in everything we do.

We work together to improve our estates and facilities, providing a good place to work and receive care into the future.

We deliver our core acute and specialist services well and support wider health and care provision to prevent ill health and with a focus on long term conditions and frailty.

We work in a joined-up way to support people to get care more locally where needed and in hospital when necessary

We build on our research and innovation to find the care for tomorrow's generation.

Our digital systems are easy to use and connect patients to better manage their own health.


NHS
Gloucestershire Hospitals
NHS Foundation Trust
SUMMARY VERSION
Our five year strategy
2025 – 2030

KEY ISSUES AND ASSURANCE REPORT
Quality and Performance Committee (QPC) for November Board meeting

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

Overall Summary:

Overall, the Committee noted **strong progress in patient experience, mortality review, and complaints improvement**, with **ongoing risks** in **maternity governance, safeguarding training, and operational pressures**.
Assurance is **strengthening but not yet consistent**, particularly in **governance capacity and workforce resilience**.
Positive culture change is evident, but sustained focus on **embedding assurance frameworks, proactive feedback loops, and learning application** is essential.

QPC reviewed both the **Patient Experience and Complaints Annual Reports**. The patient experience was an extremely well written report detailing the significant activity delivered this year. The committee aknowldged the significant leadership and activities focused on our complaints handling and support the CEO drive for a stretch target to further improve at pace

Items rated Red: ALERT (matters requiring escalation or continued Board oversight)

Item	Rationale for rating	Actions/Outcome
Maternity Services & CQC Enforcement:	Ongoing **CQC inspection** across sites, with a **Section 29A notice** expected relating to triage and early warning score documentation. One outstanding **Section 31 action** (postpartum haemorrhage risk assessment) nearing resolution. Workforce fragility and triage capacity remain risks. QPC were formally briefed of the Trust inclusion in the National Maternity Review – The letter fro Baroness Amos provided detail as to expectations.	Await further feedback Ongoing monitoring Await further communcations
Patient Safety & Governance Capacity:	**Four never events** since March (two wrong implant, one NG tube, one other).**Governance learning gaps** identified in neonatal incident reviews	Await feedback to assure QPC regarding delivery of recent investigation and actions
Safeguarding Training (Medical Staff):		QPC requested detailed action traker

Complaints and Culture:	**Wokforce CQC requirement** for full alignment with intercollegiate standards not yet met. **Capacity** in patient safety and governance functions remains a concern; structure under active review. **Behavioural and cultural themes** (particularly in Trauma & Orthopaedics) require joint oversight with the **People & OD Committee**.	Need for proactive feedback from complainants to understand satisfaction and quality of resolution Executive monitoring
Operational Pressures – Flow and Urgent & Emergency Care (UEC):	**Corridor care risk of increasing** due to ambulance offload pressures. **Four-hour performance** improving (63%) but remains below trajectory (74%). **Winter risk** identified; "Winter Watch" oversight to be established. **Ongoing tracking** and updates on endoscopy performance, echo recovery and neurophysiology to be provided as planned to November QPV	Update to QPC planned November Update to QPC planned November
Overdue Clinical Policies & NICE Guidance:	Approx. **36% of policies/guidelines overdue**; recovery work in progress.	Update to QPC planned November

Items rated Amber: Amber (to ADVISE Trust Board) These are ongoing concerns, areas needing focused improvement, potential risks, or progress being made but not yet fully resolved, which require board awareness and oversight.

Item	Rationale for rating	Actions/Outcome
Quality Governance Restructure:	Recruitment to new senior quality roles (experience, safety, effectiveness) underway; update due next month.Committee chair emphasised shift toward **Board Assurance Framework reporting**	Committee advised setting a **stretch**

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

Complaint Improvement Programme:	Notable improvement in timeliness (20% → 54%), but further ambition required.	**target** and developing **complainant satisfaction sampling** pilot.
Patient Experience & PLACE:	Increase in **PALS contacts** (access/communication issues). Decline in **PLACE results** (cleanliness/facilities) to be monitored through forward plan.	To be monitored through forward plan.
Winter Planning:	Implementation of **revised system escalation policy** and **single point of clinical access** across system. **Care Transfer Hub** pilot underway	Board oversight requested on system agility and workforce redeployment
Health Inequalities:	**Dashboard development** underway; maternity inequalities focus progressing with system partners.	

Items Rated Green ASSURE (areas where the Committee received assurance)

These are routine updates, positive developments, completed actions, minor issues, or areas where performance is stable or improving as expected, for general board awareness.

Item	Rationale for rating	Actions/Outcome
Learning from Deaths:	Process embedded and compliant across specialties. Notable improvements in **fractured neck of femur mortality** and **SHMI trends**.	
Patient Safety Training:	Positive team feedback mechanisms in place.	

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

	96% compliance for level 1; good assurance received. National patient safety alerts all closed except one (in progress).	
Complaints and Patient Safety Action Closures:	Maternity serious incidents backlog cleared. Positive external feedback from NHS England and CQC walkthroughs.	
Performance Improvement:	**Emergency flow metrics** improving across 13 of 15 indicators. **RTT 45-week breaches** reduced; **diagnostics recovery plans** on trajectory for year-end. Strong system collaboration on **UEC response and escalation**	
Child Protection Medical Assessments:	Risk levels decreasing; group established and governance embedded. Transitioning to **business-as-usual oversight**.	
<u>APLAUD (good practice, innovation, or exemplar performance)</u> **Patient Safety Training** **Complaints Handling:**	96% Level 1 compliance – a significant achievement. Marked improvement in timeliness, backlog clearance, and staff engagement via complaint improvement day. **Best National Inpatient Survey results in 20 years.**	

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

Patient Experience	**High FFT scores (92%)** and strong carer engagement. Successful **Carers Charter** and **paediatric art installations** improving environment.	
Learning and Culture:	Closure of historic maternity serious incidents and adoption of structured governance learning approach.	
Collaboration & Integration:	System-wide alignment for winter planning and flow management commended by the Committee.	

SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.

Governor Observations:

- To note the persistent ambition to reduce the amount of papers - which seems to be an ongoing challenge for the committee. Good to see the work Suzie Crowe is developing and demonstrating with the 4 A's.
- Good to see a maturing of the joint approach to Winter Planning, and healthier whole system relationships.
- Observation of healthy debate and discussion between NEDs and colleagues on the Complaints work and Patient Safety and Learning - with an ongoing focus on Culture and Communication. Intersted in CEO drive for stretch challenge
- In terms of Applaud - so good to hear about the national recognition of the work on Flow/Boarding etc by the RCN and also the evolving work on Health Inequalities, which will be very impactful for a number of organisations in the County.
- In terms of Safeguarding Level 2 - there was reference to developing more pace using the national framework, with a focus on medics, presumably this will be a continuing risk area unless more acceleration is supported (understanding the complexity of some of the demands)

Investments

Case	Comments	Approval	Actions

Impact on Board Assurance Framework (BAF)

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

All strategic risks discussed. Challenge given on current and target risk scores

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

Report to Public Board of Directors	
Date	13th November 2025
Title	Integrated Performance Report (IPR)
Author / Sponsoring Director/Presenter	Chief Operating Officer (COO) Chief Medical Officer (CMO) Chief Nurse (CN) Director for People & OD (DfP&OD) Director of Finance (DoF)

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	To obtain approval	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report

URGENT and EMERGENCY CARE

There was continued progress and improvement in almost all domains and key indicators with one exception. Patients in the department for over 12 hours increased by 60 in month. This represented the most significant point of deterioration, and specific actions have been revised to mitigate this further. This position, whilst disappointing, we did not see the Trust dip below the 90% threshold. 4-hour performance improved by 2%. There is ongoing work to improve the validation of performance currently.

Ambulance handover delays over 60 minutes decreased again, demonstrating 100 fewer patients waiting over an hour. There is some data validation to be undertaken as the majority of these delays were recorded against high acuity pathways (PPCI, Resus, Delivery Suite). This is being corrected but is dependent on SWAST changes.

PLANNED CARE

RTT (Referral to treatment)

The total RTT incompletes increased from 60,358 in August (67.27%) to 64,058 in September 2025 (69.69%), noting that the overall percentage did increase from the previous month. The number of 45-week breaches has reduced in-month, moving from 1,080 in August to approximately 850 (unsubmitted) in September. This is compared to a low of 784 in June.

The Trust's performance against the rest of the Southwest region remains favorable, particularly in relation to RTT performance and 52 weeks as a % of incompletes; September month-end performance for 52 weeks places GHFT 13th best in the country. The September month-end position has been finalised with a total of 35 reportable breaches (compared to 37 in August). Of the 35 breaches, 5 of these breaches directly relate to patients the Trust hasn't been able to treat due to national shortages (corneal graft and PFJ patients). Effectively the Trust achieved 30 breaches in month. The Divisional split was 5 for Medicine, 1 W&C, and 29 for Surgery. There were no breaches for D&S division.

DM01 (Diagnostics Waiting Times and Activity)

The September 2025 diagnostic performance position is 27.72% (4,283 breaches and 15,449 total waiting) which is an improvement of 1.41% compared to the August 2025 final validated figure: 28.51% (4,236 breaches 15,382 total waiting).

Some specialties have improved in month (Flexi Sig improved 2%, Colonoscopy 2.4%, Neurophysiology 4%) but this gain has been lost overall due to the increased deterioration in Cystoscopy (-7.94%) and ECHO (-7.98%). We are not expecting to see a significant improvement to our DM01 performance until

December 2025.

CANCER

62 Day reportable backlog is 210 (end of September) compared to 197 (August) - most of this cohort is held by Urology.

- Unvalidated 62 Day standard for September is currently 74.6% which is an improvement of 0.4%
- Unvalidated 31 Day standard for September is currently 88.4% which is a deterioration of 6%
- The unvalidated 28 Day standard for September is currently at 76.8%, which is a reduction of 2% from previous month.

To maintain this standard of 75% and achieve the new target of80% FDS, some of the planned actions include:

A. New escalation C&C process to support earlier identification of bottlenecks and concerns from day 0 and themes throughout the PTL for support – Expect to see impact in performance from October 25

B. Additional Skin minor operating capacity to be delivered through Agile in-sourcing

C. D&C modelling of first OPA capacity to book in line with Best Practice Timed Pathway

QUALITY

Patient experience

The overall Friends and Family Test (FFT) score has increased by 0.9% to 91.6% for September compared to the previous month. The increase in score is notably for maternity. Score is very slightly above average for the same time last year.

Patient Advice and Liaison Service (PALS)

The PALS team have closed 91% of concerns in 5 working days which is above the target of 75%, and an impressive 67% within one working day. The team have continued to work hard to close cases more quickly and the revised triaging criteria of cases has been working well.

Complaints

The percentage of responses sent within the required timescales has increased from 9% in April to 53% in September 2025. This improvement is expected to continue due to the drivers of the collaborative approach of the complaints team and Divisional leadership. Focused monitoring for any complaint response over 6 months continues, currently 10.

Safety incident management

Patient Safety Incident Investigation/After Event Review. (PSII/AERs)

76 Patient Safety Incidents have required review through PSII, AER, or Multiprofessional Review (MPR) in the last 12 months; an average of 6.3 per month. 5 new PSII's were declared in September 2025; 3 After Event Reviews, 2 Multi-professional reviews and one Never Event.

Clinical effectiveness

ICB Quality Improvement Groups (QIGs) (PPH and SHMI)

The ICB has 2 QIGs in place that support our improvement actions.

PPH Overall Massive Obstetric Haemorrhage The national benchmarked rate is 32.0 and our rolling 6-month average is 33.83. We continue to review safety incidents thematically and have an ongoing improvement programme. We still need to improve our booking and 36/40 risk assessment data to reach thr 85-90% standard we have set for ourselves. The CQC S31 enforcement notice remains extant and reports to the Maternity Delivery Group.

Summary Hospital-level Mortality Indicator-SHMI

The improvement focus for the SHMI QIG is on the primary diagnosis/ Charlson Scoring work on AMU, the correction of inaccurate data and clinical audits of CGH data (CGH increased SHMI relates to post discharge mortality from Oncology/Haematology/Frailty and are expected deaths). SHMI is predicted to be in the normal range in Q4 due to this improved data quality June SHMI = 1.04, reduced by 0.055 this quarter.

WORKFORCE

This month's workforce section reflects where there has been a deterioration in performance across the standard people metrics; with focus this month on sickness absence, appraisal compliance and Bank use. The supportive narrative reflects the areas/services which are contributing to this position, together with the recovery actions in train to realise an improved performance against target.

A focus on Job Planning compliance is also provided, as part of the requirements laid out in the NHS Operating Plan this year.

FINANCE

At the end of month 6, the Trust is reporting a year-to-date deficit position of c£3.4m which is c£36k favourable to plan. This position is utilising underspends in corporate areas and slippage in reserves to mitigate emerging pressures in various areas and financial sustainability.

Financial sustainability remains an area of concern with 35% of schemes being rated as red or unidentified – this does constitute an improvement on the previously reported position where 45% of schemes were in this state.

Approved by: Chief Operating Officer	**Date: 06/11/25**

Recommendation

To NOTE the contents of the update.

Enclosures

Integrated Performance Report

Report approved by: Chief Operating Officer

Approved by: A W Sheward **Chief Operating Officer -** 	**Date:** **06/11/26**

Integrated Performance Report (IPR)

September 2025

- Operational Performance
- Quality & Safety
- Use of Resources
- Workforce

SPC Chart Guidance

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

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

Operational Performance Metrics

Single Oversight Framework

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Quality of Care, Access & Outcomes	Urgent Care	Proportion of ambulance arrivals delayed over 30 minutes	*0%*	47.3%	36.7%	34.5%	29.8%	25.9%	19.9%
		Proportion of patients spending more than 12 hours in an emergency department	*<10%*	11.1%	9.7%	8.3%	10.0%	8.9%	9.2%
	Elective Care	Total elective activity undertaken compared with 2019/20 baseline		111%	106%	111%	110%	107%	117%
		Total diagnostic activity undertaken compared with 2019/20 baseline		146%	142%	157%	140%	147%	149%
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	*No Target*	161	160	125	135	144	152
		Total patients waiting over 62 days to begin cancer treatment compared with baseline	*<=6%*	8.05%	7.98%	6.03%	6.59%	6.89%	7.48%
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	82%	83%	86%	84%	80%	78%
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	356	362	341	334	334	287
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		109.92%	104.97%	109.43%	110.11%	106.29%	119.75%
	Discharge	Proportion of patients discharged from hospital to their usual place of residence	*No Target*	97.16%	97.47%	97.28%	97.62%	97.65%	97.42%
	Safe Care	Summary Hospital -level Mortality Indicator	*No Target*	1.137	1.127	1.095	1.083	1.045	1.038
		Summary Hospital -level Mortality Indicator Limits		Within	Within	Within	Within	Within	Within
		Clostridium difficile infection rate per 100,000 bed days	*104*	25.7	30.6	44.9	33.8	42.7	26
		E. coli bloodstream infection rate per 100,000 bed days	*71*	21.5	17.5	22.4	25.3	17.1	26

Watch Measures

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Watch Measures	Urgent Care	Total hours lost to ambulance handovers		1820	1099	910	753	668	489
		Average ambulance handover time	*< 40 minutes*	34	19	16	13	11	8
	Elective Care	78ww RTT	*0*	1	0	1	1	2	0
		65ww RTT	*0*	3	3	2	3	2	1
		52ww RTT	*0*	94	75	47	40	37	36
		Short notice (within 72h) cancellation rate – total	*<9%*	9.4%	8.7%	9.6%	10.8%	10.7%	15.8%
		Short notice (within 72h) cancellation rate – for clinical reasons	*<3%*	2.4%	2.0%	2.5%	2.7%	2.9%	2.4%
		Angiogram Waiting List Position		293	288	274	280	265	231
		Histopathology 10-day reporting	*90%*	56%	56%	49%	63%	62%	58%
	Flow	G&A Occupancy - CGH	*92%*	88%	89%	88%	86%	85%	87%
		G&A Occupancy - GRH	*92%*	95%	94%	92%	94%	94%	94%
		Daily Average of boarded patients	*0*	4	3	1	4	2	3
	Safe Care	VTE Assessment within 14 hours (%)	*95%*	92%	91%	92%	86%	90%	88%
		VTE assessment completed - excluding short stay (%)	*95%*	96%	96%	96%	91%	94%	93%
		Number of Category 2 pressure ulcers acquired as inpatient		15	19	11	11	21	11
		Smoking Status Compliance (%)	*95%*	97.11%	97.16%	97.09%	97.12%	97.52%	98.26%
		Severe Harm from Patient Medication Errors	*0*	2	1	0	0	1	0

UEC: Performance

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

Highlights

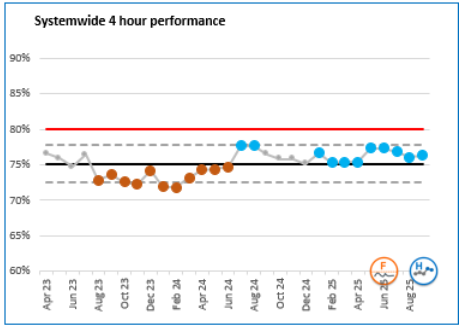
- Strong recovery in four-hour performance in Sep-25, from 60.9% to 62.8%
- 12-hour performance deteriorated very slightly, from 91.1% to 90.8%

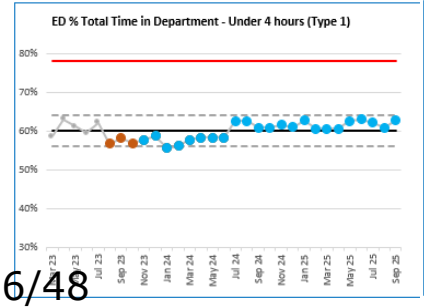
Areas of Concern

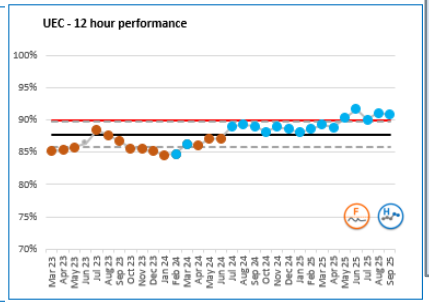
- Targeting improvement across both CGH and Paediatrics to 95% in the coming months

Looking Forward

- Change in approach to drive improvements in performance across CGH and Paeds
- Also looking to drive better performance across Non-Admitted patients







Technical Analysis

Worth noting that, despite the overall 12-hour performance having got worse in the month, adjusting out Admitted and Referred patients improves performance to 97.7%

Planned Actions

Close working between Operations and Nursing Team will drive improvements in CGH performance.

A similar approach will be employed across Paediatrics to enable the improved performance across this cohort of patients

Recognition that we need to get the Trust-wide & System-wide Escalation policies fully operational to support the Medicine Division

UEC: Performance

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

Highlights

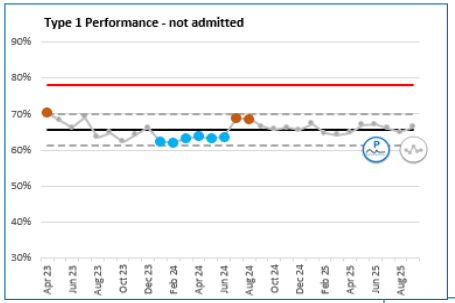
- Non-Admitted performance has improved from 65.0% to 66.4% in September
- Admitted perormance has also improved this month, from 48.0% to 50.6%

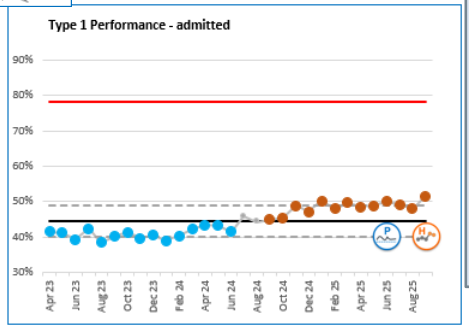
Areas of Concern

- Implementation ofTrust-wide Escalation Policy is seen as pivotal to getting the support we require from other services

Looking Forward

- Once we have a Trust-wide Escalation Policy we will map the ED Policy to it





Technical Analysis

September was definitely a better month than August with improvement across both Admitted and Non-Admitted patients

Planned Actions

Closer working arrangement between Operations and Nursing management will drive performance improvements

Same approach should yield improvements across Paediatric patients

Seek to ensure that we finalise Trust-wide Escalation Policy and align ED Escalation Policy thereto: also continue to work with the EPR Team to formalise the process whereby inaccurate breaches can be corrected

UEC: Performance

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

Highlights

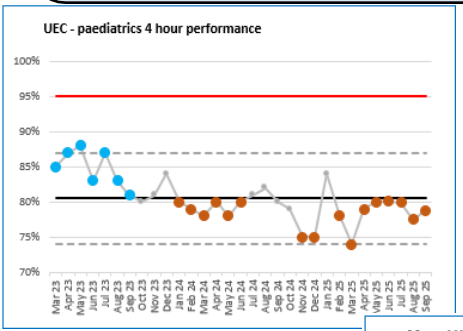
Ongoing collaboration between Womens' & Children and Medicine divisions to streamline passage of patients from Paeds ED into PAU

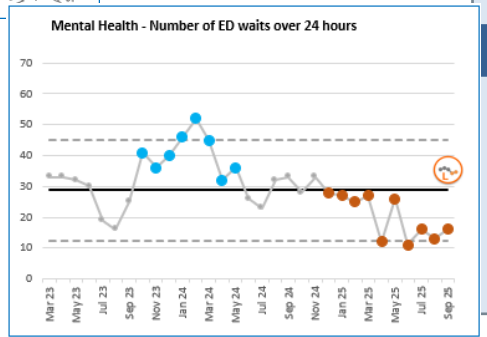
Areas of Concern

Biggest area of concern here is around ongoing challenges with maintaining compliance amongst paediatric patients

Looking Forward

Update on actions to address shortcomings in respect of the paediatric services will be brought forward to subsequent iterations of the Mandated Support meeting





Technical Analysis

As part of the ongoing review of paediatric patients in our ED, we will look to base-line our activity with reference to the proportion of patients that require Mental Health input and the time elapsed before they are seen

Planned Actions

- Discussion of staffing model at next Mandated Support meeting to seek to place specialist doctors and nurses to the service
- Closer scrutiny of Paediatric four-hour performance from October onwards

UEC: Average Handover Time

(Standard: Offloads to be completed within 15 minutes of arrival (max THP 45 Minutes)

Highlights

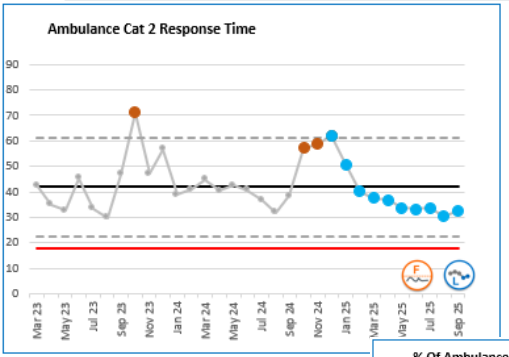
We continue to deliver progress in Ambulance Handover times; reduced further from 25 minutes in August to 22 minutes in September

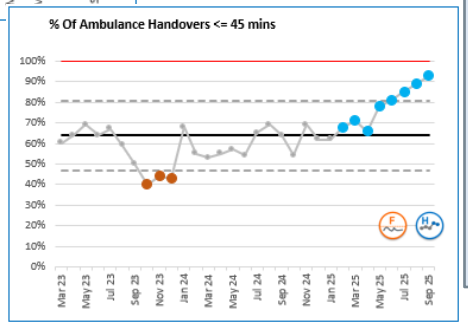
Areas of Concern

Focus remains on liaising with SWAST to ensure prompt pinning off by our partners

Looking Forward

Working to adapt our approach to manage the requirements of the new SOP (v2.3 - issued 06 October 2025) and ensure performance doesn't deteriorate as we move into winter





Technical Analysis

Performance against this metric appears well-established; we're maintaining a high level of resilience over time

Planned Actions

- Relocation of the HALO role within ED appears to have been successful – relocation will be made permanent
- The MAP initiative continues to have a positive impact on the speed of response from Tower-Block wards
- Second meeting of Trust / SWAST Working Group will be scheduled for October 2025

Elective: 45 Week Wait

Highlights

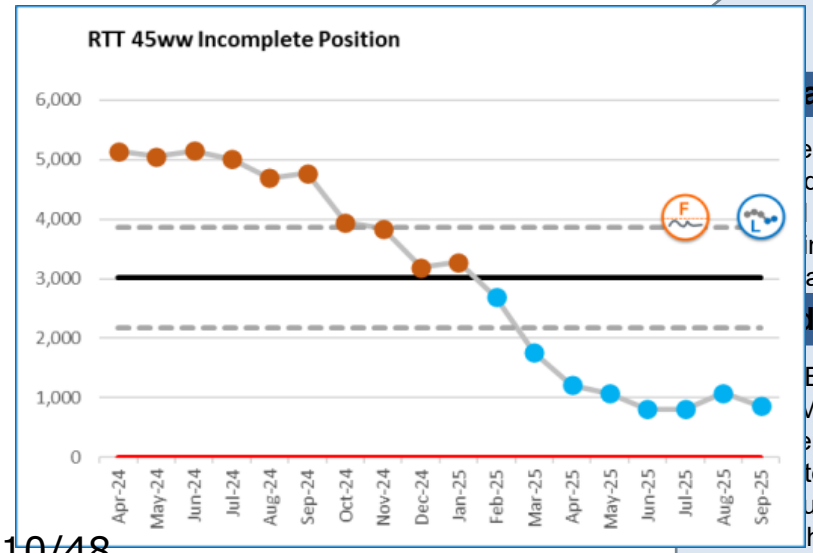
ber of 45 week breaches has reduced , moving from 1,080 in August to 50 (unsubmitted) in September. This is d to a low of 784 in June.

Areas of concern

Dermatology and GI services remain the most challenged services with GI impacted by staffing shortfalls & cancer demand. Dermatology 45wk breaches has remained static, however ASIs are increasing.

Looking forward

A continued reduction in 45wks is anticipated. As an indicator the number of 35 weeks has decreased from 4740 (Aug) to 4447 (Sept). Long waiting PFJ patients resolved and NHSE will now release Graft material for 52wk risks.



al Analysis

ember month-end position will be submitted on 17th October, with an d position around 850. Dermatology has remained static with ~224 breaches to 219 in August. T&O/Spines have made the largest reduction moving n August to 243 in September. ENT have halved their breaches from 66 to ardiology from 60 to 45.

l Actions

B having accredited 4 new independent providers; Health Harmonie, Optimised Modality Health and Pastel Health. Reductions in routine referrals have been enced, with Dermatology (42.3%); ENT (31.5%) and Gynaecology (25.5%). tology are to IPT out approximately 170 long waiting patients (~40/45 week using Modality Healthcare..

- have confirmed that Graft patients >52wks are now within cohort.
- The second validation sprint has concluded, albeit no gains were made..

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

Standard: 85%

Highlights

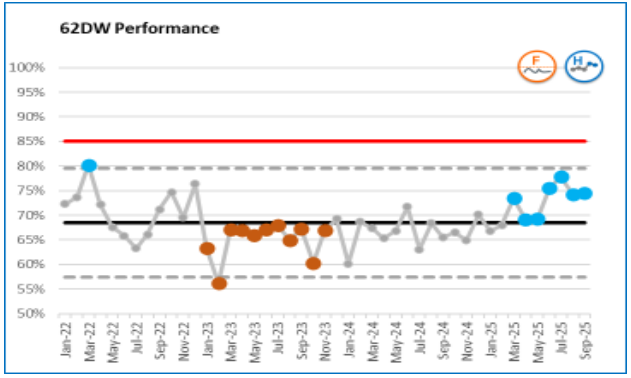
Achievement of 85% by Testicular, Breast and Skin in Aug-25.
We have also seen a massive improvement in urology.
September unvalidated is showing at 74.7% achievement which is the highest attainment since July-21

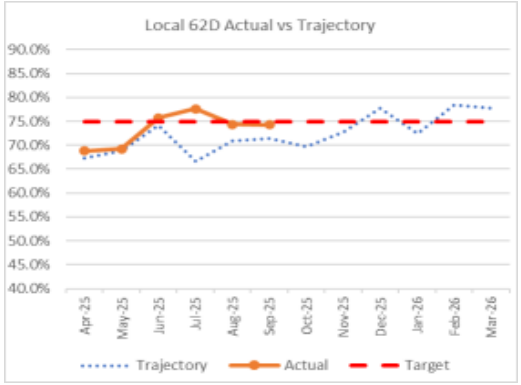
Areas of concern

Validated 62 Day standard for August is currently at 74.2% and so we will miss this target
Ongoing concerns continue to be linked to late diagnosis and limited surgical capacity for first treatments

Looking forward

Trajectory has been submitted to ICB for recovery of 62Day at a sustained position of 75% by March-26. Recovery plan shown with plotted actual performance
Due to surgical capacity constraints, we are expected to see a decline in Lower GI 62-Day position however 2 new consultants have been recruited and due to start Sept and November and will support capacity in theatres





Technical Analysis

This is slightly above our recovery trajectory of 67.3% but we are aware that due to focussing on treating some of our longer patients and significantly reducing our backlog we may see a reduction over the next few months. Reviewing the diagnostic element of the cancer pathway and focusing on improvements within this will support overall improvement of our 62 day as demonstrated in our 31-Day Performance

Planned Actions

- Focus on specialty level recovery and diagnostic pathways; Areas of focus include Urology, Gynaecology, Dermatology and LGI and individual recovery plans monitored through Cancer Delivery Group
- GHFT are involved in the 'Days Matter' initiative – aim to improve FDS, 31D and 62D standard across urology and colorectal pathways to begin with by March 26. Gynae Days Matter goals submitted with focus on 62D

Cancer: Faster Diagnoses Standard (FDS) % with trajectory

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

Highlights

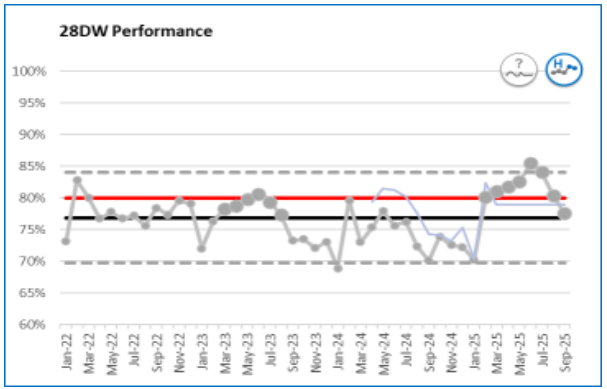
June was GHFT's highest FDS performance in 24 months.
GIRFT Days Matter campaign – expected goal of 5% improvement at the end of 3 months – majority of targets are being met.

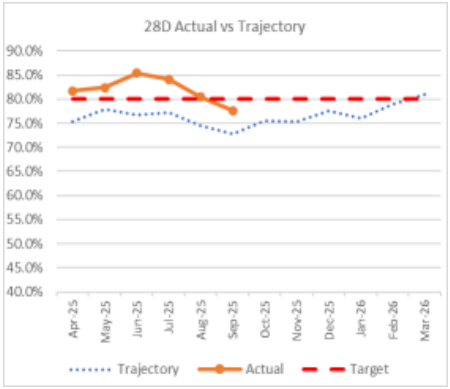
Areas of concern

While we have met the overall target for 28 day for August, there is a risk to skin activity and performance, not only impacting the speciality, but Trust performance also.
Non site specific also continues to be below the national standard for FDS

Looking forward

Recovery and sustained achievement of the FDS standard is expected by March-26
Due to increased demand on Dermatology and their operational pressures, we are at risk of declining 28 day performance both within the specialty and as a Trust. Current September performance for Skin is at 60.2% which is a 30% drop from April-25





Technical Analysis

Unvalidated 28 Day standard for September 2025 is currently at 77.5% and we are likely to not meet the national standard of 80% but will be above the minimum expectation of 75%

Planned Actions

To maintain this standard of 75% and achieve the new target of 80% FDS, some of the planned actions include:

- New escalation C&C process to support earlier identification of bottlenecks and concerns from day 0 and themes throughout the PTL for support – Expect to see impact in performance from October 25
- Additional Skin Minor Ops capacity to be delivered through Agile
- D&C modelling of first OPA capacity to book in line with BPTP

Cancer 62 Day Backlog Position

Highlights

210 on backlog as of end of September
Improved compliance in Urology

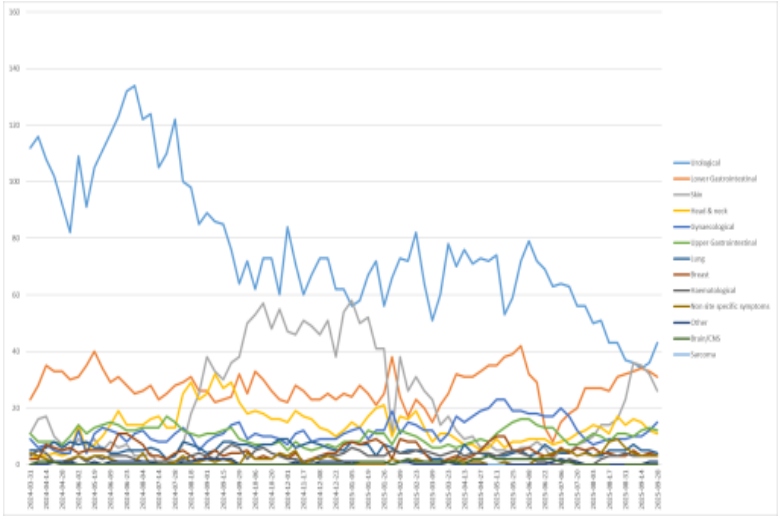
Areas of concern

Due to a template change internally for our 62 day submission, we have discovered that we have been under-reporting our weekly whole cancer backlog. Since this was identified, it has been rectified
Lower GI has also see a large increase in backlog position due to capacity issues within the surgical aspect of the pathway, complex patients and operational pressures

Looking forward

Sustained backlog recovery of no more than 6% of our PTL expected March-26. Anticipated continued non-compliance in Colorectal and Urology; increased waiting times in Endoscopy DM01 likely to create capacity pressures on the straight-to-test colorectal pathway.

Graph based on weekly snapshot dates since Mar 2024



Technical Analysis

210 on backlog as of end of September
Most of this cohort is held by Urology as demonstrated by the graph however it continues to decrease. However Lower GI and skin have increased over the last few months.

Planned Actions

- Implementation of "Day 0" pathway analysis and new escalation policy to be devised with timelines supporting treatment or discharge before day 62
- Focus on specialty level recovery and diagnostic pathways, especially within Urology
- New local check and challenge process going live 01/09 to avoid bottlenecks in pathway and ensure great scrutiny by Divisions

Cancer Waiting Times Performance for the last 3 months

Please Note – September is unvalidated

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Jul-25	Aug-25	Sep-25	Jul-25	Aug-25	Sep-25	Jul-25	Aug-25	Sep-25	Jul-25	Aug-25	Sep-25
Acute leukaemia										0.0%		100.0%
Brain/CNS	100.0%	100.0%	100.0%	100.0%	80.0%	75.0%	100.0%					
Breast	98.0%	94.8%	81.5%	97.9%	97.5%	97.1%	95.3%	97.1%	94.9%	90.9%	89.8%	93.0%
Gynaecological	97.6%	96.3%	94.0%	73.9%	81.9%	69.5%	88.1%	84.8%	80.5%	51.4%	66.7%	51.9%
Haematological	86.4%	100.0%	100.0%	40.0%	34.8%	50.0%	98.2%	100.0%	100.0%	76.3%	48.1%	75.6%
Head & neck	88.0%	92.7%	89.5%	79.4%	74.8%	77.4%	95.2%	96.9%	90.9%	78.3%	80.0%	55.6%
Lower GI	92.7%	95.0%	92.6%	80.5%	77.8%	77.6%	97.2%	85.1%	82.0%	85.1%	54.2%	63.3%
Lung	94.4%	92.6%	100.0%	88.1%	92.3%	81.3%	95.7%	96.7%	94.7%	60.0%	57.1%	64.0%
Other	100.0%			100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	80.0%	25.0%
Sarcomas							75.0%	100.0%	100.0%			0.0%
Skin	90.3%	81.0%	70.5%	85.4%	72.2%	60.4%	98.7%	91.0%	79.3%	95.3%	89.9%	66.7%
Non site specific sympto	84.1%	62.2%	22.9%	72.1%	53.8%	19.0%						
Testicular	85.7%	100.0%	66.7%	75.0%	100.0%	100.0%				100.0%	100.0%	
Upper GI	98.9%	98.3%	98.9%	95.6%	90.6%	90.7%	100.0%	96.4%	95.9%	75.8%	76.3%	84.2%
Urological	94.2%	95.4%	93.2%	53.9%	60.1%	62.2%	90.0%	94.4%	73.8%	62.1%	62.6%	75.4%
Trust Total	93.3%	92.0%	85.8%	83.4%	79.7%	76.8%	94.5%	94.4%	88.4%	77.8%	74.2%	74.6%

Diagnostics: Performance Trend

Highlights

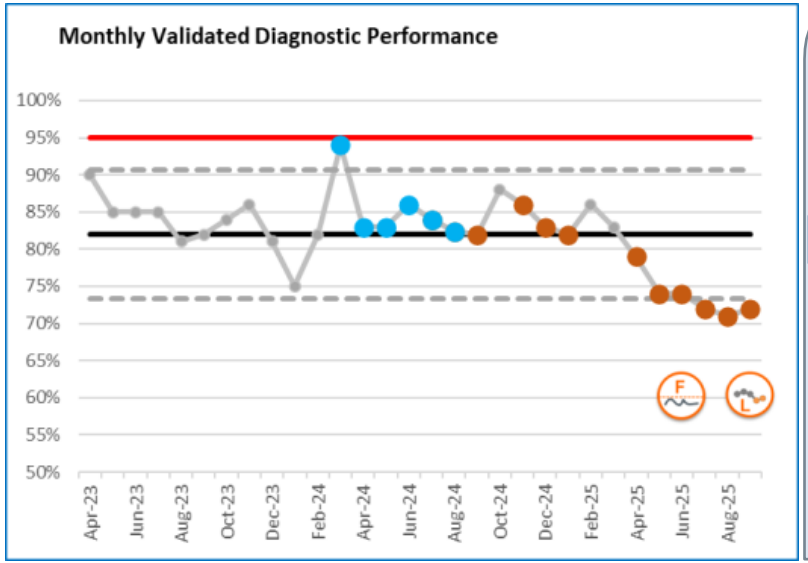
Improvement of 1.14% compared to M5.
Waiting list increase of 363 patients predominantly in ECHO (391) and Colonoscopy (262)

Areas of concern

ECHO performance continues to deteriorate – recovery reliant on recruitment or insourcing.
Endoscopy increase of breaches and total waiting list.

Looking forward

Neurophysiology performance is in line with recovery plan forecast.
Cystoscopy recovery pump-primed with Cancer Transformation Funding will see improvements
ECHO & Endoscopy waiting list will continue to outstrip demand



Technical Analysis

September '25 performance has moderately improved compared to the previous month. Some specialties have improved in month (Flexi Sig improved 2%, Colonoscopy 2.4% Neurophysiology 4%) but this gain has been lost overall due to the increased deterioration in Cystoscopy and Gastroscopy.

Planned Actions

- **ECHO** recovery plan review with Divisional Tri August 2025. Progress PSR process, Locum started 1st Sept, echo support worker started Aug 2025 and new vetting process in place Sept 2025. Improvement noted in performance August 2025 although total waiting list increased. Additional DCOO led focus on 3 enabling actions (PSR, Digital and community demand management) will be reported on in November 2025 and will measure impact in performance improvement.
- **Cystoscopy** improvement plan submitted September 2025 to ECPB; additional recovery generated through Cancer Transformation Funding in December 2025.
- **Endoscopy** - Additional recovery funding generated through Cancer Transformation and Community Diagnostic Centre funds.

Diagnostics: Performance Trend

DM01 Performance	Month					
Modality	2025-04-01	2025-05-01	2025-06-01	2025-07-01	2025-08-01	2025-09-01
Audiology - Audiology Assessments	99.38%	98.98%	99.22%	99.22%	98.27%	99.76%
Barium Enema	83.55%	99.08%	100.00%	100.00%	100.00%	100.00%
Cardiology - echocardiography	47.08%	33.24%	28.80%	22.98%	29.40%	19.63%
Colonoscopy	67.16%	72.55%	64.09%	51.96%	45.87%	48.34%
Computed Tomography	92.83%	91.28%	90.81%	89.75%	86.15%	88.47%
Cystoscopy	45.18%	38.97%	33.40%	28.29%	36.31%	28.36%
DEXA Scan	100.00%	100.00%	100.00%	99.77%	100.00%	100.00%
Flexi sigmoidoscopy	74.47%	61.40%	51.05%	45.05%	40.29%	42.34%
Gastroscopy	86.10%	80.38%	75.00%	77.54%	74.81%	73.63%
Magnetic Resonance Imaging	77.59%	76.09%	85.26%	91.42%	99.17%	98.90%
Neurophysiology - peripheral neurophysiology	40.88%	43.82%	35.68%	53.05%	56.86%	60.87%
Non-obstetric ultrasound	99.68%	99.93%	99.49%	99.18%	99.40%	99.47%
Respiratory physiology - sleep studies	98.26%	90.38%	96.73%	96.43%	97.90%	94.22%
Urodynamics - pressures & flows	76.09%	100.00%	75.81%	87.50%	100.00%	100.00%

Flow Summary

Highlights

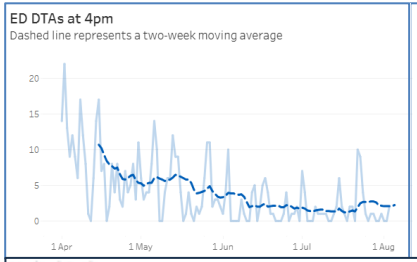
All key patient flow metrics show positive downward trends despite so key challenges around complex discharges.

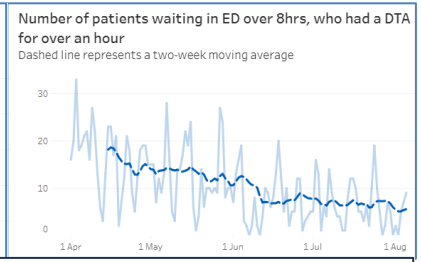
Areas of concern

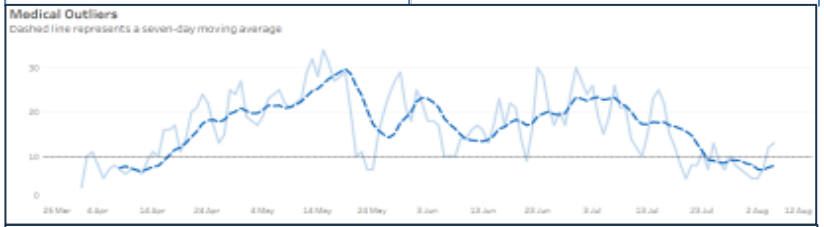
Ability to sustain performance heading into the winter surge period without a step improvement in DRD numbers

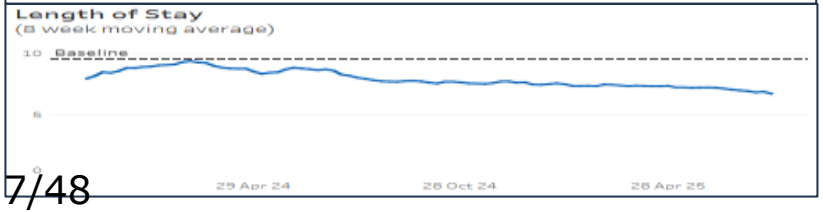
Looking forward

Ongoing improvements being driven through CVOF and wider patient flow workstreams, confident internal improvements will continue to show a positive improvement.









Technical Analysis

All internal key trajectories around flow showing positive improvements with overall LOS reductions supporting reduced bed occupancy and subsequent delays in bedding patients. It is also supporting work around RCRP and minimising the number of outliers and multiple ward moves.

Planned Actions

Ongoing work via the CVOF and wider patient flow programmes to support further reduction in LOS, delays and further enhance RCRP. This should help sustain an improvement in outliers and delays at the front door through further reductions in the average LOS.
In addition specific actions being agreed to manage periods of surge along with triggers to drive internal and system actions when performance dips.

Discharge Ready Summary

Highlights

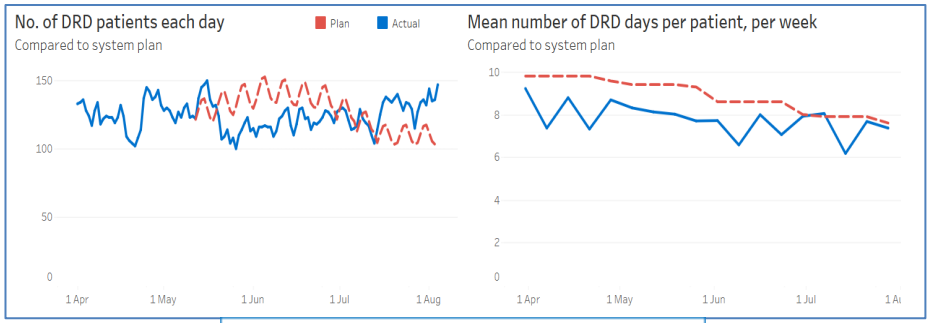
Deterioration in DRD position in terms of number of patients and the total bed day delays. However at an individual patient level we have seen a recover in terms of average delay.

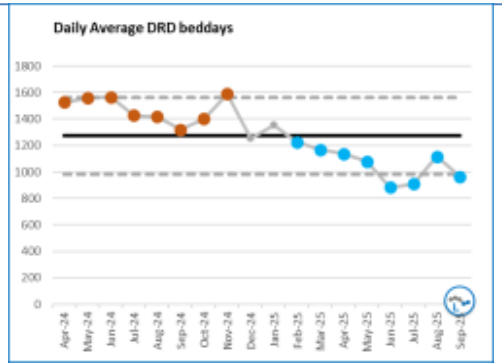
Areas of concern

Rise in DRD numbers and associated impact on flow and plans around the tower fire risk mitigation plans.

Looking forward

Issue held at system exec level with commitment to resolve and bring back in line to the DRD reduction trajectory.





Technical Analysis

Although at an individual patient level, average delays have seen a recover back with plan, the overall impact of the volumen of patients now delayed means the impact on flow and bed occupancy has deteriorated.
The number and total bed days associated with DRD remains significantly outside the system operational plan and the DRD reduction plan linked to the tower essential works.

Planned Actions

At time of writing, a system wide recover plan, along with mitigations to keep pathways on trajectory once recovery has been achieved being taken through the system Strategic Escalation Group.
Once agreed, key triggers and escalation processes are being put in place to support earlier response and resolution when we see dips in performance or increases in delays which may result in patient harm.

Delay Related Harm Summary

Highlights

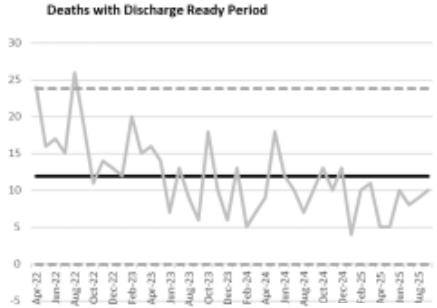
In month improvement in number of patients becoming CTR again once initially DRD. Small increase in deaths related to increase in palliative discharges in month.

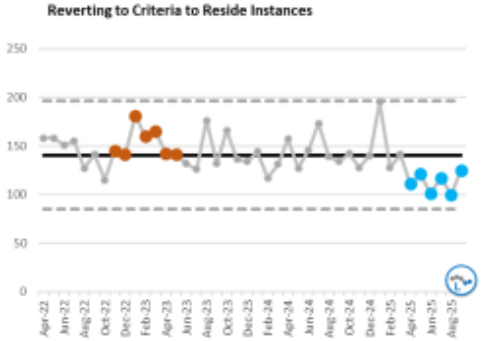
Areas of concern

CHC processes and timelines still causing delays and means patients may have missed the opportunity to have had their EOL needs met at home as per their wishes.

Looking forward

System conversations surround DRD reduction and agreement on escalation triggers should reduce both the average days DRD and subsequently the number of patients becoming unwell whilst waiting to leave hospital. A specific CHC process review has commenced at system level.





Technical Analysis

In month deaths have increased slightly, this links with an increase in EOL discharge paitents, but highlights the need to improve those processes to enable patients to be discharged before they deteriorate to the point they are not able to be discharged. reduced down following a rise last month, whereas the number of patients deteriorating whilst waiting has worsened, a switch from last month. Work still ongoing to consider the proportion of this within 24hrs vs those with DRD delays of 72hrs +. This is to help true understanding of the contribution of delays to any deteriorations.

Planned Actions

Links directly to DRD recovery plan currently with system execs to sign off, as overall DRD LOS and individual patient delays reduce, this should result in reduced incidences of patients becoming unwell or unfortunately passing away whilst waiting for discharge.
Weekly delay related harm continue as a system MDT, 1 meeting focuses on potentials and avoidance, whilst another reviews any actual delay related harm to consider any trends and learning required to avoid future instances.
System wide review of the CHC and EOL pathways and processes.

Quality Metrics

(Safety, experience and effectiveness)

Quality of Care: FFT Positive Response

Highlights

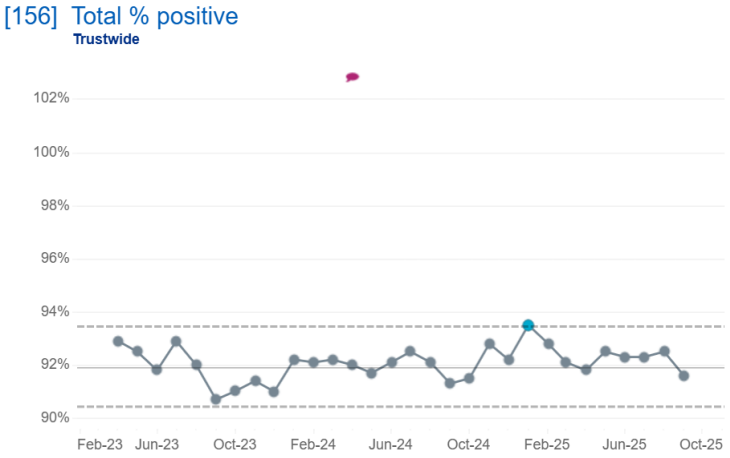
A decrease across all care types leading to an overall decrease in positive score for the Trust and the lowest since September 2024. This score also brings us below the mean.

Areas of concern

Decrease in overall positive score across all care types. This is a trend for September as our lowest scores since 2023 have been in September.

Looking forward

With improvement actions we aim to improve scores across all care types. Previous trends suggest this may happen in October



Technical Analysis

The overall Friends and Family Test (FFT) score has decreased to 91.6% for September compared to the previous month and brings the score below the mean. This is as a result of decreases in score for three out of four care areas, notably for all areas of Maternity and all areas of the inpatient care type. An increase in score for ED at GRH is the only area seeing any increase in score. These scores are really reflect the challenging position, particularly in Maternity and align with a large increase in concerns.

Planned Actions

To understand how our Trust was working during this month in order for us to learn from what has gone well.

For divisions to review their FFT data including comments in conjunction with other experience insight data including PALS, complaints and National surveys, identifying learning and improvement opportunities.

PALS

Highlights

Maintained closure rate at an incredible 91%, which is well above target of 75% with an increase in the number of concerns being received (391)

Areas of concern

Still continue to carry sickness and have had to adjust PALS Manager role to take a significantly increased caseload in order to support the team. Concern for wellbeing of team with volume of cases.

Looking forward

October has already started as a heavy month and so expecting the high numbers to continue. We have one return from sickness expected.

Technical Analysis

The PALS team have increased to 91% of concerns being closed in 5 working days which is above the local target of 75%. Positively, 67% of cases were closed within one working day. The team continue to work hard to close cases as quickly as possible and a further revised triaging criteria of cases continues to work well. A change in how we review potential complaints has also been introduced to try to support patients to earlier resolution and reduce pressure on our complaints team.

Planned Actions

We are continuing to review recording of issues within Datix to ensure we are representing the main issues correctly. This is showing little change is required. Workload distribution continues to be reviewed to support PALS staff and improve experiences of patients and has required a reduction in drop in availability to two days instead of three. A review of RAG ratings of cases also taken place to support the team. Further support of complaints team through more thorough review of potential complaints.

Patient Care: Mixed Sex Breaches

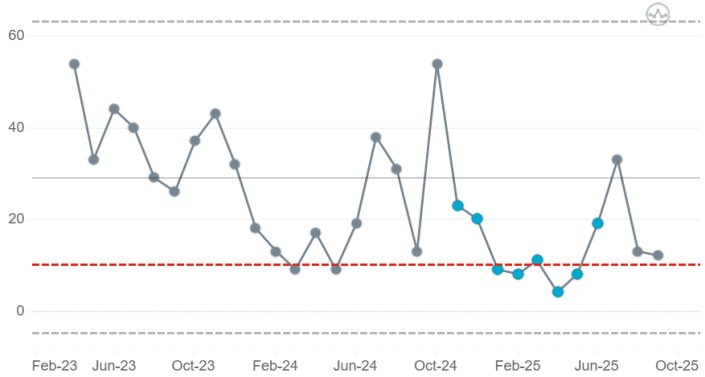
Highlights
Mixed sex accommodation breaches remain low and are an exception

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

Looking forward
Expected to remain within limits of expected performance.

[148] Number of breaches of mixed sex accommodation

Trustwide



Technical Analysis

The most recent 3-monthly periods have been in line with expected performance. Breaches remain minimal and only when no other option is available. Breaches link directly to challenges in flow towards the end of the month, this includes when patients need to transfer out of areas like Critical Care where if not completed within 4 hours a breach is recorded.

Planned Actions

There is a very low tolerance of breaches, these are discussed on the site call each day if they occur.

Infection Control: *C. difficile*

Highlights

The annual CDI threshold for 2025-2026 has been set 97; we have had 47 cases since April 2025- September 2025; we are 1.5 cases below trajectory

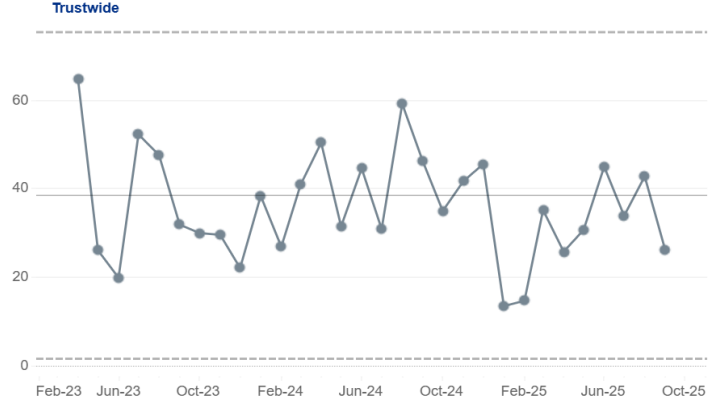
Areas of concern

Ward and equipment cleanliness e.g. mattresses and beds and estate condition, particularly floors continue to be an issue. We have seen an increase in the number of areas with star ratings below 3- being support by enhanced auditing and oversight by IPCT

Looking forward

We aim to continue to reduce the burden of CDI on our patients across the Trust and system, and come below the annual threshold

[448] C. difficile - infection rate per 100,000 bed days



Technical Analysis

For 2025-26 we have had 47 trust apportioned cases of *C. difficile;* we are currently below trajectory. Nationally and across the South-West region there has been an increase in the number of *C. difficile* cases. Model hospital data benchmarking ICBs for rates of CDI per 100,000 age-sex weighted populations (12 months rolling to quarter ends) states Glos ICB is in the lowest 25% quartile and the best in the SW compared to our ICS peers

Planned Actions

The Trust *C. difficile* reduction plan for 2025/2026 focuses on actions to address cleaning; equipment and environment, antimicrobial stewardship, timeliness of stool sampling, prompt isolation of patients and optimising management of patients with *C. difficile.* This reduction plan is monitored by the Infection Control Committee. The Trust also chairs and supports a system wide *C. difficile* infection improvement group (CDIIG) which delivers system wide CDI actions to prevent CDI infections and recurrences for all patients across Gloucestershire. This activity is reported and monitored by the ICS IPC and ICS AMS groups, which reports to the ICS Infection Prevention Management Group. The Trust also supports work in the regional Southwest CDI collaborative led by NHSE. The IPCT have now set up weekly meetings with GMS Facilities to review programmes to support areas with failed technical cleaning audits; the IPCT attend all re-audits for failed areas

Safety Priority: Patient Falls

Highlights

Number of falls within the trust remain static and number of falls of injurious falls also remains static. In the past month, 2 of the falls with injury were neck of femurs

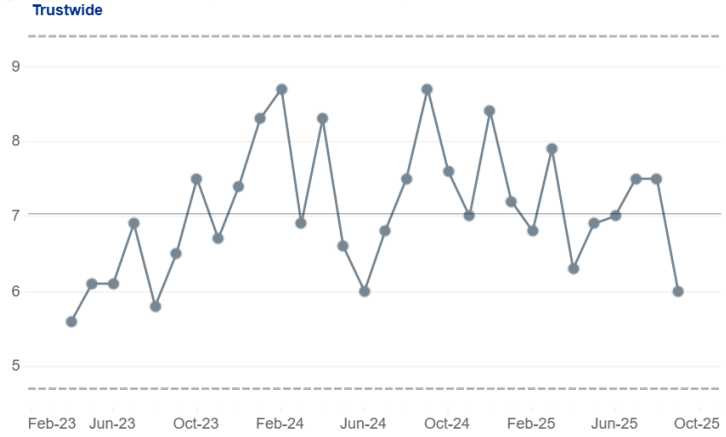
Areas of concern

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

Looking forward

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

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



Technical Analysis

The previous 12 reporting periods have demonstrated a period of control in the rate of falls, (note the y axis scale causing a saw-tooth effect in the data). However, the rate remains higher than before the Trust increased controls on the use of enhanced care HCSWs on our wards.

Planned Actions

Improvement focus is on specialist review of patients who have fallen twice during admission, if appropriate. A comprehensive training package has been launched by the Falls Team and is being very well attended; this is a key focus for us.
Quality improvement programmes continue, with Datix development and EPR documentation near completion. Work on Immediate Post Falls assessment for Nurses and Doctors is very close to being launched.

Maternity Care: Postpartum Haemorrhage >= 1,500 ml

Highlights

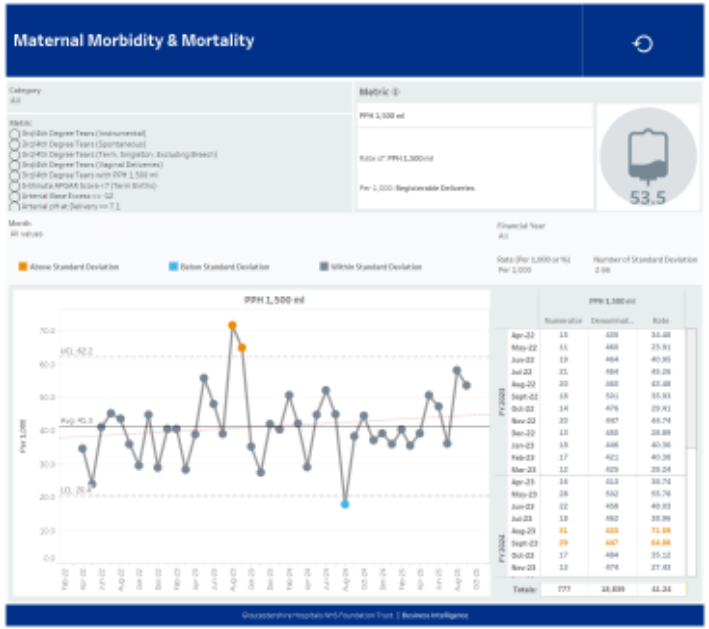
The national benchmarked rate is 32.0 and our rolling 6-month average is 33.83. We continue to review safety incidents thematically and have an ongoing improvement programme (July 2025 data).

Areas of concern

We still need to improve our booking and 36/40 risk assessment data to reach the 85-90% standard we have set for ourselves.

Looking forward

The QI work continues with oversight reported to the Perinatal **Delivery Group**. The next focus is to re-focus work on risk assessment completion at booking and at 36/40.



Technical Analysis

This month this metric is not above standard deviation when 2.66 is used.
Risk factors for PPH may present antenatally or intrapartum; care plans should be modified as and when risk factors arise.
In this group - 2 women had a PPH > 3L.
We are now able to look at this data by ethnicity and this month the breakdown is 14 white (78.8%), 6 Asian (8.5%), 1 black (4.6%), 3 mixed (4.2%) women had PPH>15L.

Planned Actions

We have a **CQC S31 enforcement notice** that requires us to enable improvement for the management of haemorrhage.
We have a team of clinicians, Team PPH, who are leading this improvement work who analyse the safety incident data and take action depending on the themes
Reports are being tracked to see how we can support individuals with the completion of booking and 36/40 risk assessment checks.
An audit of attendance in the emergency situation will be completed in Oct 2025 as this has been delayed due to unannounced CQC activity.

Safety Priority: Pressure Ulcers Cat 3

Highlights

A recent pressure ulcer summit has given insight into challenges at a ward level, analysis of the feedback will facilitate new quality improvement for the coming months

Areas of concern

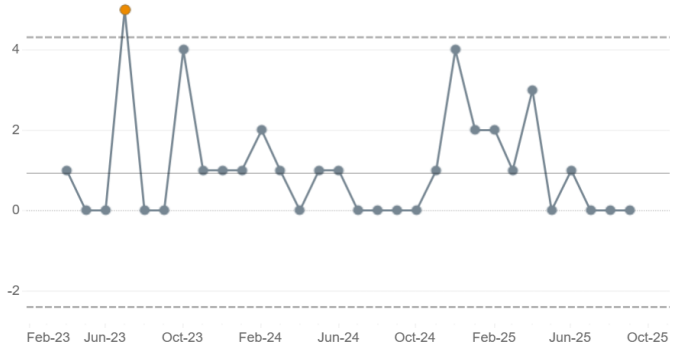
These serious pressure ulcers have remained a challenge for the Trust, whilst numbers appear low our ambition is to have lower than average cases and over the last couple of months cases are static.

Looking forward

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

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

Trustwide



Technical Analysis

There have been no Cat 3 pressure ulcers for 3 months

Planned Actions

Improvement focus continues to focus on specialist review of all hospital acquired category 3 pressure ulcers. Specialist equipment for prevention of pressure ulcers has been procured by individual wards. The Tissue Viability Team deliver comprehensive simulated training in the prevention of pressure ulcers monthly at a variety of locations.
Quality Summit on 31 July provided opportunity for specific Quality Improvement projects and specific areas of improvement which will be monitored through the pressure ulcer improvement group. Relaunch of the pressure ulcer improvement group on the 9/10/2025

Mortality – SHMI National Data

Highlights

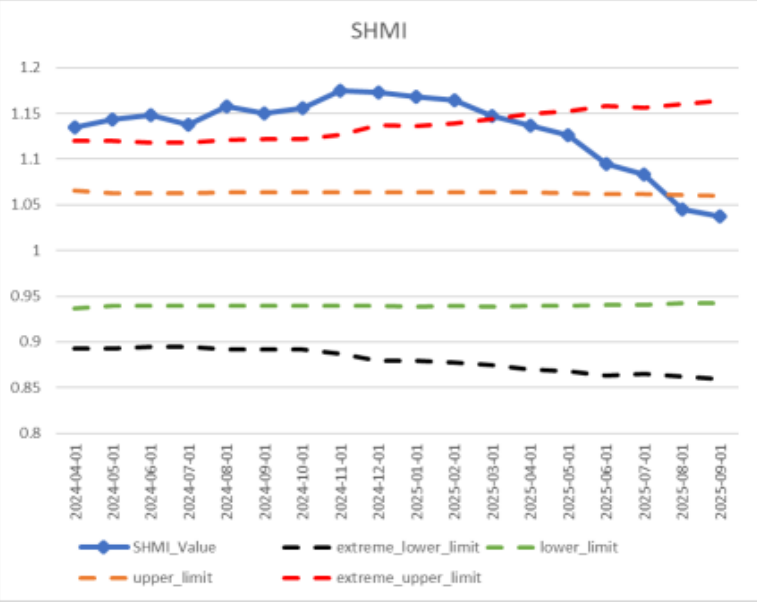
Latest SHMI (NHS Digital) = 1.04
within expected limits

Areas of concern

Sustainability of coding work – moving to Business as Usual

Looking forward

SHMI remaining in expected limits



Technical Analysis

Continued fall in 12m rolling SHMI
In/Out of hospital, CGH/GRH and weekend admissions all now within expected range
NHSE Mortality Insight visit feedback - enhanced surveillance with SHMI QIG no longer needed due to significant progress.

Planned Actions

SHMI Sustainability Action Plan ongoing:

EPR change: Active / Inactive Health Issues
New Coding policies for CKD / LVF / Dementia / Access to JUYI records
QI projects in AMU to improve CKD diagnosis and recording, SAU to improve co-morbidity capture

PSIRF Learning Responses

Highlights

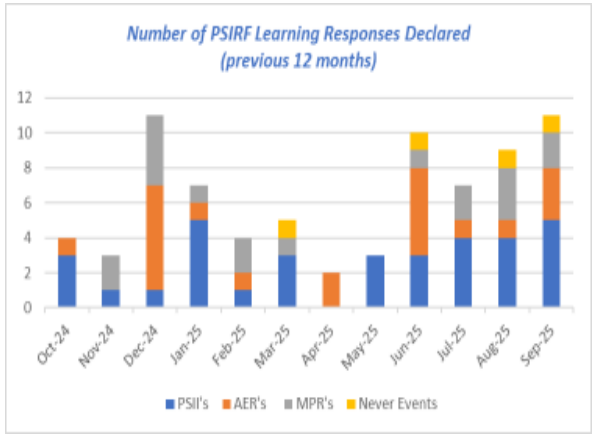
76 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 6.3 per month

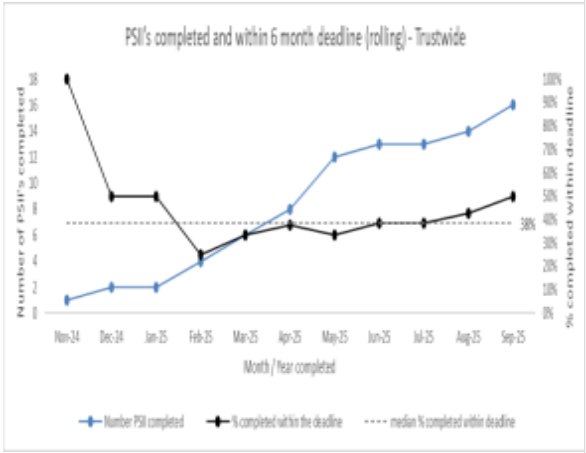
Areas of concern

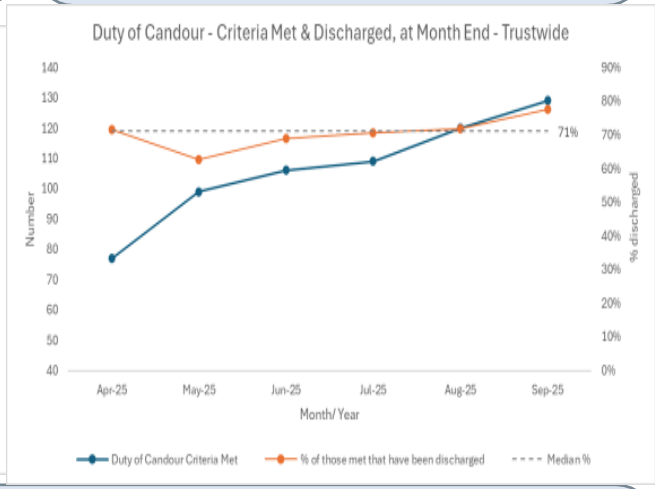
Timeframes within which learning responses are completed. Median on time for PSII's is 38%, for AER's 55% and MPR's 64%.

Looking forward

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







Technical Analysis :

PSII – Patient Safety Incident Investigation. Declared when a problem in care is considered to have contributed to death, or a safety concern is such that a detailed systems approach investigation is indicated

AER – After Event Review. Declared when there is a need for further information to inform action/learning to reduce the risk of recurrence

MPR – Multi Professional Review - Retrospective review of care by relevant specialists; documentation in a summary form

Planned Actions: Implementation of the Quality Governance Framework

Complaint Performance 2025/2026

Highlights

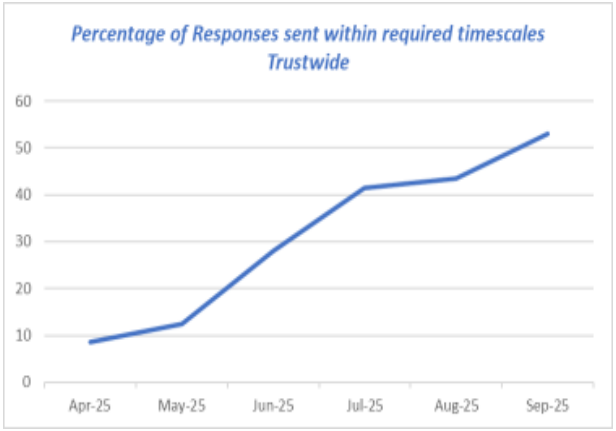
The Trust wide commitment to improve response timeframes has enabled a significant backlog to be cleared and the month on month upward trajectory in the percentage of responses being sent within required timeframes.

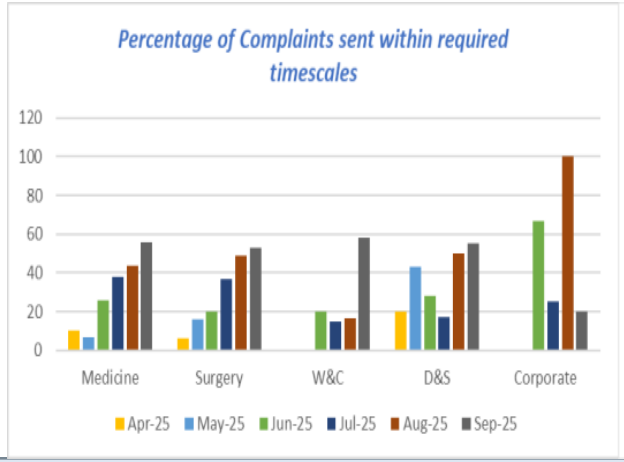
Areas of concern

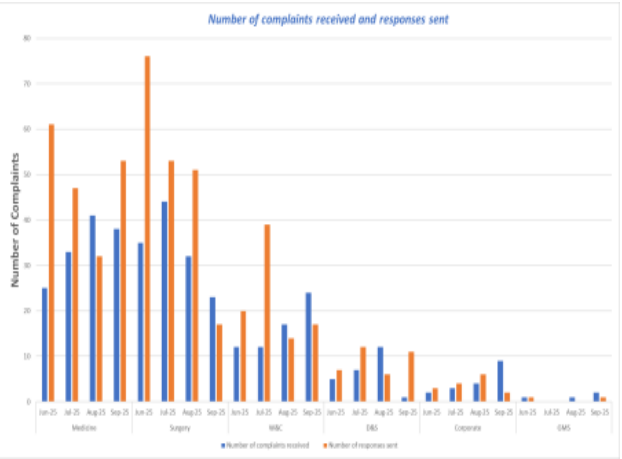
There are 10 complaints that have not had a response within 6 months. Whilst the response rate (figure below) continues to require improvement, significant progress is evident and is expected to continue month on month.

Looking forward

The new Complaint Framework has been implemented (QI pilot approach) in multiple specialties. The Complaint Improvement Group, are working through the wider improvement plan; in respect of efficiency, responsiveness, quality and learning.







Technical Analysis and Planned Actions:The percentage of responses sent within required timescales has increased from 9% in April 2025 to 53% in September 2025. This improvement is expected to continue, month on month. The drivers for sustained improvement are the collaborative approach of the Complaint teams and Divisional Leadership teams, the same providing a forum for regular discussion and escalation, alongside implementation of alternative ways of working under the New Complaint Framework. The number of complaints that have not received a response within 6 months is being monitored, with a requirement for weekly updates on progress with actions.

Use of Resources Metrics

Financial Metrics

Highlights

Revenue is £36k favourable to plan deficit of £3.46m.
Agency spend is £284k higher than NHSE target.
Bank spend is £863k higher than NHSE target
FSP is £3.5m adverse to plan.
Capital spend is £8.1m behind plan.
The Trust is holding 12 days operating cash.

Areas of concern

FSP shortfall is the main area of concern and is under-delivering by £3.5m. In addition, system savings targets aren't delivering. These pressures have been managed YTD though additional funding and non-recurrent actions.
Capital spend continues to be behind plan.

Looking forward

Recovery actions totalling £12.8m have been identified to improve the forecast deficit position. These actions reduce the forecast deficit to £15m. Significant mitigations continue to be required to deliver the planned breakeven position.

	Metric		Month 1			Month 2			Month 3			Month 4			Month 5			Month 6		
			Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	Ytd £'000s	-5,266	-5,473	-207	-10,580	-10,582	-2	-8,677	-8,658	19	-2,926	-3,411	-482	-6,147	-8,167	-2,020	-3,455	-3,419	36
		Forecast £'000s	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Agency spend against NHSE target		-737	-713	24	-749	-897	-148	-702	-870	-168	-723	-1,024	-301	-705	-892	-187	-625	-909	-284
	FSP	Ytd £'000s	1,435	762	-673	2,899	2,883	-16	8,355	8,124	-231	11,851	10,350	-1,501	15,333	12,123	-3,210	18,808	15,293	-3,515
		Forecast £'000s	41,775	41,775	0	41,775	41,775	0	41,775	41,775	0	41,775	41,775	0	41,775	41,775	0	41,775	41,775	0
	Capital vs budget plan	Ytd £'000s	958	927	-31	5,797	1,763	-4,034	7,987	3,716	-4,271	10,200	4,900	-5,300	12,450	6,001	-6,449	15,800	7,700	-8,100
		Forecast £'000s	57,092	57,092	0	54,941	55,754	813	54,941	55,754	813	54,941	55,754	813	57,456	57,456	0	57,456	57,456	0
	Nos days operating cash		5	22	17	5	20	15	5	15	10	5	19	14	5	15	10	5	12	7
	BPP - nos invoices paid in 30 days		95%	98%	3%	95%	98%	3%	95%	98%	3%	95%	92%	-3%	95%	99%	4%	95%	98%	3%
	Bank spend against NHSE target		-3,534	-4,272	-738	-3,062	-4,007	-945	-3,347	-3,779	-432	-3,221	-3,765	-544	-3,086	-3,805	-719	-2,945	-3,808	-863

Risks

The Trust financial position is faced with significant risks including:

- FSP delivery. There remains £5.6m unidentified schemes at M6 with a further £8.9m rated as high risk. Total risk £14.46m, which is an improvement of £2.3m from prior month.
- Industrial action in response to pay award
- Delay in capital schemes starting due to lack of approved business cases and ability to deliver approved schemes
- Non delivery of the financial position and intervention by NHS England.

M6 Revenue Position

Highlights

The Month 6 in month position is £4.8m surplus which is £2.1m favourable to plan. The YTD position is £3.42m deficit which is £36k favourable to plan. The ytd plan is £3.46m deficit.

Areas of concern

- FSP £3.49m, of which £3.52m is pay
- System wide savings not being delivered £1.3m. This has improved from previous month by £485k due to CDC funding agreed.
- Maternity cover (in addition to funded element c.54%) £1.1m

Looking forward

The Trust and ICS are reporting breakeven positions in line with plan for 2025/26.
The internal financial position is c£15m deficit against breakeven plan if recovery actions are implemented immediately.

Summary I&E Position (Trust only)	Current Month Budget £000	Current Month Actual £000	Current Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000	YTD Variance excluding Pass-through, donated assets & IFRIC 12 £000
Income	(72,354)	(77,225)	(4,871)	(413,241)	(424,417)	(11,176)	(8,157)
Pay	42,362	43,070	708	254,245	257,599	3,354	3,354
Non Pay	27,300	29,375	2,075	162,450	171,589	9,138	4,771
(Surplus)/Deficit	**(2,692)**	**(4,780)**	**(2,088)**	**3,455**	**4,770**	**1,315**	**(36)**
Donated Assets/Impairments/IFRIC 12 Adj	**0**	**(24)**	**(24)**	**0**	**(1,348)**	**(1,348)**	
Adjusted (surplus)/deficit	**(2,692)**	**(4,804)**	**(2,112)**	**3,455**	**3,422**	**(36)**	**(36)**

Technical Analysis

The income variance is largely driven by pass-through drugs & devices income and income one-off prior year true-up of £1m from commissioners, mainly NHSE.
The non pay variance includes pass through drugs & devices costs and system wide savings not being delivered.
The outstanding pressure is within pay due to undelivered FSP £3.49m.
Donated Assets, impairments and IFRIC 12 adjustments are technical NHS accounting adjustments that remove the costs from the reported position for the Group.

Forecast Outturn and Recovery

Highlights

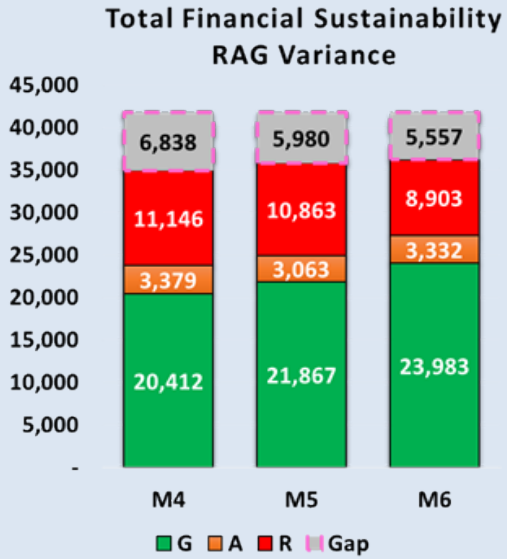
Forecast position has improved following the identification of recovery actions but there remains a gap.

Forecast outturn is £15m deficit which is £12m improvement from earlier estimates.

Improvement is driven by:

- Reduction in FSP gap and red-rated schemes £2.1m
- Additional controls and reviews of non-pay, drugs, contracts and balance sheet £4.5m
- Interest receivable and payable £2.2m
- Divisional improvements £3.2m

Improvement in FSP



Recovery – steps taken and action needed

Steps Taken

- Divisions submitted recovery plan actions on 26/9/25 to reduce level of overspend and deliver revised control totals.
- Review of medical staffing including
  - WLI
  - Locum/Agency premium
  - Vacancy review
- Review of nursing including
  - Bank cover controls including review of all current shifts
  - Reducing early and late bank shifts from 7.5hrs to 6hrs
- Review and control non pass through drugs
- Consider freeze on discretionary spend
- Explore opportunities through GMS
- Reduce contract leakage
- Review of all deferred income

Further Action Needed

Exec owned recovery plan including:

- Exec intervention and support to the Medicine Division
- Trust-wide Workforce – Pay Grip & Control
- Private Patient Income
- Discretionary Spend / Non-Pay, including procurement controls, approval processes etc.
- Financial Sustainability Plan – closing the gap, including actions and escalation of risks.

Governance arrangements will be strengthened to ensure each aspect of the recovery plan is reported and updated on a fortnightly basis.

M6 Pay

Highlights

Pay is overspent by £3.4m.

This includes £0.585m due to industrial action.

Areas of concern

Non delivery of FSP continues to be a significant pressure (£3.5m). The temporary staffing workstream and workforce change programme are behind plan.

Looking forward

Medical staffing costs are forecast to overspend if mitigating actions are not taken soon. Under delivery of FSP will add further pressure to this. Underspends against infrastructure and other clinical posts are helping to support the pay position but this is assumed to be non recurrent until posts are removed.

Summary Pay Position (Trust Only)	M6 YTD Plan £000s	M6 YTD Actuals £000s	M6 YTD Variance £000s
Infrastructure	41,635	39,833	(1,802)
Medical & Dental	78,761	80,357	1,596
Nursing	99,775	100,438	663
Other Clinical Staff	37,583	36,895	(687)
Total (excl reserves)	**257,754**	**257,523**	**(231)**
Reserves (FSP & Other Staff)	**(523)**	**(84)**	**439**
Divisions (FSP target & vacancy factor)	(2,986)	160	3,145
Adjusted (Surplus)/Deficit	254,245	257,599	3,354

Summary Pay Variance Trust Only)	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Total
Infrastructure	(2,070)	137	(52)	45	35	104	(1,802)
Medical & Dental	67	49	1,037	30	321	93	1,596
Nursing	144	(102)	2,861	(1,268)	(368)	(604)	663
Other Clinical Staff	43	(667)	(94)	61	(46)	16	(687)
Other Staff Sub	103	73	1,209	439	1,125	635	3,584
YTD Variance	(1,713)	(511)	4,962	(693)	1,066	244	3,354

Technical Analysis (further info on following slides)

Nursing overspend of £663k, of which £522k is due to unfunded maternity cover.

Medical staffing overspend of £1.6m of which £585k is industrial action and £303k is due to unfunded maternity cover.

Infrastructure underspend of c£1.8m, of which c£2m is within corporate, primarily CIO.

Planned Actions

Recovery plans are being developed to mitigate the financial position.

M6 Nursing Pay

Highlights

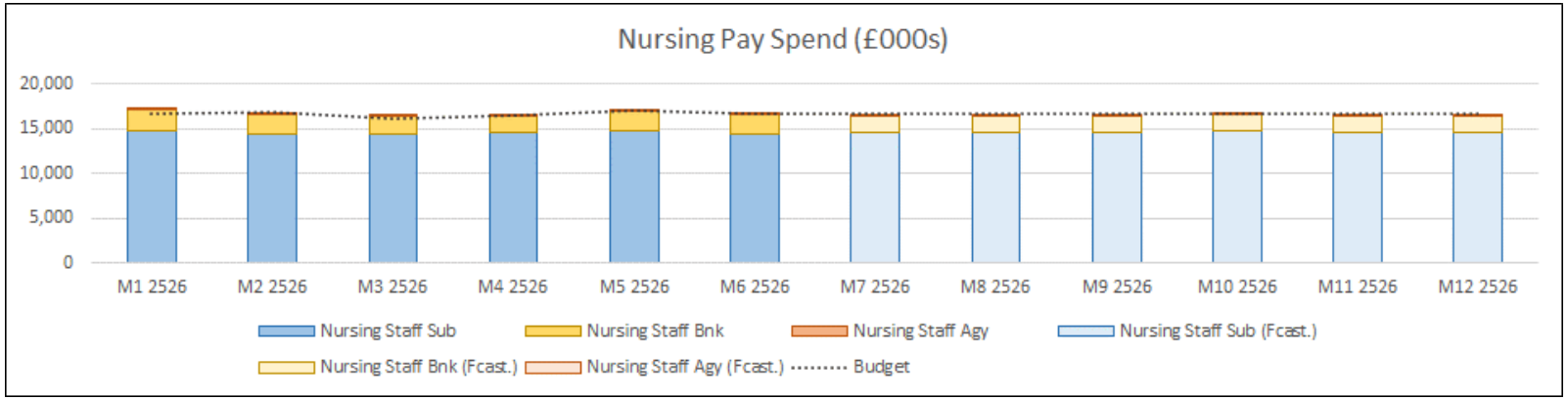
The Month 6 YTD nursing position is £663k overspent of which £522k is unfunded maternity leave cover. YTD spend is £100.4m against a budget of £99.8m.

Areas of concern

Nursing run rate has reduced (improved) by £101k when compared to the average for M1 to M5. Agency has increased in month 6 due to increased bookings of temporary midwives

Looking forward

Nursing rate of overspend seems to be reducing overall although Medicine is still pressured. It is expected to improve in future months due to ED rostering and reduction from 7.5hours to 6hours for bank shifts.



Technical Analysis & Actions

The main area of focus continues to be Medicine nursing and the use of bank nursing.

Mitigations to manage the financial position will include specific nursing actions that are being discussed with Executives.

M6 Medical Pay

Highlights

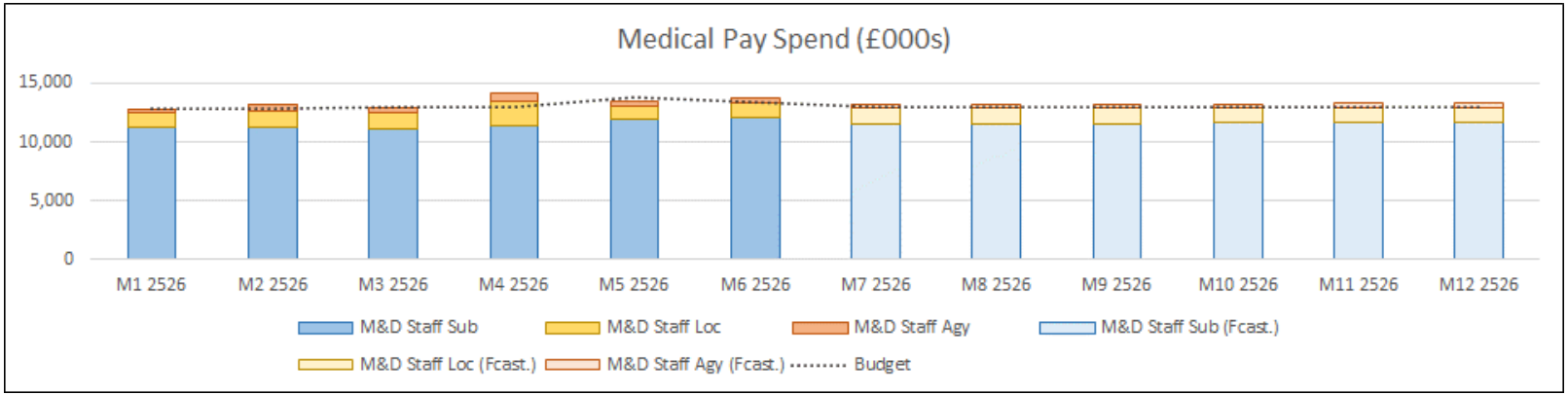
Medical staffing overspend of £1.6m of which £585k is industrial action (IA) and £303k is due to unfunded maternity cover. YTD spend is £80.4m against a budget of £78.8m.

Areas of concern

Medicine and Surgery continue to be the biggest areas of overspend, driven by sickness, vacancy cover and WLIs.

Looking forward

Medical pay is forecast to be c£4m overspent. Recovery actions to reduce the level of spend include WLI reduction for locum and substantive staff, temp staff premium reduction and vacancy review.



Technical Analysis & Actions

Medical Grip & Control meetings chaired by the Medical Director meet on a fortnightly basis. Divisions provide explanations and recovery plans for high earners, locum spend and WLI.

M6 Income

Highlights

The income position is £11.2m favourable to plan. This includes £4m pass through drugs & devices income overperformance, £3.1m unexpected depreciation funding and (£1.2m) clawback of funding.

Areas of concern

Private Patient income is below plan in all divisions except for Surgery. Growth is assumed as part of FSP delivery plans and recovery of the financial position.

Looking forward

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

Income	M6 YTD Plan £000s	M6 YTD Actuals £000s	M6 YTD Variance £000s
HEE Income	(9,363)	(11,389)	(1,997)
Other Income from Patient Activities	(9,893)	(10,371)	(478)
Other Operating Income	(13,423)	(14,212)	(789)
PP Overseas and RTA Income	(3,349)	(2,999)	350
SLA & Commissioning Income	(377,213)	(385,476)	(8,263)
Total Income	(413,241)	(424,446)	(11,176)

Technical Analysis

HEE income is £2m above plan and is covering pay costs.

SLA and Commissioning Income is £8.2m above plan due to £4m pass through drugs income, £3.1m unexpected depreciation funding and (£1.2m) clawback of funding, £0.3m API overperformance and £1m prior year income mainly from NHSE.

M6 Capital Position

Highlights

As at of the end of September (M6), the Trust had goods delivered, works done or services received totalling £7.7m, against a planned spend of £15.8m, equating to a variance of £8.1m behind plan.

Areas of concern

- There are many schemes in the programme without an approved business case.
- Back ended programme increasing in year deliverability risk.

Looking forward

At M6, the Trust is reporting a breakeven forecast in line with the current gross capital spend allocation of £56.6m. Last month, agreed mitigations were put in place that overcommitted the programme by £0.2m. This was on top of an expected high slippage risk of £4m. The internal forecast has seen some of the high risks materialise and has effectively erased the overcommitment and reduced the slippage required to balance the programme now to £1.5m.

in £000s	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	4,810	2,706	2,104	11,500	11,500	0
DIGITAL - IFRS16	0	0	0	101	101	0
MEDICAL EQUIPMENT	2,175	1,001	1,174	6,980	6,981	(0)
MED EQUIP - IFRS16	43	193	(150)	1,312	1,312	0
ESTATES	6,745	3,520	3,225	24,158	24,158	0
ESTATES - IFRS16	166	146	20	516	516	0
SLIPPAGE RESERVE	730	0	730	(4,040)	(4,040)	0
OVERCOMMITMENT OF PROGRAMME	0	0	0	(210)	(210)	0
NBV OF ASSET DISPOSALS	0	(265)	265	(265)	(265)	(0)
Total Charge against Capital Allocation (incl. IFRS 16)	**14,669**	**7,300**	**7,369**	**40,053**	**40,053**	**(0)**
NAT PROG: CIR FUNDING	0	21	(21)	9,710	9,710	0
NAT PROG: CDC PATHWAY OPTIMISATION	0	0	0	25	25	0
NAT PROG: CONST STANDARDS FUNDING - DIAGNOSTIC	430	(5)	435	1,237	1,237	0
NAT PROG: DIGITAL DIAGNOSTICS	184	0	184	783	783	0
NAT PROG: CANCER FUNDING	0	0	0	2,916	2,916	0
IFRIC 12	266	266	0	533	533	0
DONATIONS VIA CHARITABLE FUNDS	258	135	123	1,317	1,317	0
Total Expenditure against Additional Funding	**1,138**	**417**	**721**	**16,521**	**16,521**	**0**
Gross Capital Spend Total	**15,807**	**7,717**	**8,090**	**56,574**	**56,574**	**(0)**
Gross Capital Spend Total	**15,807**	**7,717**	**8,090**	**56,574**	**56,574**	**(0)**
Less Donations and Grants Received	(258)	(135)	(123)	(1,317)	(1,317)	(0)
Less PFI Capital (IFRIC12)	(266)	(266)	0	(533)	(533)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	177	177	0	353	353	0
Total Capital Departmental Expenditure Limit (CDEL)	**15,459**	**7,493**	**7,967**	**55,077**	**55,077**	**(0)**

Technical Analysis

The main contributors to the year-to-date variance are a) Delay in Estates schemes whilst assessing BS regulations on projects and project interdependencies. b) Digital infrastructure delays linked to the business case exploring other data centre solutions, c) Delays in agreeing contract for the electrical infrastructure project. d) Pauses in CGH South Electrical Sub-station due to fire surveys, asbestos…

The Trust submitted a gross capital expenditure plan for the 25/26 totalling £57.1m. Since the plan, the Trust has received additional national programme capital of c£0.5m for digital diagnostics, a further £2.0m of system capital has been allocated for the UEC incentive scheme and a reduced ask against the constitutional standards funding by £3.0m

Planned Actions

Project progress is being regularly to discussed. The project leads should update their profile spends each month and have now been tasked to provide more detailed progress assurance on each project to demonstrate how developed the project plans are and how on track the deliverability of the spend is.
This information is reported to the Capital Delivery Group and Finances and Resources Committee monthly so that further intervention, action and/or mitigations can be identified to maintain a breakeven forecast outturn position.

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

Cash Flow

Highlights

- The cashflow reflects the Trust position.
- The table is for an 18 month period and is based on the assumption that income and expenditure will be at similar levels from April 2026 onwards.

Areas of concern

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

Looking forward

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

	Sep 25 £'000	Oct 25 £'000	Nov 25 £'000	Dec 25 £'000	Jan 26 £'000	Feb 26 £'000	Mar 26 £'000	Apr 26 £'000	May 26 £'000	Jun 26 £'000	Jul 26 £'000	Aug 26 £'000	Sep 26 £'000	Oct 26 £'000	Nov 26 £'000	Dec 26 £'000	Jan 27 £'000	Feb 27 £'000
Opening Balance	42,353	28,628	38,209	31,276	30,965	19,212	13,718	3,347	11,785	5,518	1,386	6,225	2,428	(4,950)	7,150	(6,290)	(3,645)	(18,123)
Receipts																		
SLA Income	65,247	63,043	65,096	67,350	63,620	60,554	66,685	62,415	65,017	64,179	63,249	65,124	63,249	69,740	62,568	63,549	63,549	62,429
Other NHS	3,875	21,786	2,155	2,371	4,321	11,080	2,313	17,771	2,578	2,745	15,283	2,215	2,017	22,446	2,155	2,371	4,161	11,080
Other Non-NHS	2,095	2,672	2,401	2,146	2,773	2,610	2,736	2,810	2,503	2,554	3,077	2,602	2,679	2,773	2,401	2,095	2,675	2,610
VAT	2,679	4,358	2,479	2,095	2,989	1,688	2,214	2,628	2,455	2,961	2,841	3,218	2,166	1,935	2,479	2,095	2,989	1,688
Total Receipts	73,895	91,859	72,131	73,962	73,703	75,931	73,948	85,624	72,553	72,439	84,450	73,159	70,111	96,894	69,602	70,110	73,375	77,806
Payments																		
Payroll - Direct payments	(28,167)	(28,742)	(28,430)	(28,441)	(28,864)	(28,627)	(28,545)	(28,458)	(28,719)	(28,411)	(28,444)	(28,798)	(28,481)	(28,782)	(28,430)	(28,441)	(29,446)	(28,627)
Payroll - On costs	(24,790)	(21,508)	(21,508)	(21,487)	(21,504)	(21,491)	(21,493)	(21,503)	(21,500)	(21,528)	(21,560)	(21,487)	(21,487)	(21,508)	(21,508)	(21,506)	(21,493)	(21,491)
Payables	(29,931)	(29,789)	(25,273)	(16,766)	(28,390)	(27,769)	(25,415)	(26,383)	(27,925)	(24,675)	(28,707)	(25,604)	(21,908)	(31,667)	(28,912)	(13,744)	(29,891)	(27,880)
Loan Principle & Interest	(1,167)	0	0	0	0	0	(1,142)	0	0	0	0	0	(1,125)	0	0	0	0	0
PDC Payments	(2,975)	0	0	0	0	0	(3,790)	0	0	0	0	0	(2,938)	0	0	0	0	0
Total Payments	(87,031)	(80,039)	(75,211)	(66,694)	(78,758)	(77,887)	(80,385)	(76,344)	(78,144)	(74,613)	(78,711)	(75,890)	(75,939)	(81,956)	(78,850)	(63,691)	(80,830)	(77,999)
Capital																		
Capital Funding Grants & PDC	0	1,453	2,497	2,708	2,237	3,761	2,015	0	0	0	0	0	0	0	0	0	0	0
Capital Payables	(590)	(3,692)	(6,349)	(10,287)	(8,935)	(7,299)	(5,950)	(842)	(676)	(1,957)	(900)	(1,066)	(1,550)	(2,837)	(4,193)	(3,773)	(7,024)	(6,650)
	(590)	(2,239)	(3,852)	(7,579)	(6,698)	(3,538)	(3,935)	(842)	(676)	(1,957)	(900)	(1,066)	(1,550)	(2,837)	(4,193)	(3,773)	(7,024)	(6,650)
Net Cashflow	(13,726)	9,581	(6,932)	(311)	(11,753)	(5,494)	(10,372)	8,438	(6,267)	(4,132)	4,838	(3,796)	(7,379)	12,101	(13,441)	2,646	(14,479)	(6,842)
Closing Balance	28,628	38,209	31,276	30,965	19,212	13,718	3,347	11,785	5,518	1,386	6,225	2,428	(4,950)	7,150	(6,290)	(3,645)	(18,123)	(24,966)
Number of days operating cash held	12	17	14	13	8	6	1	5	2	1	3	1	(2)	3	(3)	(2)	(8)	(11)

Technical Analysis

- Income is shown as per our FOT
- Expenditure is shown at current run rates. Any achievement in recovery actions will improve the cash balances.
- Currently this does not assume any funding for capital cash support
- Trust held 20 days operating cash (c£2.3m per day) at the end of April – at the end of March 2026 this would be equivalent to 1 days.

Planned Actions

- Complete a capital cash funding request to NHSE
- Enhance recovery governance arrangements to secure improvements

Workforce

Workforce Performance Indicators

KPI	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Turnover	11.0%	9.9%	10.0%	9.4%	9.4%	9.3%	9.0%	8.8%	9.0%	8.7%	8.5%	8.4%	8.3%	8.6%	8.1%
Vacancy	8.0%	7.4%	7.5%	7.5%	7.4%	7.7%	7.3%	7.4%	7.2%	7.3%	7.3%	7.5%	7.5%	8.0%	6.9%
Sickness	4.0%	4.0%	4.2%	4.6%	4.4%	4.6%	4.9%	4.3%	4.2%	4.4%	4.4%	4.6%	4.4%	4.4%	
Appraisal	90%	82%	82%	81%	81%	81%	82%	81%	81%	82%	82%	83%	84%	84%	84%
Essential Training	90%	87%	88%	88%	88%	89%	89%	89%	90%	90%	90%	90%	91%	91%	91%
Agency FTE	-	102.09	90.71	90.68	82.25	74.00	85.52	81.50	108.26	94.46	90.35	84.28	73.39	85.37	58.13
Agency % of Establishment	2%	1.3%	1.1%	1.1%	1.0%	0.9%	1.1%	1.0%	1.3%	1.2%	1.1%	1.0%	0.9%	1.0%	0.7%
Bank FTE	-	591.24	586.68	585.85	575.34	570.92	536.54	637.2	639.27	650.71	572.59	568.92	546.37	577.37	562.28
Bank % of Establishment	7%	7.3%	7.3%	7.2%	7.1%	7.1%	6.6%	7.9%	7.9%	8.0%	7.0%	7.0%	6.7%	7.1%	6.9%

Sickness

Trust / Divisional Position

	August		September		Variance	
	Monthly	12m Avg	Monthly	12m Avg	Monthly	12m Avg
Trust	4.43%	4.39%	3.97%	4.39%	-0.46%	0.00%
Corporate	3.86%	3.83%	3.58%	3.85%	-0.27%	0.02%
D&S	4.17%	4.21%	3.80%	4.19%	-0.38%	-0.02%
Medicine	4.69%	4.54%	4.03%	4.55%	-0.66%	0.02%
Surgery	4.38%	4.46%	4.20%	4.50%	-0.18%	0.04%
W&C	5.38%	5.06%	4.31%	4.95%	-1.06%	-0.11%

Top 10 Absence Reasons by FTE Days Lost

Absence Reason	Headcount	Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	1181	2,200	28,727.84	23.8
S13 Cold, Cough, Flu - Influenza	4015	6,643	15,895.89	13.2
S25 Gastrointestinal problems	3087	4,895	12,883.41	10.7
S12 Other musculoskeletal problems	747	1,229	9,621.67	8.0
S26 Genitourinary & gynaecological disorders	633	1,022	6,436.04	5.3
S28 Injury, fracture	362	528	6,406.82	5.3
S30 Pregnancy related disorders	312	922	4,964.85	4.1
S16 Headache / migraine	1728	2,807	4,677.27	3.9
S99 Unknown causes / Not specified	533	1,009	4,434.09	3.7
S11 Back Problems	480	711	4,134.00	3.4

- Overall, the Trust sickness position has slightly improved by just under 0.5%
- All divisions have seen an improvement with W&C the highest at 1%

- Looking at the top 10 reasons for sickness absence with Anxiety/Stress/depression being the highest, it is paramount that managers maximise support to staff, referring to work wellbeing, signposting to EAP, and any other suitable wellbeing/psychological support that is available.
- With cold, cough, flu being the second highest reason it is an indicator that managers should be encouraging their staff, especially those in clinical roles to take up the flu vaccine.

Workforce - Appraisal

Highlights

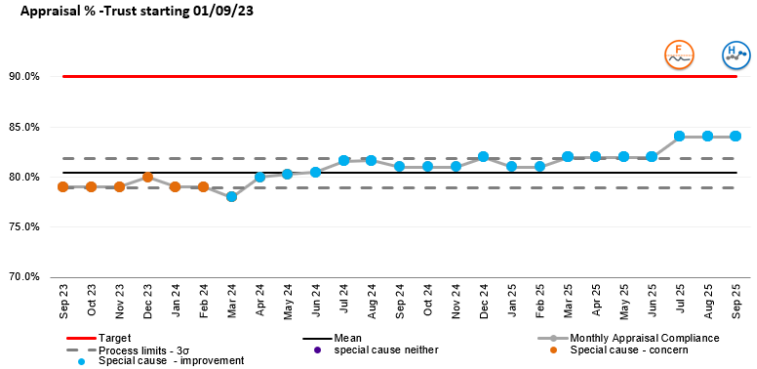
- Overall Compliance remains static and at its highest in over three years
- Delivery of the redesigned effective appraisal training

Areas of Concern

- Significant low compliance of less than 70% in Estates and Ancillary staff group and multiple service lines within corporate division
- Wellbeing meetings are incorrectly being recorded on ESR

Looking forward

- Internal Audit of Appraisals planned Q4
- Further engagement sessions planned in low compliance staff groups and service lines.
- Digitisation of Appraisal Process



Division / Date	30-Sep-25
Corporate Division	77%
Diagnostic & Specialty Division	84%
Medicine Division	87%
Non-Division	76%
Surgery Division	86%
Women & Children Division	79%
GHT Total	**84%**

Staff Group / Date	30-Sep-25
Add Prof Scientific and Technic	85%
Additional Clinical Services	86%
Administrative and Clerical	78%
Allied Health Professionals	81%
Estates and Ancillary	67%
Healthcare Scientists	83%
Medical Staff - Consultants	89%
Medical Staff - SAS	77%
All Medical Staff	**87%**
Nursing and Midwifery Registere	86%
GHT Total	**84%**

Technical Analysis

The current appraisal compliance rate stands at 84%, unchanged for the third consecutive month. Whilst this remains below the organisational target of 90%, it represents the highest compliance in over three years, indicating a sustained improvement trend. Compliance across staff groups remains largely static, with estates and ancillary staff continuing to be significant outliers at 67%. Divisional data also shows minimal change, but notably, multiple service lines within corporate division continue to have compliance of less than 70%

Planned Actions

Continued outreach to teams identified as high quality and high compliance to learn from and share good practice
Focused interventions in estates and ancillary staff groups and service lines within corporate division with less than 70% compliance, which will include support to Service leads and enrolment to training if necessary.
Exploring digital solutions to enhance adherence to new process, compliance recording and staff experience ongoing
Embedding the appraisal learning and development offering into the managers development programme
Development of point of need learning resource

Workforce - Bank

Highlights

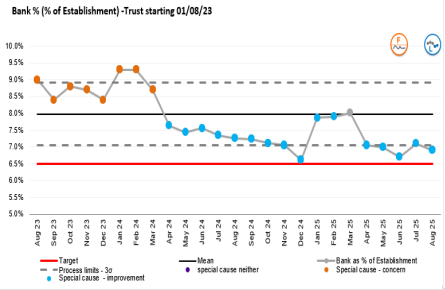
RN/HCSW WTE has increased above last year for the first time in M5.
M5 saw an increase in 6 WTE compared to the same point last year.
M5 has seen a fall in Medic Locum use of 24 WTE from M4.

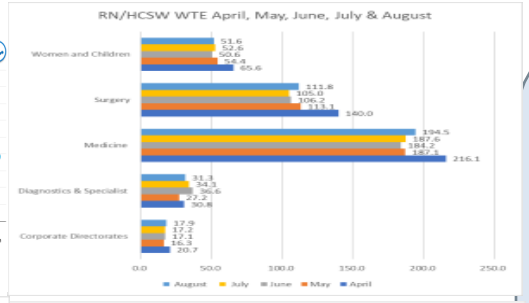
Areas of concern

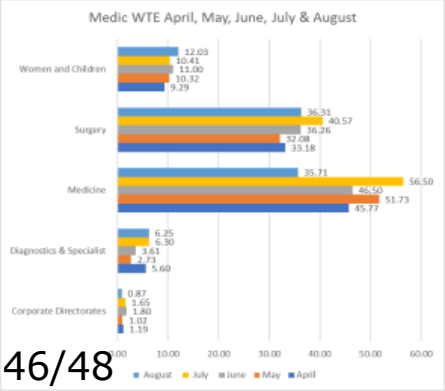
- The Trust target of 6.5% has not been achieved in month 5.
- Overall WTE and £ use of bank is not yet at the trust reduction target of 15% in M5.
- RN/HCSW use has exceeded the previous FY for the first time.

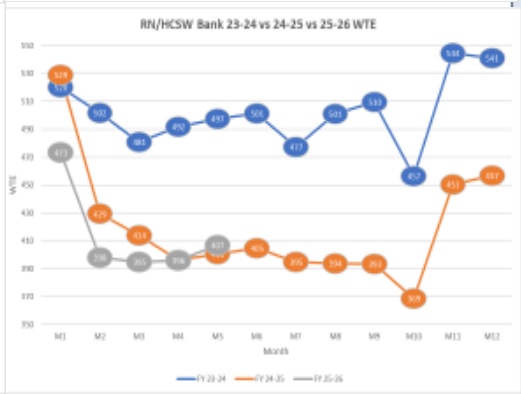
Looking forward

- As the trend of FY23-24 and 24-25 is broadly similar, and FY 25-26 appears to be following that trend, it is reasonable to assume that M5 will also see a similar WTE use for FY 25/26.









Technical Analysis

- The trust has seen an increase reduction in temporary RN/HCSW Staffing from 473 WTE in M4 396 WTE to M5 407 WTE.
- In comparison with M4 of the 2024/2025 FY, there has been no reduction of WTE RN/HCSW use.
- Medicine is the highest user of Bank & Locum staff.
- ED, COTE, Stroke and Acute Medicine are the highest users of temporary staffing in Medicine.
- A year-on-year WTE comparison of RN/HCSW temporary staffing use shows the improvements achieved throughout the FY.

Planned Actions

- Continued scrutiny and redesign of Nurse & HCSW rosters, reducing agency & bank use through tightened authorisation procedures and accurate reflections of WTE funded position.
- Effective recruitment to key vacancies inside the trust that are resulting in high use or spend in clinical roles.
- Continued scrutiny of bank and agency use through Grip & Control meetings.
- Implementation of e-Rostering solution for Medical Workforce, to deliver reductions in temporary staffing use.

Job Planning Compliance – 95% April 2026 Target

Background / Highlights

- Job Planning has this year been included in PWR reporting and is also an NHS England Improvement Programme
- The medical e.rostering work is providing a helpful lever as up to date job plans are required for e.rostering
- All job plans are now in date, with a process in place to republish job plans, ensuring no job plans are expired.
- The October 2025 target of over 60% of job plans signed off by 1st October has been met

Areas of concern

- Since data submissions have been required for job planning metrics, the definitions and requirements have changed frequently. This reports aligns with the most recent PWR requirements, with job plans that are in date (within last 12 months) and at least first signed off (by Clinical Lead CL or Speciality Director SD) included in the numerators. Data for a total of 577 Consultants and SAS doctors is included

Looking forward

- NHS England target is for consultant and SAS job plans is for 95% signed off ahead of the next financial year.
- The Allocate job planning software contract expires this Autumn providing an opportunity for review and procurement

Technical Analysis

-There have been issues with Allocate systems this month nationally, meaning it has not been possible to run several of our usual reports. Allocate has provided assurance that the issues will be resolved imminently.
-There has been a positive impact of the move to e.rostering which has taken place first in the Acute Medicine. This is then being extended across the Medical Division.
-Departments are provided with their job planning compliance metrics monthly, showing their job planning performance and progress.
Additionally, emails have been sent to all clinicians whose job plans are not signed off, to encourage and support their engagement with the process
-When a job plan is republished for its annual review, the Allocate system records it as no longer signed off, even if an in date signed off job plan exists for that clinician. As such, there will always be approximately 1/12 of job plans not meeting the sign off criteria.

Planned Actions

Utilise the lever of e.rostering to improve job planning

Send additional communications regularly to leads where sign offs are needed and to clinicians monthly where their engagement is required, to emphasise the importance of job planning and enable full participation

Continue monthly reporting to support SDs and CLs

The Job Planning department continues to support clinicians and leads with the process

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Gloucestershire Hospitals
NHS Foundation Trust

Thank you

Report to Board			
Agenda item:		**Enclosure Number:**	
Date	November 2025		
Title	Learning from Deaths report (Q2,3 and 4 2024/2025)		
Author /Sponsoring Director/Presenter	Jo Mason-Higgins, Acting Associate Director of Safety (Investigation and Family Support) & Charlie Candish, Associate Medical Director (Safety) Prof Mark Pietroni, Medical Director and Director of Safety		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

Assure

The Trust continues to demonstrate robust governance in reviewing all deaths, with every case undergoing initial scrutiny by the Medical Examiner and Bereavement Team.

Structured Judgement Reviews (SJRs) are embedded across all divisions, with a notable improvement in timely completion—73.6% of reviews completed within 3 months in Q4 2024/25.

The Trust's Summary Hospital-level Mortality Indicator (SHMI) has returned to "as expected" levels (1.04), with a sustained 9-month downward trend across both Cheltenham General and Gloucestershire Royal Hospitals.

Family feedback remains consistently positive, particularly regarding compassionate care and staff professionalism.

Advise

Continued focus is needed to improve the percentage of SJRs completed within three months and to ensure learning from these reviews is systematically integrated into Trust-wide quality improvement and PSIRF priorities.

The Trust is advised to maintain momentum on the coding improvement programme, which has significantly contributed to SHMI reductions. Sustained investment in coding teams, clinician education and enhancements to the Electronic Patient Record where needed are essential.

The Mortality Insights Visit in July 2025 commended the Trust's progress and recommended further integration of business intelligence, clinical, and quality teams, alongside enhanced training and development of a mortality dashboard.

A pilot initiative to proactively share SJR findings with families is being launched in Oncology and Respiratory, with the potential to improve family experience and reduce complaints.

Alert

Due to the observed increase in mortality associated with a more than 8 hour delay to admission in patients presenting to the Emergency Department (ED), ongoing focus in improving flow within ED is being led by the Clinical Vision of Flow programme.

An increase in stillbirths during Q3 2024/25 (9 cases) has prompted a comprehensive review and action plan, now under active monitoring by the Maternity Safety Experience and Review Group.

LeDeR reviews continue to face delays, with limited feedback reaching staff due to consent constraints. This impacts timely learning and staff development.

While SHMI improvements are encouraging, embedding structural data quality process changes are vital to ensure long-term sustainability.

Recommendation

To Note the Report

Enclosures

Learning from Deaths Report

LEARNING FROM DEATHS – BOARD REPORT – NOVEMBER 2025

1. Aim

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 This report covers the period July 2024 to March 2025 and is an update from the previous report to Board.

2. Learning From Deaths

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties.

c. Serious incident/PSII review and implementation of action plans.

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. Death's that trigger a Structured Judgment review are entered on to the Datix system to support the SJR process.

2.3 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through individual speciality and divisional processes. The main learning from Structured Judgement Reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some themes continue to be identified which are in common with known areas of quality. Divisional learning is presented to HMG on a rolling basis. Presentations are available for review, as required

2.4 All specialties receive individual monthly data on SJR performance and report to HMG on a rolling basis where performance is reviewed. Most SJRs are undertaken within 2 months.

2.5 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. Feedback from bereaved families is largely positive.

2.6 Family feedback is analysed by the End of Life Improvement Group and triangulated with the (NACEL) national end of life survey/audit data and recommendations.

2.8 All Serious Incidents (SIs) and Patient Safety Incident Investigations (PSII's) have action plans based on the identified learning which are monitored by Safety Experience and review Group through to completion. Summary reports on closed action plans and high level learning themes are fed into expert Trust groups. A learning summary example is provided in this report.

2.9 Deaths outside the SJR process are included in the tables below:

Deaths by Special Type	Jan-March 2023	April-June 2023	July - Sept 23	Oct-Dec 23	Jan to March 24	April-June 24	Jul-Sept 2024	Oct-Dec 2024	Jan-March 2025
Maternal Deaths (MBBRACE)	0	0	0	0	0	0	0	1	0
SI/PSIRF Learning Response Deaths ***Figures represent date investigation complete rather than date SI or PSIRF learning response, declared**	6	*1	*9	8*	7*	6*	3*	4	6
Learning Difficulties Mortality Review (inpatient deaths)	6	5	5	4	6	11	4	11	4

	Jan - Mar 23	Apr-Jun 23	Jul-Sep 23	Oct-Dec 23	Jan-Mar 24	Apr–June 24	Jul-Sept 2024	Oct-Dec 2024	Jan-March 2025
SB >24 wks	3	6	1	5	5	6	2	9	3
NND >24 wks Born at GRH/Died GRH	0	0	2	1	1	1	0	0	2
NND <24 wks Born at GRH/Died GRH	2*	0	1*	3	0	1*	2* (x1 TOP)	0	3
NND >24 wks Born & Died Elsewhere	2	0	1	0	0	0	1	1	0
NND <24 wks Born & Died Elsewhere	0	0	1	0	0	0	0	1	0

NND >24 wks Born GRH & Died Elsewhere	0	0	0	1	1	0	1	0	1
NND <24 wks Born GRH & Died Elsewhere	0	1	1	0	0	0	0	0	0

Post Neonatal death				1**	1	0	1	0	0

S2.10 Learning from Patient Safety Incidents

The following is an illustrative case study of a Safety Investigation that concluded within the reporting period

Clinical Summary:

A 78-year-old woman with longstanding left shoulder pain underwent pre-operative CT imaging in December 2022 to plan for shoulder replacement surgery. The radiology report, issued in January 2023, identified an incidental 2.2 x 2.6 cm lung mass and was marked as a 'RED ALERT'. Although the alert was acknowledged by the referring orthopaedic surgeon, no action was taken. The imaging was used solely for surgical planning via specialist software, which did not display soft tissue findings or the radiologist's report. The patient underwent successful shoulder surgery in June 2023 but was referred back in July 2023 with persistent pain. At this point, the lung mass was found to have progressed and invaded the spine, making curative treatment impossible. The patient received palliative care and died in February 2024

Learning from the Investigation:

The investigation identified several contributory factors:

- The process for following up radiological findings relied on a single email alert, which was acknowledged but not acted upon.
- The use of specialist planning software led to the radiologist's report and soft tissue findings being overlooked.
- There was no robust system to ensure that incidental findings unrelated to the primary reason for imaging were reviewed and acted upon by the referring clinician.

Key recommendations include:

- Linking this case to ongoing Trust-wide work to improve the visibility and actioning of 'red flag' radiology results and reduce alert fatigue.
- Reviewing and strengthening processes so that all relevant imaging findings, including incidental non-bone pathology, are considered during pre-operative planning.
- Implementing additional checks to ensure that radiology reports are reviewed in full, not just acknowledged

Support for the Patient's Family:

The Trust recognises the impact of the delayed diagnosis on the patient and her family and is committed to sharing learning and improvements arising from this case. The patient was informed of the missed finding and the investigation process during her care. The Trust's Patient Safety Team and Family Liaison Officer have provided ongoing support to the patient's family; sharing the full investigation report with them. Meetings with our Chief of Service for Surgery and clinicians involved have taken place, with verbal as well as written apologies, provided. The patient's family have been invited to contribute to a patient story; a personal account that reflects who the patient was, what went wrong in her care, the impact this has had on her family, and what the Trust has learned as a result. This will be used in a number of meaningful ways—such as at internal Safety and Quality Committees, in staff training to highlight the human impact of clinical errors, and in internal learning bulletins

S3. Mortality Data

S3.1 SHMI (Summary Hospital Level Mortality Indicator)

SHMI stands for Summary Hospital-level Mortality Indicator. It's a way to measure how many patients die in a hospital, compared to how many deaths were expected.

SHMI compares the actual number of patients who die (either in hospital or within 30 days of leaving) to the number of deaths that were expected, based on things like:

- Age
- Type of illness
- Other health conditions
- How serious the illness was

What do the numbers mean?

A SHMI of 1 means the number of deaths is as expected.
A SHMI above 1 means more people died than expected.
A SHMI below 1 means fewer people died than expected.

Important to know:

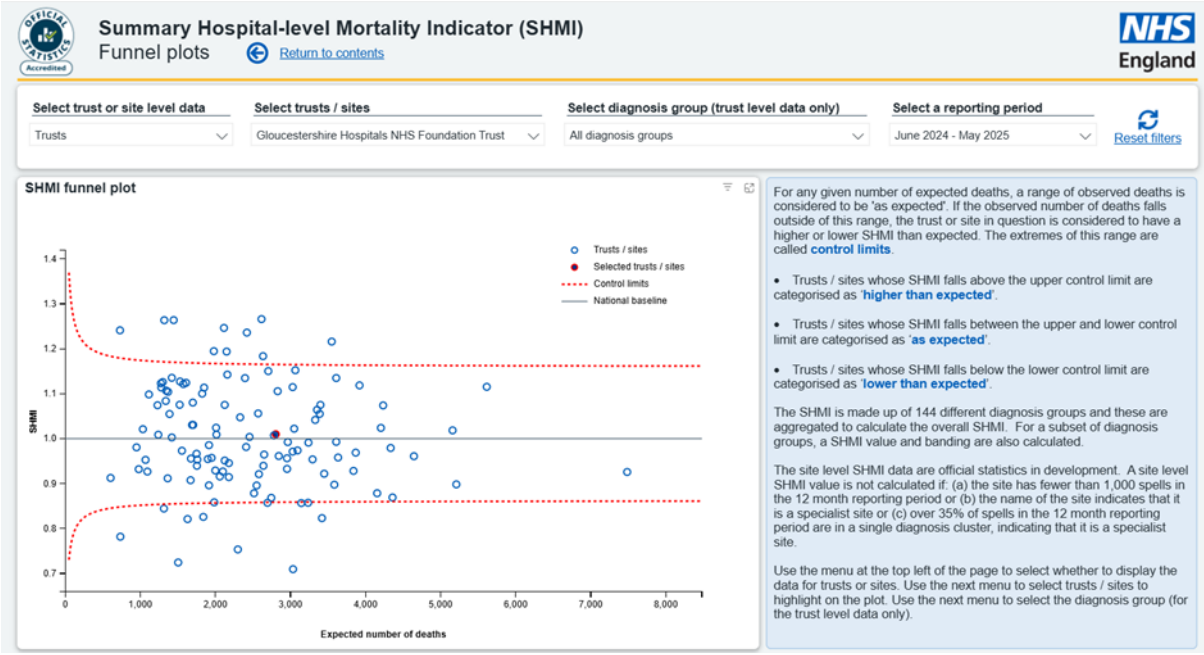
A higher SHMI doesn't always mean poor care. It could be due to other factors like:

The hospital is treating more seriously ill patients
Differences in how data is recorded

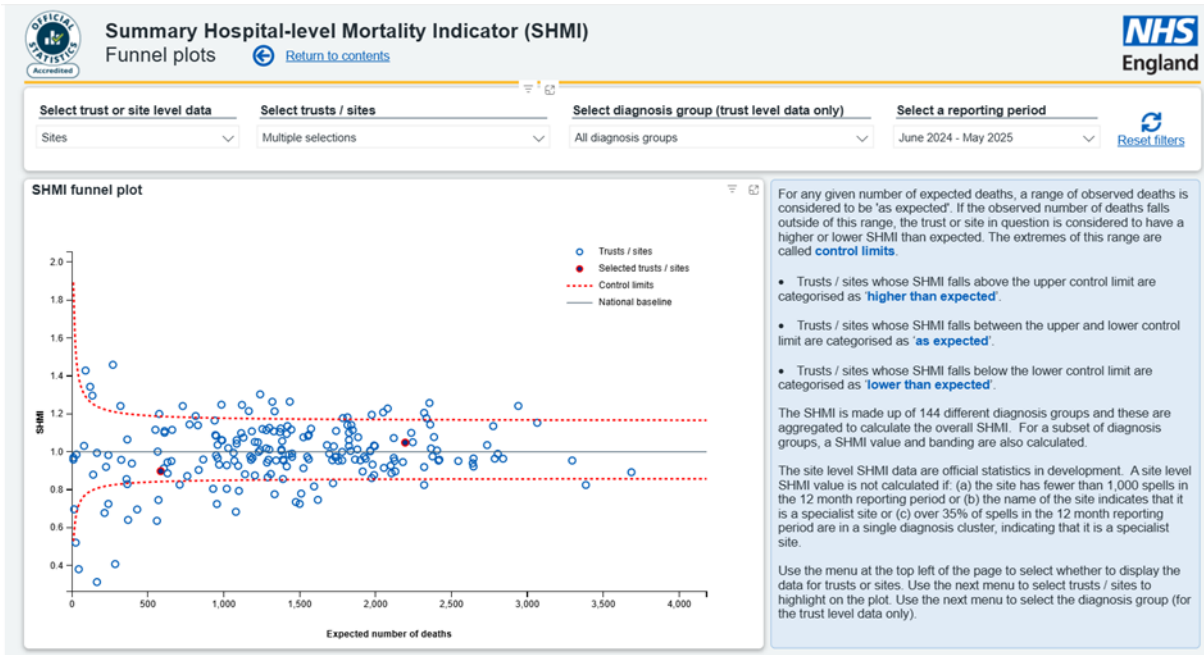
SHMI is just one of many tools used to review hospital mortality

S3.2 NHSE Data

The slide below demonstrates that SHMI for the Trust is "as expected" at 1.04 and within the mid-range when compared with other Trust's.



The slide below represents data by Trust site (Cheltenham General Hospital CGH) and Gloucestershire Royal Hospital (GRH. The slide demonstrates that SHMI for GRH is 1.07 and for CGH 0.97. This is to be expected as there are fewer emergency admissions to CGH.



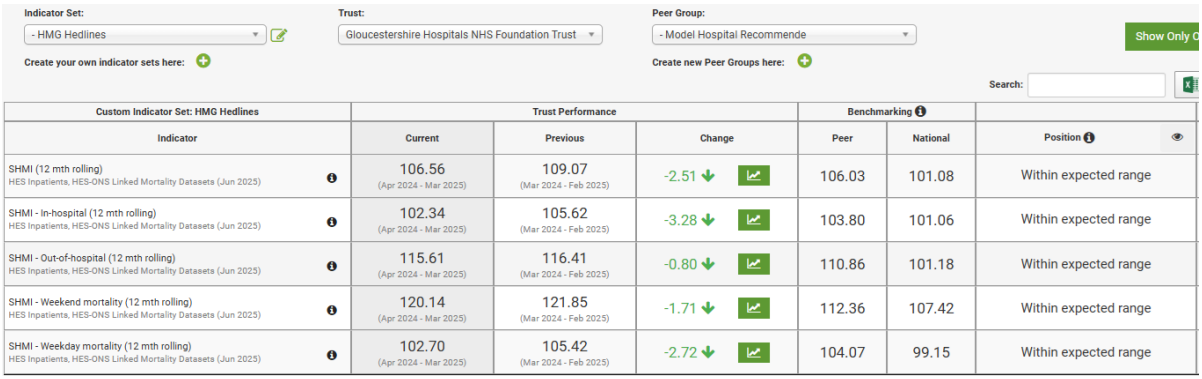
S3.3 HED (Hospital Episode Data)

Hospital Episode Data is a collection of information about patient care in hospitals. Every time someone goes into hospital—whether for a planned operation, an emergency visit, or even just a short stay—details of that "episode" are recorded. These details include things like:

- Why the patient came to hospital (diagnosis)
- What treatment or procedures they received
- How long they stayed
- What the outcome was (e.g. discharged, transferred, or sadly, passed away)

This data is anonymised (personal details are removed) and used to help improve healthcare services. For example, it can show trends in patient care, help identify areas where hospitals can improve safety or efficiency, and support research into better treatments.

The data and below demonstrates SHMI has fallen for 9 consecutive months and is within expected range. All values are now within expected range. SHMI has fallen for in-hospital deaths, out of hospital and weekend admissions.

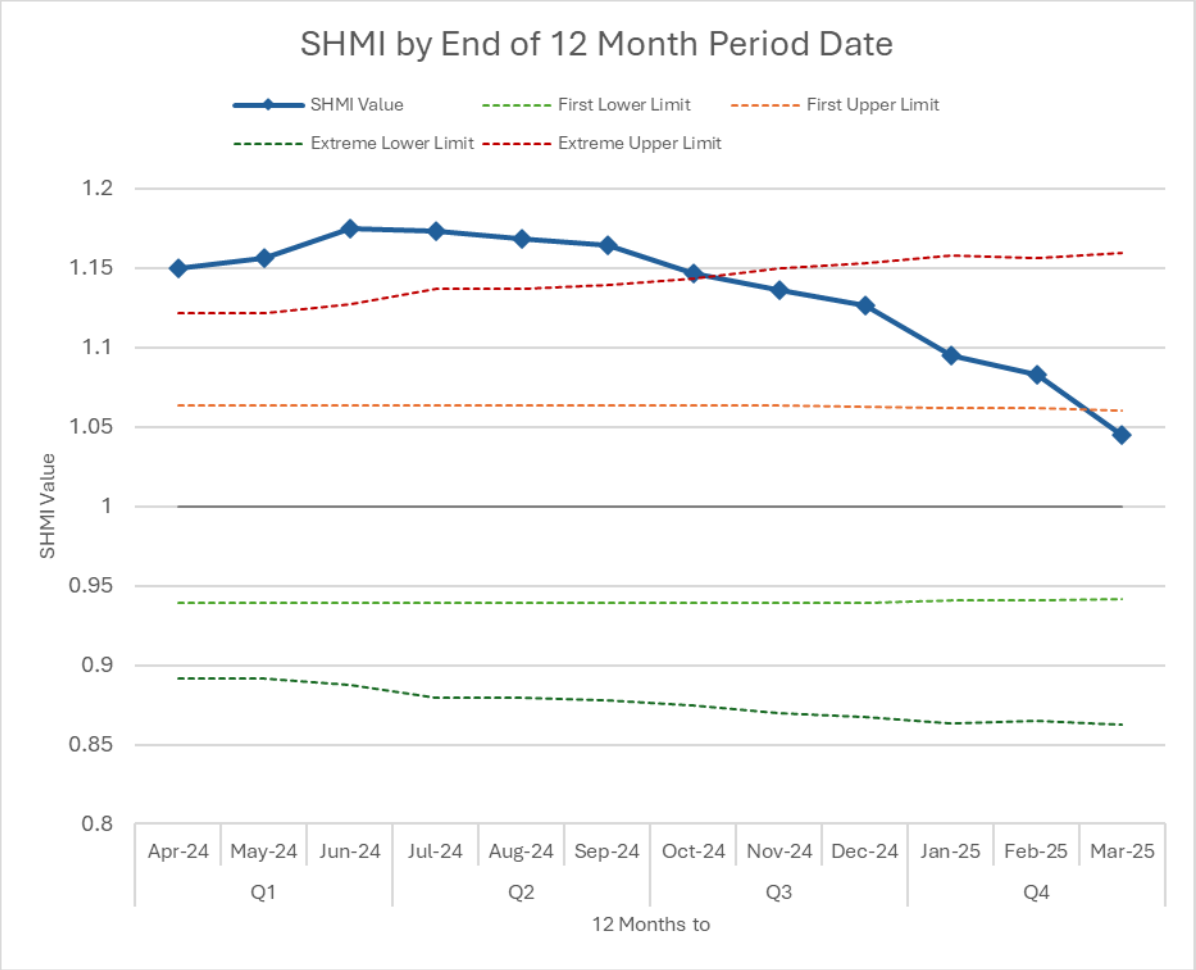


Indicator Set: - HMG Hedlines
Trust: Gloucestershire Hospitals NHS Foundation Trust
Peer Group: - Model Hospital Recommende
Show Only
Create your own indicator sets here:
Create new Peer Groups here:
Search:

Custom Indicator Set: HMG Hedlines	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Jun 2025)	106.56 (Apr 2024 - Mar 2025)	109.07 (Mar 2024 - Feb 2025)	-2.51	106.03	101.08	Within expected range
SHMI - In-hospital (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Jun 2025)	102.34 (Apr 2024 - Mar 2025)	105.62 (Mar 2024 - Feb 2025)	-3.28	103.80	101.06	Within expected range
SHMI - Out-of-hospital (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Jun 2025)	115.61 (Apr 2024 - Mar 2025)	116.41 (Mar 2024 - Feb 2025)	-0.80	110.86	101.18	Within expected range
SHMI - Weekend mortality (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Jun 2025)	120.14 (Apr 2024 - Mar 2025)	121.85 (Mar 2024 - Feb 2025)	-1.71	112.36	107.42	Within expected range
SHMI - Weekday mortality (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Jun 2025)	102.70 (Apr 2024 - Mar 2025)	105.42 (Mar 2024 - Feb 2025)	-2.72	104.07	99.15	Within expected range

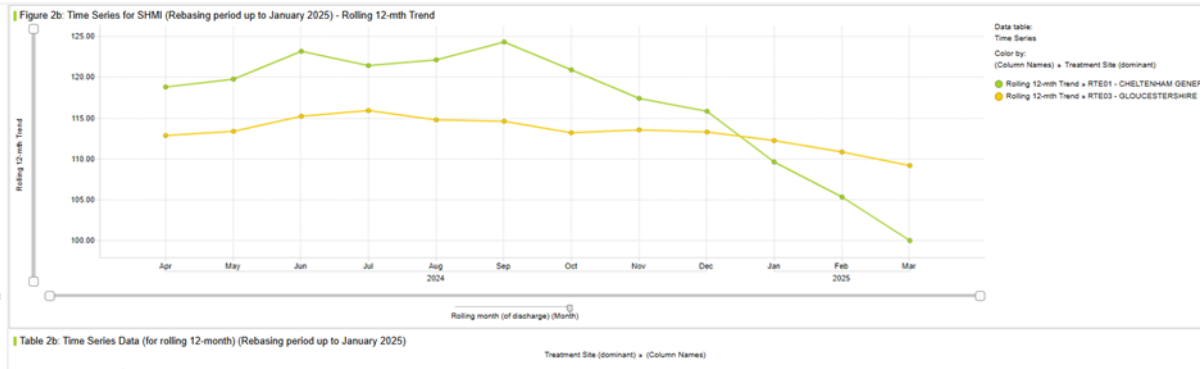
S3.4 SHMI Rolling 12 month Trend

The graph below provides further demonstration of SHMI having fallen for 9 consecutive months, Trust wide. Improvements since August 2024 are clearly shown



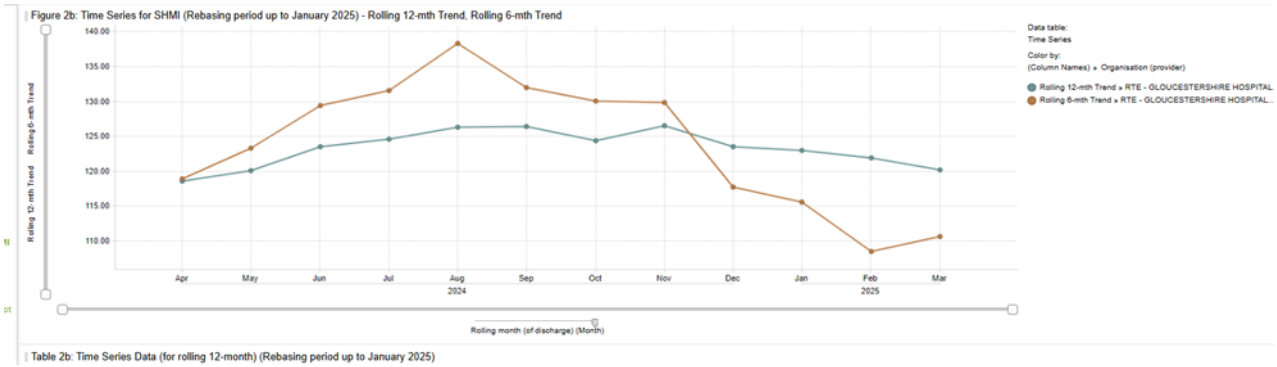
S3.4.1 SHMI-rolling 12 month trend by Treatment Site

The following graph demonstrates a (rolling) 12 month falling trend visible at GRH with a sustained drop at CGH



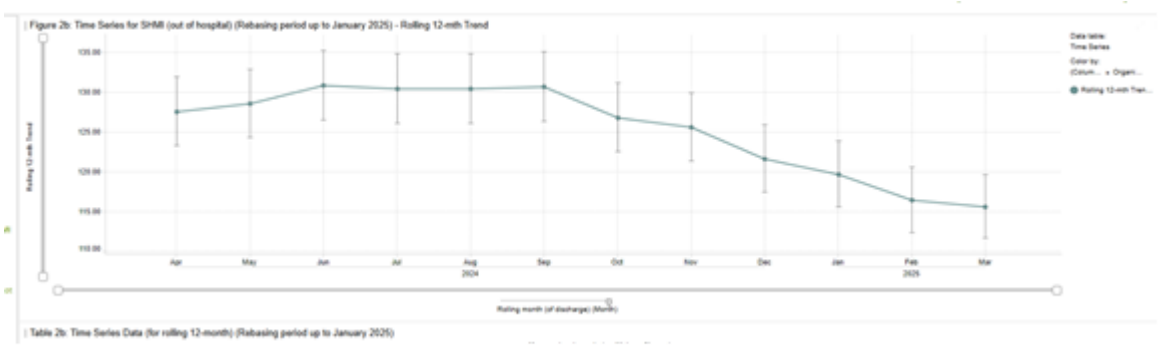
S3.4.2 SHMI-rolling 12 month trend by Day of Admission - Weekend Mortality

The following graph demonstrates a falling trend in weekend mortality in Q4 of 2024/2025



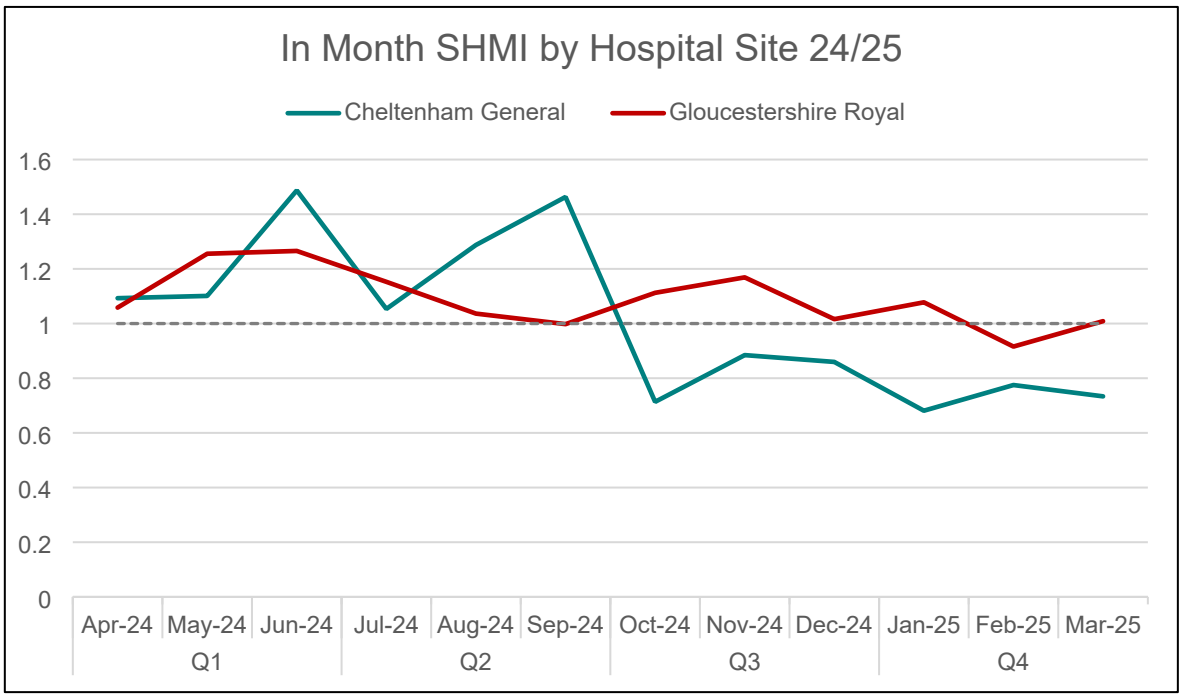
S3.4.3 SHMI-Out of Hospital rolling 12 month trend 30-day mortality indicator shows

The following graph demonstrates a falling trend in 12m rolling; deaths within 30 days, outside of hospital**.**



S3.4.3 In-month SHMI Values (HED) by Site

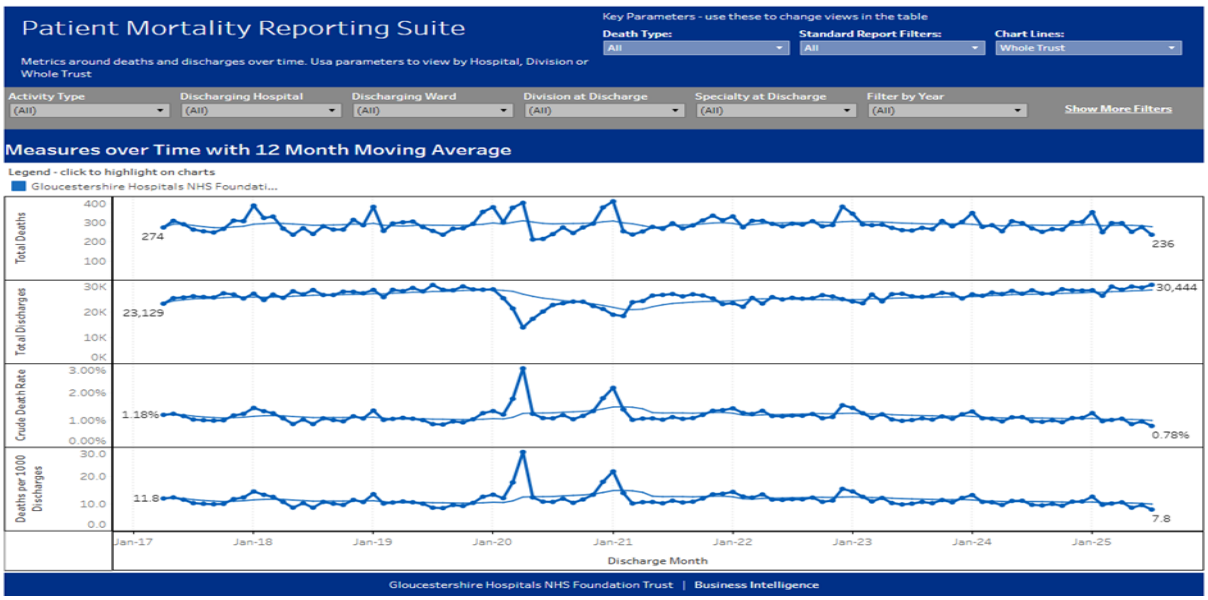
The following graph demonstrates SHMI values based on individual months of discharge. The data confirms a marked improvement in both hospital sites, particularly Cheltenham, following the start of coding improvement and remedial coding in October 24.



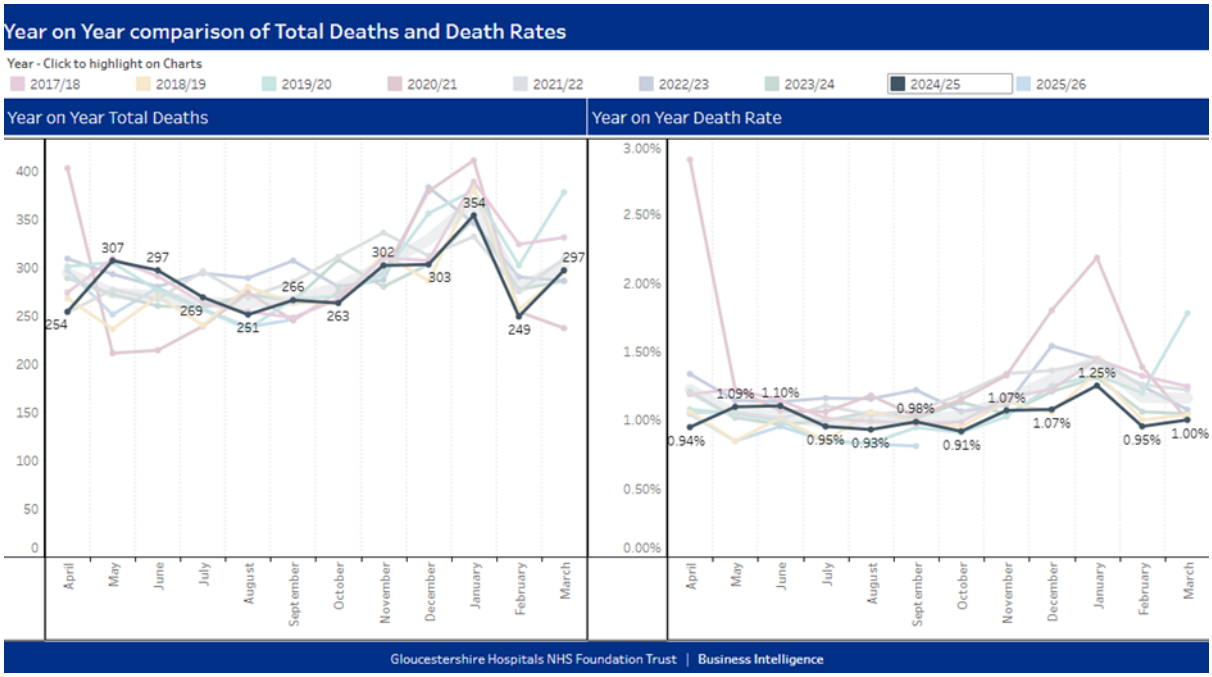
S3.5 Actual (crude) Mortality

Crude mortality rates measure how many people die in a population over a certain period of time—usually one year. It doesn't look at the cause of death or the age of the people who died. It just gives a general idea of how common death is in that population.

The table below demonstrates that 12 month rolling hospital crude mortality trend is still falling over the reporting period with the usual uptick in winter seen in December/January.



The graph below provides a year on year comparison for combined in hospital and 30-day community deaths and demonstrates a lower overall mortality in 24/25 than previous years



S3.6 Coding Audit and Coding Improvement Project

Insufficient data capture of the complexity / co-morbidities of in-patients has been a key factor in adverse SHMI data. This has been addressed through our SHMI Quality Improvement Group.

Simple coding guides for junior clinicians clerking patients on admission have been produced, promoted and distributed via cards, screen savers, education packages and at Grand Round. Remedial changes to clinical documentation and coding have had a dramatic effect. Plans have been produced by Business Intelligence and Clinical Coding to aid sustainability of this improvement.

Targeted work has identified 2 main missed co-morbidities-Chronic Kidney Disease and Chronic Small Vessel Disease.

The use of R codes has decreased. These codes are used when a specific primary diagnosis is not coded and the lower the rate of R codes, the higher our data quality is. This reduction in R codes has improved our SHMi position.

S3.6.1- Charlson Co-morbidity Index

The Charlson Comorbidity Index is a medical tool used by doctors to estimate how likely a person is to live for the next 10 years, based on their existing health conditions (called comorbidities). It helps guide decisions about treatment plans, especially for people with multiple health issues.

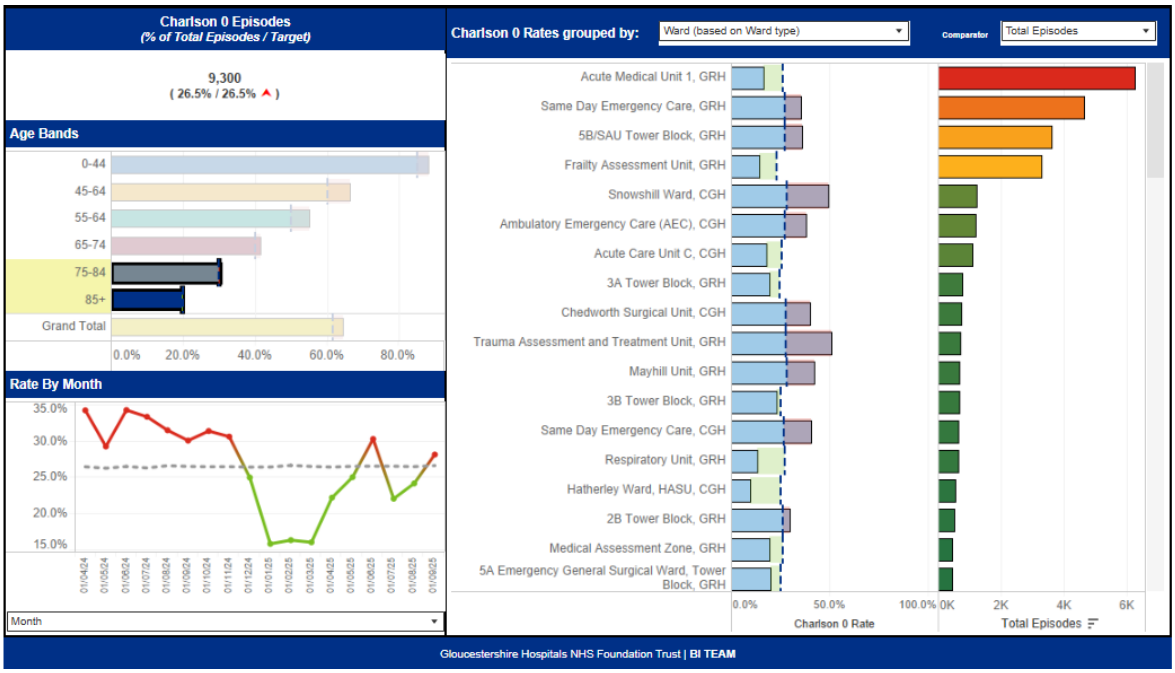
The index looks at 17 different health conditions, such as heart disease, diabetes, cancer, and AIDS.

Each condition is given a score based on how serious it is and how much it affects survival.

Age also adds points: the older you are, the higher your score. The scores are added up to give a total Charlson score.

A Charlson score of 0 means the person does not have any of the listed serious health conditions, their estimated 10-year survival rate is high, they are generally considered low risk when it comes to complications or mortality from other treatments or illnesses. The score is helpful in understanding a patient's overall health risk, how aggressive treatment should and plans for hospital stays, surgeries, or long-term care.

The graph below provides Charlson 0 data, filtered by patient's over 75 years of age. It demonstrates improvements since April 2024, particularly for emergency admissions, showing a reduction in the number of "Charlson Zero" coded patients, showing that the coding teams are now capturing the medical complexity of our patients



S3.7. Delay Related Harm (ED >8h)

Delay-related harm in the context of NHS hospital admission refers to physical or psychological harm that a patient may experience due to delays in receiving necessary clinical treatment or care.

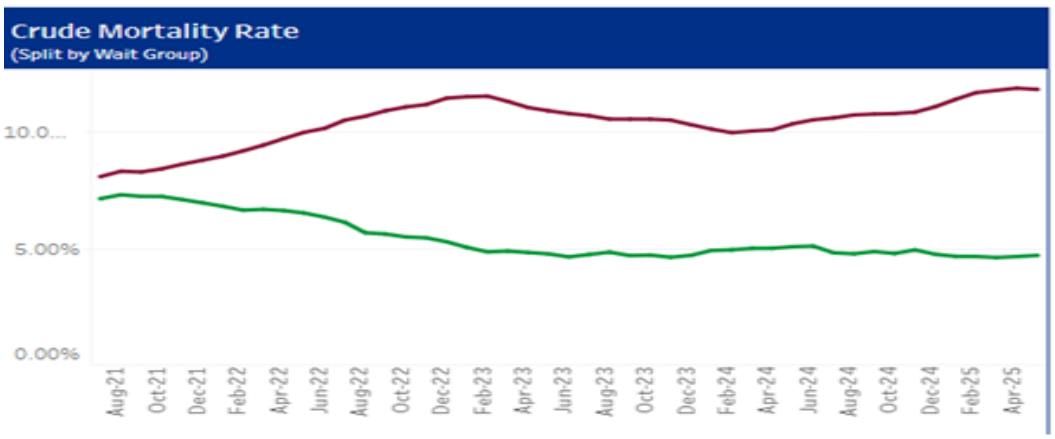
Delay related harm in respect of Emergency Department waiting times (>8 hours to admission) has been reported at a national level.

In GHT, mortality rates between these 2 wait groups are 15.7% in those waiting >8hrs compared to 9.7% in those <8hrs. This affects overwhelmingly older patients, with over 70's contributing 304 of the 348 excess deaths.

Flagging up these issues has been a key priority for Hospital Mortality Group (HMG) ongoing and requires the Clinical Vision of Flow team, Frailty Clinical Program Group, System Mortality Group and all Gloucestershire Partner organisations to improve joint care in particular for the frail, elderly population, who are at more risk from delay related harm

- Earlier use of RESPECT/Advanced Care Planning
- Focus on Patient's wishes for place of care and intensity of medical input
- Admission voidance by better use of Community based care teams/Primary Care
- Direct admission to FAS (Frailty Assessment Unit), SDEC (Same Day Emergency Clinic) or Medical Assessment Unit (MAU) avoiding ED (Emergency Department) wherever possible
- Quicker turnaround and discharge for frail, elderly patients who do require input from secondary care
- Reduction of deconditioning and hospital harms, with fewer ward moves

The graph below demonstrates crude mortality rates of patients in the two cohorts: < and > 8 hour waits in the Emergency Department.



S3.8 Mortality Insights Visit

Although outside the reporting period for this report, the Trust hosted a Mortality Insights Visit in July 2025. Executive, Non-Executive, Safety, Quality and Improvement leads from our Integrated Care Board and NHS England (Southwest), visited the Trust, meeting with our Executive team, Associate Medical Director (Safety), Chief Registrar, Mortality, Digital, Patient Safety and Improvement leads. The visit was part of our SHMI improvement programme and arranged to provide assurance to colleagues on intensive work undertaken to reduce SHMI.

The Trust were commended for successfully returning its Summary Hospital-level Mortality Indicator (SHMI) to within expected limits. The visit highlighted the Trust's strong clinical focus, effective collaboration between clinicians and coders, and the implementation of quality improvement initiatives.

Key recommendations from the visit include closer integration between business intelligence, clinical, and quality teams; standardisation of quality markers across directorates; and a review of frailty and deconditioning strategies. The visit also emphasised the need for robust training in structured judgment reviews, succession planning, and the development of a mortality dashboard. The Trust were encouraged to continue strengthening system-wide collaboration and to ensure clear accountability and governance structures.

The System Quality Improvement Group process was concluded after this visit. The Trust's Hospital Mortality Group are responsible for the resulting action plan; monitoring and assuring the action plan through to closure.

S3.9 Conclusion:

- 12 month rolling SHMI for the Trust at end of March 2025 is "As Expected"

- Hospital Mortality group in combination with Gloucestershire Mortality Group under the ICB have now completed the workplan supported by NHSE to investigate and improve data and care factors which have an impact on SHMI.

- To date, all issues found relate to data rather than care. Ongoing Quality Improvement work involving clinical and coding teams have already shown data improvements which have led to increases in calculated mortality risk hence large reduction in monthly SHMI.

- Resourcing remedial coding is required to maintain these improvements to SHMI and prevent recurrent resources used up by external scrutiny process.

4. Structured Judgement Review Process

4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They continue to ensure all deaths are recorded in real time.

4.2 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach is embedded within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.4 The following table illustrates the percentage of deaths (requiring review) that were reviewed within 3 months in the reporting period. There is a notable upward trajectory in the reporting period.

	Total Deaths	SJR's Completed	% Review within 3 mths
Q2 2024/2025	471	123 (22.9%)	60%
Q3 2024/2025	558	69 (12.4%)	67%
Q4 2024./2025	576	121 (21.7%)	73.6%

4.5 Key themes relate to communication, documentation and End of Life care pathways

4.6 The following table compares SJR related data between 2024/2025 and 2023/2024

	2024/2025	2023/2024
Total Number of Adult Deaths	2142	2091
Deaths investigated as harm incidents/complaints (No SJR undertaken)	8	9
Deaths selected for review under SJR methodology with concerns	59	122

Deaths selected for review under SJR methodology with no concerns	349	322
Total number of Deaths selected for review under SJR methodology (% of total deaths)	17.8%	*Data Anomaly
Deaths investigated as serious or moderate harm incidents Following SJR	1	2

4.7 The Trust have met the overall 10% death review standard in 2024/2025. Completion of key learning messages remains low across divisions, though showing quarter-to-quarter improvement

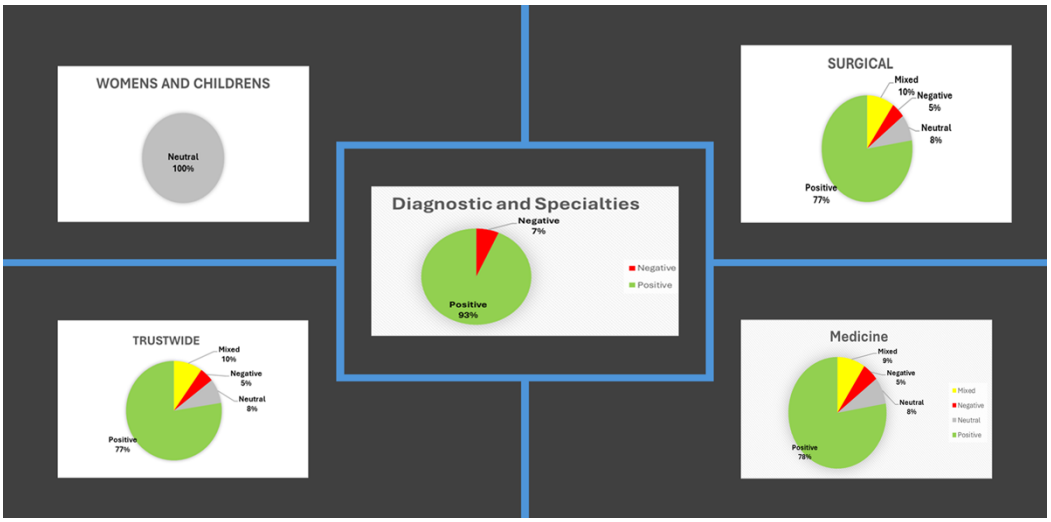
5. Family Feedback from Bereavement team

The following summarises the category of family feedback in the reporting period as captured by the bereavement team:

Review of family feedback in Q2, Q3 and Q4 of 2024/2025 confirms that positive feedback is consistently high regarding the care provided, with the care experience being described as good and a number of staff being named individually. Communication is identified as a negative theme within the feedback collected.

Overall, positive trends focused on good care and considerate staff, while negative trends primarily involved communication and nursing contact, with several referrals made to PALS across specialties.

The following illustrates the nature of feedback as at Q4 of 2025/2025:



6. LeDeR Report (Learning from lives and deaths - people with a learning disability and autistic people)

On average there are 1 – 2 deaths per month of a person with a Learning Disability, but this average does mask peaks and troughs. All deaths of patients with a Learning Disability and/or Autism (confirmed diagnosis) are reported to LeDeR. The Learning Disability Team also contribute time to assisting reviewers with interpretation of notes of people who had been in hospital, but died elsewhere.

LeDeR reviews usually do not reach the QA panel until at least 6 months after the person has died, as it takes that long for the reviewers to be able to interview family and carers and to review professionals' notes and then write their report. Feedback on deaths of people with LD or autism will therefore not reach staff involved for at least 6 months. Even

then, feedback can only be shared if family have given permission for this, and whether they give this consent or not is variable. In the majority of cases to date in 2024/2025 consent has not been given. The LeDeR QA panel have been questioning how helpful this is to staff and are looking at ways of feeding back to staff without sharing disproportionately.

There has been variation in numbers of deaths throughout 2024/2025, in that the 'odd' quarters have had high numbers of deaths and the 'even' quarters had low numbers of deaths. LeDeR have only completed reviews on 2 of the 4 deaths in Q4. These were both graded as 'good'.

All Q1 deaths have been graded as either good or excellent care, with the exception of one case still awaiting coroner feedback. 2 of the 4 deaths in Q2 have concluded LeDeR reviews – one of these was graded excellent and the other was graded 'adequate' because that person's final care home was sub-optimal, not because of hospital care. Only 4 of the 11 deaths in Q3 have concluded LeDeR reviews. These were all graded 'adequate' or 'good'. One of the reviews graded 'adequate' was a lady who was in the Emergency Department at GRH for an excessively long time.

Relatives of these patient cohorts regularly comment that they would like side rooms as bays are too noisy. The LeDeR QA panel are well aware that our supply of side rooms is very limited and Infection Control has first call on them. Relatives consistently comment very positively on the support they receive from the Learning Disability Liaison Nurses and the Palliative Care team, as well as the bereavement calls which are made by both ED and DCC.

7. Increased Incidence of Still Birth

There has been an increase in the incidence of still births (September to December 2024). There were 9 stillbirths at GHNHSFT across quarter 3. All stillbirths have undergone a robust review and have been referred to the Patient Safety Review Panel.

An initial cluster review was undertaken and a number of themes were identified. Immediate learning was shared with the relevant teams and each stillbirth was presented at Patient Safety Review Panel for oversight, escalation and agreement on the appropriate review process. The action plan arising from the still birth review is being monitored and assured through to closure by the Maternity Safety Experience and Review Group meeting. Any additional learning, action improvement identified through the individual PSII investigations will be linked or added to this action plan.

8. Conclusions

8.1 All deaths are reviewed within the Trust via the independent Medical Examiner Service.

8.2 There is good local learning from concerns in care and ensuring these are being reflected within specialties. The need for the outcome of SJR reviews to be reflected in Trust-wide improvement programmes and PSIRF safety priorities is recognised as is the need to improve the percentage of SJR's being completed, within three months. A review (utilising a QI approach) of SJR process, compliance and outcomes is ongoing

8.3 Learning from safety incidents that meet the criteria for serious incidents and PSIRF learning responses, is monitored and assured through SERG; Safety Experience and Review Group. Summaries of learning from those incidents (where the patient has subsequently died) are found in Appendix 1 (for QPC only).

8.5 It is clear that the positive feedback is consistently high regarding the care provided. A review of the Trust's process for feeding back (to families) findings of SJR is being undertaken. It is recognised that proactive feedback may improve experience and reduce concerns and complaints. Piloting of the approach will be taken forward by Oncology and Respiratory in the coming weeks.

8.6 12 month rolling SHMI for the Trust at end of March 2025 is "As Expected"

Hospital Mortality group in combination with Gloucestershire Mortality Group under the ICB have now completed the workplan supported by NHSE to investigate and improve data and care factors which have an impact on SHMI.

To date, all issues found relate to data rather than care. Ongoing Quality Improvement work involving clinical and coding teams have already shown data improvements which have led to increases in calculated mortality risk hence large reduction in monthly SHMI.

Resourcing remedial coding is required to maintain these improvements to SHMI until the planned structural changes to processes are embedded

Authors: Jo Mason-Higgins, Acting Associate Director of Safety (Investigation and Family Support)
Charlie Candish, Associate Medical Director (Safety and Mortality)

Presenter/s: Charlie Candish, Associate Medical Director (Safety and Mortality)
Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO

Report to Public Board				
Date	13 November 2025			
Title	Tower Block, Gloucester Royal Hospital, Essential Works Briefing			
Author / Sponsoring Director/ Presenter	Mark Pietroni			
Purpose of Report (Tick all that apply ✓)				
To provide assurance		To obtain approval		
Regulatory requirement		To highlight an emerging risk or issue		
To canvas opinion		For information		✓
To provide advice		To highlight patient or staff experience		
Summary of Report				
The report provides an overview of the Tower Block Essential Works Programme.				
Risks or Concerns				
This programme sets out a plan for mitigating the Trust fire risks associated with the Tower building at Gloucester Royal Hospital (GRH). Risks and issues are recorded on a Programme Risks and Issues register. Risks of 12 and above are reported regularly and reviewed at the Monthly Programme Board Meeting. The current risks, 12 and above, relate to potential delays in implementing the Essential Works and ability of the system to deliver the Discharge Ready Date plan and the associated responsiveness to Urgent Emergency Care demand.				
Financial Implications				
N/A				
Approved by: Director of Finance / Director of Operational Finance			**Date:**	
Recommendation				
Recommendation to accept this paper as a briefing on the Programme.				
Enclosures				
Tower Essential Works Briefing Nov 2025				

Gloucestershire Hospitals
NHS Foundation Trust

GHFT Tower Essential Works - Update
Briefing for Public GHFT Trust Board meeting - November 2025

1. Introduction

This paper provides an update on the GRH Tower Programme of work.

2. Overview of the Programme and works

The Tower Block is 50 years old and has stood as a landmark on the Gloucester skyline since the 1970s, providing care for thousands of patients over the decades. While the exterior has recently benefited from a £11 million upgrade to help improve energy efficiency, and an improved external appearance, we must now turn our attention to the inside of the building.

A critical area of work will be upgrading the fire infrastructure system in the tower, including the fire alarm and fire doors, to meet the latest safety regulations, protect our patients, staff and visitors, and ensure our buildings are fit for the future.

In order to replace the fire infrastructure system there is a need to carry out works on each ward within the Tower. The scope of the work will include the replacement of the fire infrastructure system, the nurse call bell system, planned work to develop same day emergency services in the Tower and improve the overall ward environments.

To undertake this work there is a need to decant each ward within the Tower. The plan is to empty two wards on a floor of the Tower and to use this as a decant space, enabling the Contractors to upgrade two wards, one floor, at a time. It is estimated that the work will take approx. 4-6 months per floor (overall approx. 4 years to complete the Tower wards).

3. Creating the decant floor

The creation of the decant floor (2 wards) is now underway as outlined below:

Neurology
Temporarily move Neurology services (including the Neurology Ward, Brain Injury and Neuro therapy) from GRH to Prescott at CGH. It is proposed that these services remain at CGH until the Tower works are complete. This temporary move will release a ward for a decant ward.

The briefing of staff impacted by the Neurology service commenced in July. Staff continue to be fully involved and engaged in the plans for this temporary move. It is anticipated that the move will take place in May/June 2026, dependent on build timescale requirements at Prescott, CGH.

Getting people Home
Reconfigure three wards in the GRH Tower, to create a colocated Vascular and Endocrine Ward, a General Medicine Ward and release a ward to be used as a decant ward. This move is supported by and aligned to a system Programme, to support patients who are fit to leave hospital (Discharge Ready Date – DRD) to move to the most appropriate setting, whether that's at home or in another community setting across October to December.

The above ward changes required staff consultation which commenced in September with formal consultation completed on 4 November. All staff impacted by these changes have been supported to find suitable roles in the Trust.

4. Impact of the planned change

The Tower Essential Works Programme will not impact on acute hospital services remaining in GRH Tower.

There will be some changes to service locations to accommodate this work, but all moves associated with the Tower Essential Works are considered temporary.

There will be no change in the range of Neurology services provided, including the Neurology Ward, Neurotherapy and Brain Injury services. However, there will be a change in location for these services.

- Inpatient services - patients requiring a neurology admission will be admitted to CGH
- Outpatient services – some services will move to CGH eg hot clinics and patients who need to attend a therapy gym

The proposals for the Tower Essential Works at Gloucestershire Royal were presented to HOSC for discussion and supported.

5. Benefits and Risks

The primary benefit of the Tower Essential Works Programme is to ensure compliance with fire safety standards and to make sure that the Tower is safe for our patients, staff and visitors. Upgrading the overall ward environment will also improve patient experience and staff working environment.

The Trust currently has the fire risk on the risk register. The risks of not addressing fire-safety non-compliance in the Tower, outweighs the risk of implementing these temporary service moves.

6. Department of Critical Care (DCC)

The DCC is out of scope for this Programme, but is part of a separate piece of work, to develop a new build on the GRH site, to accommodate this service.

7. Timeline

Once the preparatory moves have taken place and the sixth floor in the Tower is released, the essential works will commence in the Tower. This will begin with an upgrade of the sixth floor, which will be used as the decant ward for the first two years. Subsequently the eight floor will be used for decant during years three to four, and thereafter will be available for alternative use, including decant.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Tower Essential Works

Ward Changes Decant Plan – Presentation to TLT 30 Oct 2025

the Best Care for Everyone
care / listen / excel

Ward decant and ward end location plan

Fire Safety infrastructure and Nurse Call Systems need to be replaced in the Tower. To do this work, Tower wards will need to be decanted. Works to be carried out by floor (approx. 6 months per floor, overall, 4 years).

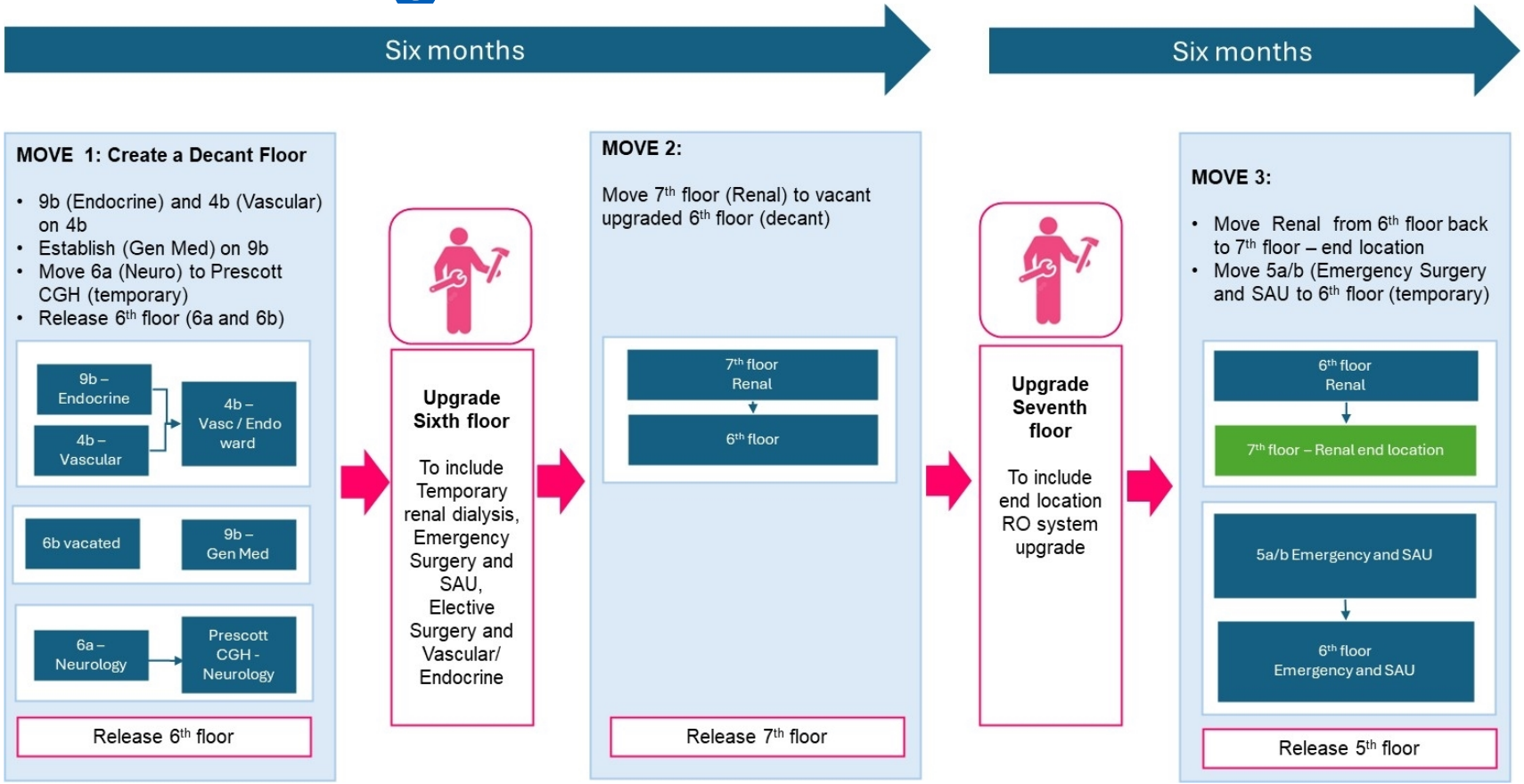
Decant: First step is to create a decant floor:

- Neurology services (Neurology ward, Brain Injury, Neurotherapy) temporarily move to CGH
- Vascular and Endocrinology - bed base on 4b
- General Medicine ward created on 9b
- Supported by a system plan, to enable patients who are fit to leave hospital (Discharge Ready Date – DRD) to move to the most appropriate setting.
- 6th floor released as a decant floor

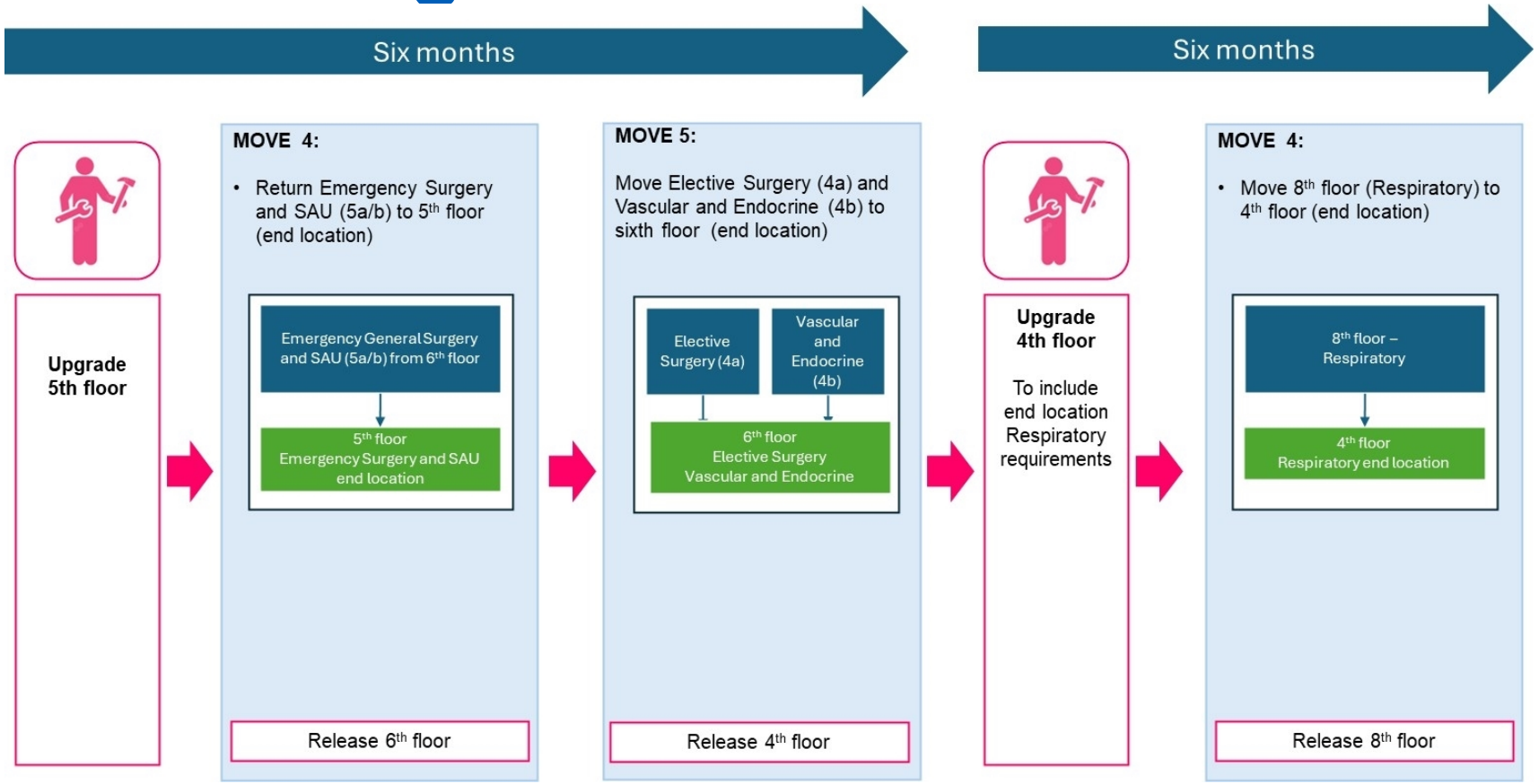
Ward end location: Majority of wards return to their base wards, apart from

- Respiratory moves from 8th floor to 4th floor (to reduce fire/clinical risk)
- Vascular, Endocrine and Elective Surgery move from 4th floor to 6th floor r

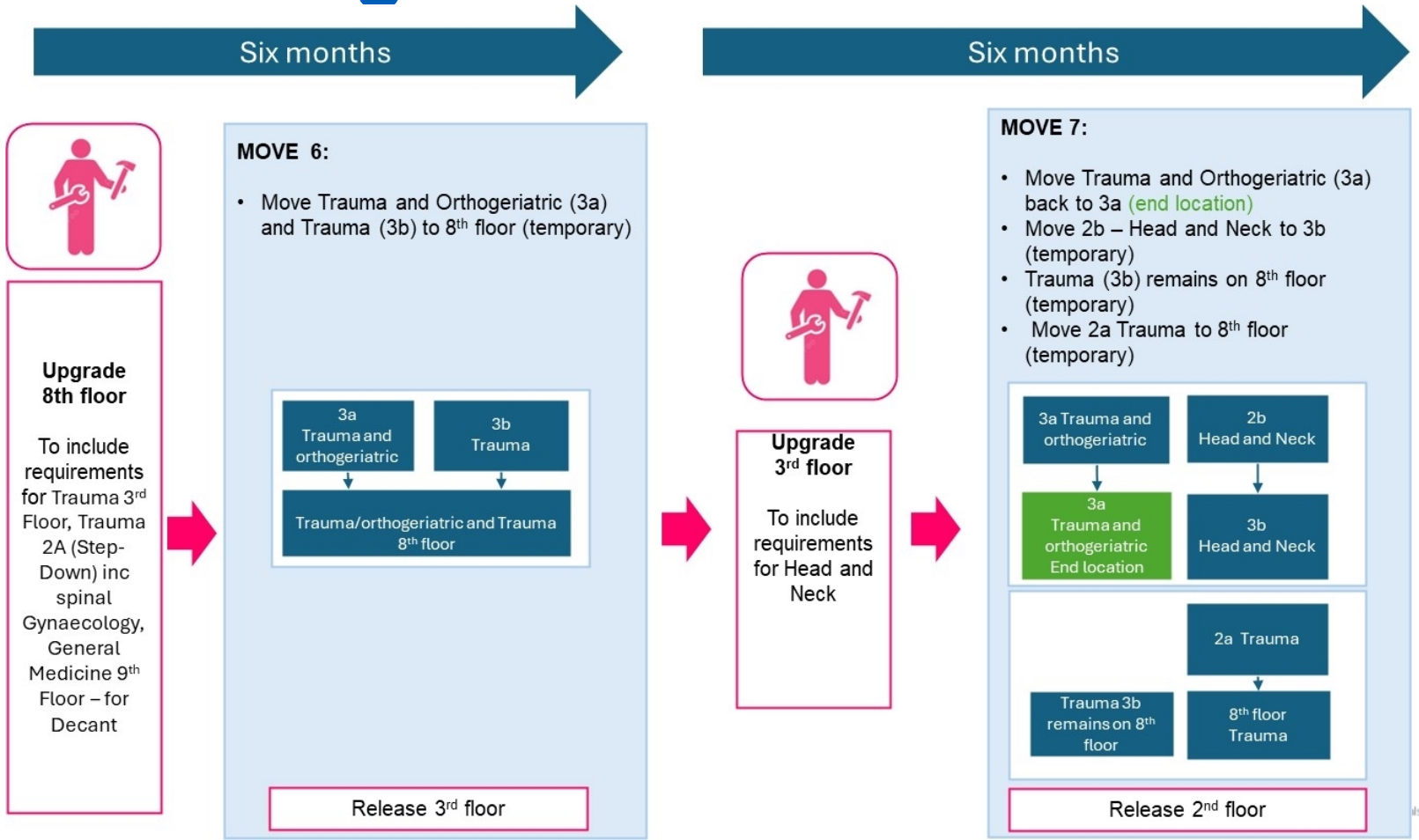
Ward change decant Year 1



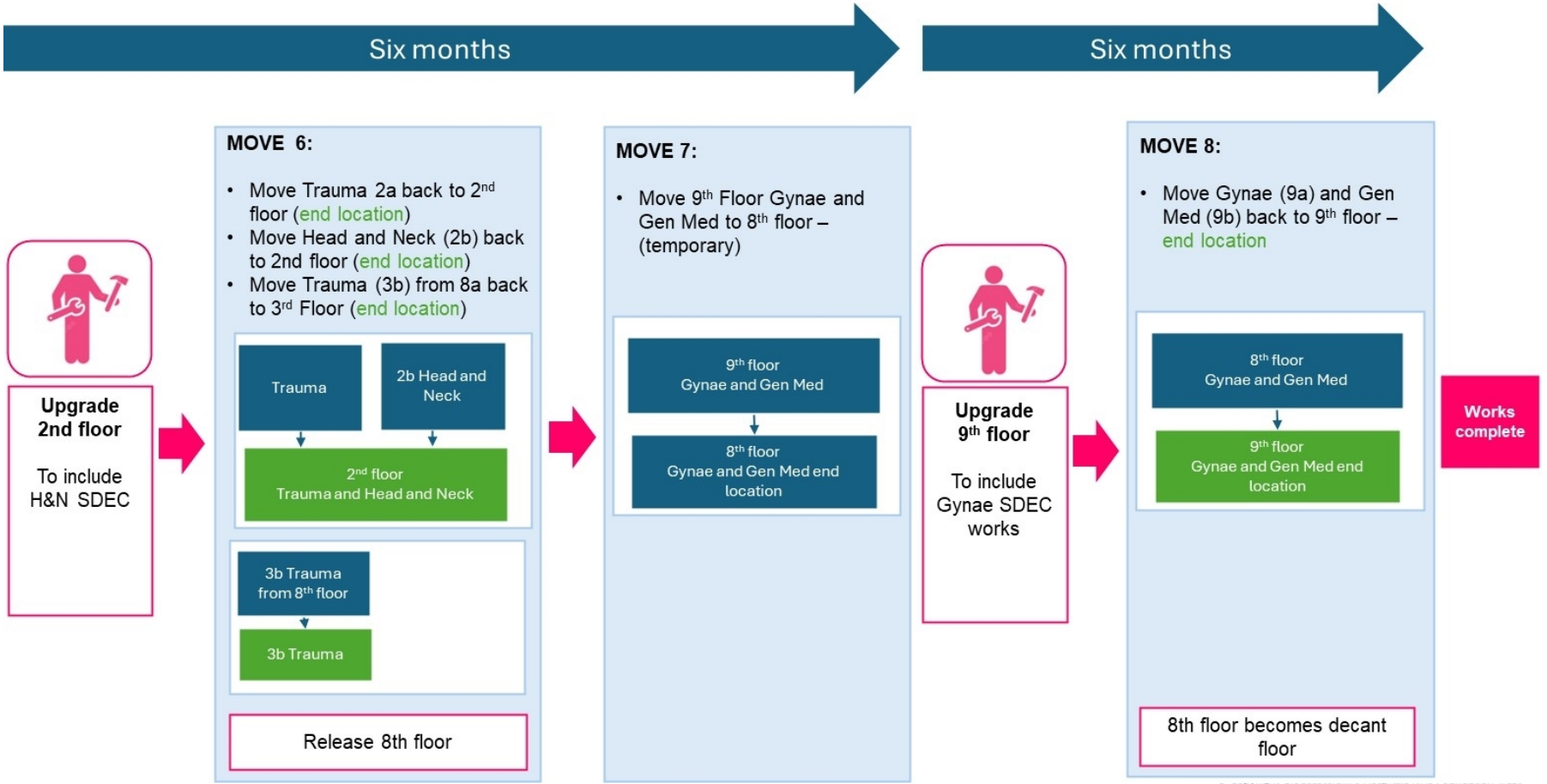
Ward change decant Year 2



Ward change decant Year 3



Ward change decant Year 4



Ward End Location

By Year

Year 1	7 a/b Renal
Year 2	5 a/b Emergency Surgery and SAU 6 a/b • Elective Surgery • Vascular and Endocrine 4 a/b Respiratory
Year 3	3a Trauma and orthogeriatric
Year 4	2 a/b Trauma and Head and Neck 3b Trauma 9 a/b • Gynae • Gen Med end location

At end of Programme

9 th floor	Gynae / Gen Med
8 th floor	Future Decant Floor
7 th floor	Renal
6 th floor	Elective Surgery / Vascular and Endocrine *
5 th floor	Emergency Surgery and SAU
4 th floor	Respiratory *
3 rd floor	Trauma and Orthogeriatric
2 nd floor	Trauma and Head and Neck

* Change in ward end location

KEY ISSUES AND ASSURANCE REPORT
PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE - September 2025

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Phlebotomy strike	Whilst the service impact was minimal, and no excess costs have been incurred, it has a bad effect on morale of those on strike and is time consuming to manage	CEO /HRD/ Director of Nursing to: 1.Pursue all routes to resolution in a timely way 2.continue to build negotiations with the phlebotomists 3. continue to develop and socialist the Health care support worker role model
Workforce sustainability programme	Bank and Agency staff usage are not reducing to meet targets for the year. This is more problematic with medical than nursing staff usage	PODC does not see bank and agency staff usage by Division. Further dialogue is needed at Trust Leadership team level about how to achieve reductions in temporary workforce and the role of HR in supporting this

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Workforce change model	No equality impact assessment has been done on the likely effects of this, either within the Trust or ICB wider. There are no metrics around discussions with GHC on closer collaboration to save money and create more robust systems.	Develop on EIA on the workforce change programme and a retrospective report to inform future programmes Mutually agree some tangible change programmes with GHC
New HR operating model	Due to be implemented in Jan 26 but needs further development.	Report to PODC at next meeting with more granular detail on operating model and key deliverables with timescales
EDI	Remains amber since previous PODC. Lack of support to inclusion networks is reported to Non-Exec Director links.	Report from inclusion networks themselves to PODC. Trust needs to

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

		articulate its aims and deliverable from equalities work
Cultural heatmap	This is promising and is to be piloted in priority areas. Assurance gap is around work being resumed and developed.	Report needed to next PODC on timescales for progress on initial priorities, and for developing and embedding
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Items not Rated		
Risk register:		

Report to Board of Directors

Date	13th November 2025
Title	Workforce Disability Equality Standard (WDES) Workforce Race and Equality Standard (WRES)
Author / Sponsoring Director/ Presenter	Coral Boston EDI Manager, Dr Claire Radley Director for People & OD

Purpose of Report (Tick all that apply ✓)

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

Summary of Report

Introduction: This report presents the Trust's Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) indicators for the 2024/25 reporting period.

The Workforce Race Equality Standard (WRES) was introduced in 2015, with the first report published in 2016. It was developed to monitor progress across nine key indicators aimed at tackling inequality and unfair treatment experienced by Black and Minority Ethnic (BME) staff in the workplace. The Workforce Disability Equality Standard (WDES), introduced in 2019, is designed to help NHS organisations compare the workplace experiences of disabled and non-disabled staff across 10 key metrics.

Following the recent publication of the WDES and WRES data, an Equality, Diversity & Inclusion (EDI) action plan has been developed to address key findings and drive forward improvements across the Trust.

The WRES and WDES Action Plan has been approved by the Equality, Diversity and Inclusion Steering Group (EDISG), the People & OD Group (PODG), and the People & OD Committee. Oversight and monitoring of the Action Plan will be maintained by EDISG and PODG, with progress also tracked at divisional level to ensure continued delivery and impact.

WORKFORCE DISABILITY EQUALITY STANDARD

WDES Metrics Overview

Metric 1: Representation
Percentage of staff in each pay band (Agenda for Change, medical/dental, and very senior managers) who have declared a disability, compared to the overall workforce.

Metric 2: Recruitment
Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants.

Metric 3: Capability Process
Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.

Metric 4: Harassment and Bullying
Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- Patients/service users/public
- Managers
- Other colleagues

Metric 5: Career Progression
Percentage of disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion.

Metric 6: Presenteeism
Percentage of disabled staff feeling pressure from their manager to come to work despite not feeling well enough.

Metric 7: Feeling Valued
Percentage of disabled staff compared to non-disabled staff who are satisfied with the extent to which their organisation values their work.

Metric 8: Workplace Adjustments
Percentage of disabled staff reporting that their employer has made reasonable adjustments to enable them to carry out their work

Metric 9: Staff Engagement
Staff engagement scores for disabled staff compared to non-disabled staff, based on the NHS Staff Survey

Metric 10: Board Representation
Percentage of Board members who have declared a disability compared to the overall workforce.

The Trust has made notable progress across the Workforce Disability Equality Standard (WDES) indicators during the 2024/25 reporting year. Improvements were observed in 9 out of 14 metrics, including indicators 1, 2, 4a–4d, 7, 8, and 10. While some gains were modest, they reflect a positive trajectory and a clear commitment to advancing disability equality.

Disabled staff representation is gradually increasing yet remains disproportionately low in senior roles. Perceptions of career progression are notably lower among both BME and disabled staff, reflecting ongoing national concerns. While uptake of reasonable adjustments is improving in line with national trends, the Trust continues to perform below average across all indicators particularly indicators 3, 5, 6, and 9 highlighting the need for targeted action.

Workforce Data Highlights

Non-Clinical Staff:

- Staff declaring a disability increased by 1.2% (from 110 to 134).
- Non-disabled staff rose by 25.6% (from 1,041 to 1,539).
- Unknown/undeclared status decreased by 26.9%, improving data transparency.

Clinical Staff:

- Staff declaring a disability increased by 1.6% (from 175 to 263).
- Non-disabled staff rose by 25.1% (from 2,967 to 4,333).
- Unknown/undeclared status dropped by 26.7% (from 2,477 to 965).

Senior Leaders (Bands 8A+):

- Increase of 9 staff members declaring a disability (from 19 to 28).
- Highest representation in Band 9 at 14.29% (2 out of 14).

AfC Pay Bands:

- Representation in senior bands (8C, 8D, 9, VSM) increased by 1 staff member (3.1%).
- Highest representation in Bands 1–4, with 5.8% (91 staff) declaring a disability.

Board Representation:

- Positive change with one additional board member identifying as disabled in 2025.

WORKFORCE RACE EQUALITY STANDARD

Indicator 1: Percentage of staff in each of the AfC (Agenda for Change) pay bands (or medical and dental subgroups) compared with the overall workforce.

Indicator 2: Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.

Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

Indicator 4: Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months.

Indicator 7: Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion.

Indicator 8: Percentage of staff personally experiencing discrimination at work from a manager,

team leader or other colleagues.

Indicator 9: Percentage difference between the organisation's Board membership and its overall workforce with respect to BME representation

The Trust has made progress in six of the nine WRES indicators (1, 5, 6, 7, 8, and 9), demonstrating the impact of targeted actions taken over the past year. However, indicators 2 and 3 have declined, signalling areas that require further strategic focus. While BME representation is improving, gaps remain at senior levels, in contrast to more significant national progress.

Recruitment bias persists, with white applicants more likely to be appointed, a trend mirrored nationally. Additionally, perceptions of career progression and experiences of bullying and harassment remain less favourable among BME and disabled staff, reflecting ongoing concerns both locally and across the NHS.

Workforce Data Highlights

Non-Clinical Staff:

- BME representation increased by 1.3% (from 191 to 217).
- White representation remained stable, with a slight 0.2% increase.
- Unknown ethnicity declarations decreased by 1.6%, improving data accuracy.

Clinical Staff:

- BME representation rose by 2.7% (from 1,280 to 1,417).
- White representation decreased by 1.3% (from 3,590 to 3,479).
- Unknown ethnicity declarations dropped by 1.3%.

Senior Leaders (Bands 8A+):

- BME senior leaders increased from 41 to 43 which equates to an increase of 0.4%
- Highest representation seen in Band 8C, with 15.6% BME staff, an increase of 3.36%.

Risks or Concerns
N/A

Financial Implications
N/A

Approved by:	**Date:**

Recommendation
The Board is requested to review and assure the implementation of the WRES and WDES Action Plan. Although formal assurance is pending, the **draft** action plan has been published in advance to meet the NHS England submission deadline of 31st October 2025. In accordance with NHS England requirements, the Trust must publish its WRES and WDES action plans. Compliance with this mandate is monitored by NHS England to ensure transparency, accountability, and continuous improvement in workforce equality outcomes.

Once assurance is received, the draft action plan will be replaced with the final version.
Enclosures
WRES/WDES 2025-2027 Action Plan

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Workforce Disability Equality Standard (WDES)

ACTION PLAN

2025–2027

Workforce Race and Equality Standard Indicators

1. Indicator 1: Percentage of staff in each of the AfC (Agenda for Change) pay bands (or medical and dental subgroups) compared with the overall workforce.
2. Indicator 2: Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.
3. Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.
4. Indicator 4: Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff.

Staff Survey Indicators

5. Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
6. Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months.
7. Indicator 7: Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion.
8. Indicator 8: Percentage of staff personally experiencing discrimination at work from a manager, team leader or other colleagues.

Board Representation Indicator

9. Indicator 9: Percentage difference between the organisation's Board membership and its overall workforce with respect to BME representation

WDES Metrics Overview

Metric 1: Representation

Percentage of staff in each pay band (Agenda for Change, medical/dental, and very senior managers) who have declared a disability, compared to the overall workforce.

Metric 2: Recruitment

Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants.

Metric 3: Capability Process

Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.

Metric 4: Harassment and Bullying

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- Patients/service users/public
- Managers
- Other colleagues

Metric 5: Career Progression

Percentage of disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion.

Metric 6: Presenteeism

Percentage of disabled staff feeling pressure from their manager to come to work despite not feeling well enough.

Metric 7: Feeling Valued

Percentage of disabled staff compared to non-disabled staff who are satisfied with the extent to which their organisation values their work.

Metric 8: Workplace Adjustments

Percentage of disabled staff reporting that their employer has made reasonable adjustments to enable them to carry out their work

Metric 9: Staff Engagement

Staff engagement scores for disabled staff compared to non-disabled staff, based on the NHS Staff Survey

Metric 10: Board Representation

Percentage of Board members who have declared a disability compared to the overall workforce.

WRES/WDES Indicator and Trust Action	Aligns with High Impact Actions 1, 2, 3, 4, 5 and 6			
	Current position	**Objective**	**Action Planned for 25-27**	**Outcome Measures**
WRES Indicators 1, 2 and 7 **WDES Indicators 1, 2 and 5** **Aligns with EDI Trust Action 4 – EDI Team Actions**	22% of our workforce identify as being from Ethnic Minority backgrounds. 4.9% of our workforce identify as Disabled. Despite this, there is a disproportionate underrepresentation of both EM and Disabled colleagues in senior clinical and non-clinical roles.	To improve the representation of Ethnic Minority and Disabled staff across senior levels of the organisation	Complete detailed WRES and WDES data analysis at divisional level to identify disparities in: ***Divisional Workforce Analysis*** • Applications, shortlisting and recruitment outcomes • Promotion and career progression opportunities • Access to secondment and acting up roles ***Inclusive Recruitment & Selection*** • Review and revise recruitment and selection processes to ensure equitable access and outcomes for EM and Disabled applicants • Increase representation of EM and Disabled colleagues on selection panels • Introduce targeted training for panel members to reduce bias and promote inclusive decision making ***Career Development Support*** • Develop tailored career development pathways for EM and Disabled staff, including mentoring, coaching and leadership programmes • Ensure accessibility and reasonable adjustments are embedded in all development opportunities • Monitor uptake and outcomes to ensure equitable access and progression • Continue with Interviewing with Impact Workshops using our feedback to shape future workshops for our colleagues across the organisation. This will also include support with personal statements and job applications	• Aim to Increase the number of EM staff in senior roles (Band 8a and above). Baseline (2025): 43 EM staff out of 474 (9.07%). Target (2027): Increase to at least 48 EM staff (10.13%). • WDES: Aim to increase the number of Disabled staff in senior roles (Band 8a and above). Baseline (2025): 28 Disabled staff out of 474 (5.91%). Target (2027): Increase to at least 34 Disabled staff (7.17%). • Greater diversity represented on Interview panels. Ensure Inclusion Champions are present on all Band 8a+ interview panels and that all Inclusion Champions have undergone a new and refreshed Inclusion Champion training by 2027. • By 2027 we aim to have more positive feedback from EM and Disabled staff on career development and progression opportunities • Increased awareness and inclusive behaviours among senior leaders through reciprocal mentoring. A target (by 2027) of

			Reciprocal Mentoring Programme • Launch a reciprocal mentoring initiative for members of the Inclusion Network, pairing them with Senior Leaders to share lived experiences and perspectives related to varying members of the Inclusion Network • Use insights from the programme to inform inclusive leadership practices and drive cultural change ***Monitoring & Accountability*** • Establish divisional accountability for progress against WRES and WDES indicators • Report quarterly on progress and impact to the Trust Board and EDI Steering Group	establishing at least 30 active mentoring pairs. • Use insights from reciprocal mentoring programme to inform inclusive leadership practices and drive cultural change. Embed learning into leadership development and EDI strategy
WRES Indicator 1 **WDES Indicator 1** **Aligns with EDI Trust Action 4 – EDI Team Actions**	22% of staff as identify as being from Ethnic Minority backgrounds. 4.9% of staff identify as Disabled. Declaration rates on ESR remain lower than expected, limiting the accuracy of workforce data and the ability to target support effectively.	Increase the number of staff completing their equality and diversity declarations on ESR, enabling more accurate workforce data and better-informed EDI interventions.	***ESR Declaration Campaign*** • Launch a Trust-wide campaign to encourage staff to update their personal data on ESR, focusing on ethnicity, disability, sexual orientation and other protected characteristics. • Particular focus around understanding how and why to complete for disability status • Communicate the importance of declarations for improving inclusion, representation and access to support • Knowledge sessions around declarations and using Access to Work ***EDI Team Support*** • The EDI team will offer direct support to staff through drop-in sessions, guidance materials, team support in low declaration rate areas, and one-to-one assistance • Collaborate with staff networks and divisional leads to promote the campaign and address concerns around confidentiality and data use ***Monitoring and Reporting*** • Track declaration rates monthly and report progress to the EDI Steering Group and Trust Board • Use improved data to inform targeted actions across WRES and WDES indicators	• Increased declaration rates on ESR across all protected characteristics. We aim to decrease from our 2025 position of 11% unknown ethnicity to 9% unknown ethnicity by 2027. • For disability, we want to decrease from our 2025 position of 16.59% unknown disability to 14.59% unknown disability by 2027. • More accurate workforce data to support strategic planning and inclusive practice • Greater staff confidence in data privacy and the purpose of declarations • Enhanced ability to monitor and address disparities in recruitment, progression and experience
WRES Indicator 2, 3, 5, 6 and 8	Staff Network Co-Chairs are often the voice for Ethnic Minority and	Strengthen the leadership, visibility and strategic impact	***Co-Chair Development Programme*** • Design and deliver a structured development programme tailored to the needs of Staff Network Co-Chairs to include modules on: - Strategic influencing and leadership within the NHS	• Increased confidence and leadership capability amongst Staff Network Co-Chairs

WDES Indicator 4b, 4c, 4d, 6, 7, 8 and 9 **Aligns to EDI Trust Action 6 – Staff Experience Improvement Programme**	Disabled staff, representing lived experiences and advocating for inclusion. However, many Co-Chairs have expressed the need for additional support to build confidence, leadership capability and strategic influence to effectively fulfil Eden Charles is currently collaborating with the board to develop more effective ways of working that truly advance race equality and inclusion	of Staff Network Co-Chairs by providing targeted development and support, enabling them to confidently represent their members and influence organisational change.	- Public speaking and presentation skills - Navigating governance and decision-making structures - Advocacy and allyship. ***Board and Senior leadership Development*** Collaborate with the Board and Senior Leaders to develop more effective ways of working that advance inclusion. This includes challenging traditional mindsets that hinder progress and enabling leaders to think differently, respond creatively, and lead with greater impact. The work, supported by Dr Eden Charles, engages participants in reimagining their leadership to build inclusive cultures and deliver equitable outcomes for staff and patients. ***Confidence Building and Peer Support*** • Facilitate regular Co-Chair meetings for peer learning, reflection and shared problem-solving • Provide access to coaching and mentoring, including reverse mentoring opportunities with senior leaders ***Visibility and Voice*** • Create opportunities for Co-Chairs to present at Trust Board, EDI Steering Group and divisional meetings • Recognise and celebrate Co-chair contributions through internal communications and awards • Embed Co-Chair input into policy development, service design and strategic planning • Strengthen the connection between Executive Sponsors and their corresponding Network Co-chairs through regular meetings and involvement from Executive Sponsors in network activity ***Monitoring and Feedback*** • Collect feedback from Co-Chairs on the effectiveness of the programme • Monitor impact through engagement levels, confidence ratings and visibility in decision-making spaces	• Greater visibility and influence in strategic decision making • Positive feedback on development and support • Enhanced staff voice aligned with WRES and WDES indicators • Stronger advocacy for Ethnic Minority and Disabled staff across the Trust • By 2027 we aim to have 100% of Board and Senior Leaders participate in development sessions • Evidenced shift in leadership behaviours through evaluation and feedback • Inclusive leadership principles embedded in strategic decision-making • Improved WRES indicators and staff experience scores

			Staff Networks • Continually review and evaluate purpose and strength of all staff networks, establishing areas to increase engagement and amplify staff voice where possible. • Review and strengthen purpose and process for Inclusion Council meetings	
WRES Indicator 1, 2, 3 and 7 **WDES Indicator 1, 2, 3 and 5** **Aligns to EDI Trust Action 5 – EDI Principles within Recruitment Process**	There are currently 6 RCN Cultural Ambassadors within the Trust, with plans to increase this number. These individuals play a vital role in promoting inclusive practice, challenging bias and representing the lived experiences of Ethnic Minority and Disabled staff. Cultural Inclusion Champions are currently used on some interview panels, however without consistency, definitive guidance on the role or adequate training.	To strengthen the role of Cultural Ambassadors and Inclusion Champions through training, increased visibility, and insight gathering, ensuring they are confidence and equipped to influence inclusive decision-making across the Trust. Implementation of Inclusion Champion Feedback Pack for Senior Recruitment Panels. To Ensure fairness, transparency and equity in recruitment processes for Band 8A and above roles by	***Training and Development*** • Deliver a structured training programme for Cultural Ambassadors and Inclusion Champions including modules on: - Inclusive recruitment - Unconscious bias - Cultural competence - Case review protocols • Provide ongoing development opportunities and peer support forums ***Deployment in key processes*** • Include Cultural Ambassadors on all interview panels for senior roles and other key appointments • Involve RCN Cultural Ambassadors in case review meetings as needed, to provide an inclusion lens and challenge bias • Identify and confirm differences in roles, responsibilities and uses of Inclusion Champions and Cultural Ambassadors ***Insight Gathering*** • Conduct regular surveys with Inclusion Champions and Cultural Ambassadors to identify emerging trends, themes and areas of concerns. • Use findings to inform Trust-Wide EDI strategy and targeted interventions ***Expansion and Visibility*** • Increase the number of Cultural Ambassadors and trained Inclusion Champions across divisions • Promote their role and impact through internal communications and staff engagement events ***Inclusion Champion Pack*** Develop and roll out a standardised Inclusion Champion Pack for use by panel members following each interview. This pack will include reflective questions, observations on inclusivity and space to record any concerns or good practices.	• If funding is secured, we aim to Increase the number of RCN Cultural Ambassadors from 11 to 20 by 2027. This reflects the size and diversity of our organisation and supports inclusive recruitment. • Improved staff perception of fairness and inclusion in decision-making Insight reports from surveys informing strategic EDI actions • Increase visibility and recognition of RCN Cultural Ambassadors' contributions • Subject to training, RCN Cultural Ambassadors will take part in interview panels and case review meetings, helping to ensure fair and transparent decision-making. • Increased accountability and transparency in senior recruitment • Richer data to support equitable recruitment decisions • Evidence-based improvements to recruitment policies and training

		collecting structured feedback from Inclusion Champions after each interview	Collaborate with the Recruitment Team review, update and implement inclusive recruitment, in terms of: • Diverse recruitment panels • Positive Action The data collected will be used to: • Monitor and evaluate the fairness of recruitment practices • Identify patterns or barriers affecting diverse candidates • Inform continuous improvement in inclusive recruitment strategies • Increase in positive feedback from candidates from underrepresented groups.	
WRES Indicators 1, 2 and 5 **WDES Indicators 1, 2 and 7** **Aligns with EDI Trust Action 5 – EDI Principles within Recruitment Processes**	Current recruitment processes do not consistently hold panel members accountable for ensuring fair and equitable recruitment processes. There is also no process in place for monitoring and evaluating the fairness of recruitment practices. We already undertake the gender Pay Gap reporting: the gap has reduced from 2024/25/ 25.7% to 23.3% (Mean average, in favour of males). 17.2%	The improvement and standardisation of recruitment processes that hold those recruiting accountable, and ensure a fair and equitable recruitment process.	***Review of Inclusion Champion Role*** • Conduct a review of the Inclusion Champion role to assess whether the current process is effective. • In conjunction with recruitment, develop diverse and inclusive recruitment and selection training for recruiting managers and interview panel members on conscious and unconscious bias, favouritism, and prejudice and create accountability • Develop a training programme which will include positive action, unconscious bias and empowerment. This will be done in collaboration with the Recruitment team and discussed at the Equality, Diversity and Inclusion Steering Group (EDISG) to determine necessary actions for improvement ***Interviewing with Impact Workshops*** Continue with Interviewing with Impact Workshops using our feedback to shape future workshops for our colleagues across the organisation. This will also include support with personal statements and job applications ***Pay Gap Reports*** The continuation of reporting the Gender Pay Gap and the Ethnicity Pay Gap, plus the introduction of the Disability Pay Gap for 2025/2026. ***Appraisal Review*** In July 2025, a new appraisal pathway was introduced. It places greater emphasis on regular, meaningful conversations throughout the year, including Code of Conduct reviews, Wellbeing Conversations, and the Appraisal Conversation. The refreshed approach is fully aligned with the NHS People Promise.	• The Trust has 69 identified Inclusion Champions however we are aware that there are more. We aim to have all Inclusion Champions identified, and having undertaken the refreshed and relaunched Inclusion Champion training. • Standardisation of the Inclusion Champion role • Implementation of a training programme to better equip inclusion champions to be successful in their role • Colleagues feeling more equipped going into job applications and interviews thanks to improved workshops • A more equitable and fair recruitment process • The completion of the gender pay gap, ethnicity pay gap and disability pay gap reports • Improved recruitment training for managers, increasing understanding around how to recruit in a fair and equitable way

	higher from 19.1% in 2024. The Ethnicity Pay Gap was introduced this year. In 2024/25, the mean pay gap was 3.2% in favour of EM staff, and the median pay gap was 5.25% in favour of EM staff.		***Inclusive Recruitment Task and Finish Project*** • Development of a recruiting manager toolkit with suggestions to include - What is inclusive recruitment - Introducing new policies and ways of working - Short videos for managers to provide information - Tips and advice for creating the best job adverts - How to effectively use AI to support recruiting managers - Understanding the audience and defining key USPs for department/division • Recruiting manager training for all recruiting managers and all new management starters	
WRES Indicator 6 and 8 **WDES Indicator 4b, 4c and 4d** **Aligns with EDI Trust Action 6 – Staff Improvement Programme Including Anti-Discriminatio n Workstream**	We have held regular drop-in clinics for staff to share experiences and raise concerns. In July 2025 we launched the Report Support and Learn platform for staff to raise concerns of inappropriate behaviour.	Staff have a clear understanding of how and where they can raise concerns of inappropriate behaviours and feel comfortable doing so. Expectations around what consists of inappropriate behaviours are solidified, and the message of zero tolerance for these behaviours will be reinforced.	***Inappropriate Behaviours*** • We will continue to support staff through holding regular drop-in clinics, providing a confidential and safe setting for staff to raise their concerns and experiences. • The embedding of the Report, Support and Learn Platform for Staff will enable colleagues to feel increasingly able to report inappropriate behaviours. • Awareness posters on inappropriate behaviours will be developed and distributed to promote understanding and reinforce expected standards	• Improved staff confidence in reporting inappropriate behaviours • Decrease in occurrences of inappropriate behaviours
			Reciprocal Mentoring Programme	

WRES Indicator 9 **WDES Indicator 10** **Aligns with EDI Trust Action 1 – Board Requirements**	Each board member is an executive sponsor for a specific protected characteristic within the Trust and have clear and measurable EDI objectives for which they are individually and collectively accountable.	Staff are given an amplified voice and are able to share their experiences working within the Trust via a reciprocal mentoring programme.	A proposal has been written for us to take part in a reciprocal mentoring programme, pairing members of our Inclusion Network with Senior Leaders across the organisation. This programme will be facilitated by the Trust's Organisational Development team.	• Increased understanding from Board members of the experiences of members of the Inclusion Network • Increased visibility and amplified voice for the members of the Inclusion Network taking part in the scheme • We aim to have a minimum of 30 active reciprocal mentoring pairs by 2027.

WRES/WDES Action Plan, awaiting Board Assurance

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – SEPTEMBER 2025

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meetings are available. This report is a summary of discussions held at the meeting – a slightly different format as we move towards the new, Advise, Alert and Assure reporting approach.

Items rated Red

Item	Rationale for rating	Actions/Outcome
SRO9 Failure to deliver Recurrent Financial Sustainability	- Continued shortfall in delivery of recurrent FSP resulting in a deficit at year end - Overspending in certain Divisions – particularly staffing costs - Concerns over the impact of this and the depreciation shortfall on cash balances - Potential for attracting an increased level of regulatory insight The year to date position at month 5 is a deficit of £4.8m which is £2m adverse than plan. This has been achieved through release of reserves and other one-off measures and cannot be sustained. Forecast outturn at ICB and Trust levels remains at breakeven.	Forecast outturn position to be prepared for next meeting. Peer review underway. Briefing to full Board in October re impact of measures which will be necessary to bring about a balanced position and updated cash management proposals
Capital and Estates Programme delivery	- A reworking of the programme, in part as a consequence of delays in obtaining Building Standards approval, highlighted the fragility of existing teams to deliver this complex and changing programme including new business cases. - Continued identification of new risks as a consequence of Survey work eg asbestos – necessary information but with significant costs attached to them. To date, expenditure totalled £6m against a plan of £12.5m – a £6.5m variance. An emerging issue of risk is the changing nature of digital expenditure whereby items previously classed as capital expenditure no longer qualify.	Forecast outturn position including month by month analysis for next meeting. Application to NHSE for an allocation of capital cash to be resubmitted. Assessment of the impact of capitalisation of Digital costs to next meeting. Board level discussion about the impact of the NHS Ten Year Plan digital priorities on the overall capital programme in future years.

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

Security services	- ICB have approved the Business case for an improved model of delivery with a proviso that the Trust absorb the increased costs - Continued risk to staff and patients due to delays in implementing what is an agreed priority area.	Consideration of when the new model can be implemented as part of forecast outturn position. Highlight in Risk Register
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Building Standards Regulation Approval	Continued delays (at national level) in the approval process and a completion date. This lack of clarity on a major component of the Trust's safety plans and capital programme is leading to difficulties in programming capital works in 25/26 and 26/27, consequent pressure on delivery teams and safety standards.	To be added to Board Assurance Framework.
Production of a comprehensive Estates strategy	The "Fit for the Future" strategy (now implemented) served as a proxy strategy in recent years. Although various tactical plans have been agreed since that time, there is no comprehensive Estates strategy in place. The Trust is committing significant capital and revenue monies without an overarching strategy to guide them.	Draft due to Committee by November The post of Estates Portfolio Director has been filled, providing a much needed additional resource.
Helipad at Gloucester Hospital	Recent changes in standards for helipads mean that the current facility requires improvement. Although the hospital does not receive a huge volume of helicopters it remains a receiving site	Emergency Preparedness, Resilience and Response team to review current arrangements and identify any shortfalls.
Items		**Actions/Outcome**
Items rated Green		
Gloucestershire Cancer Institute.	Early planning of this project is felt not to have been sufficiently robust – a revised project timeline has been agreed and communicated to the Charity. Planning approval and programme/design issues are more complex than usual due to the new	Charitable Funds Committee to be informed. Regular reports to this Committee as a consequence of including this scheme

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

	building being at the front of Cheltenham DGH which has listed status.	within mainstream work programme
New financial system	This system is long overdue (the current one is over thirty years old) and will facilitate modern standards and improvements in business intelligence. The risks are around the implementation of such a crucial piece of digital infrastructure with no room for error. A revised “go live” date of 1/4/2026 has been agreed rather than an in-year date.	A mock “go live” exercise to be undertaken- the results of which to be reported to the Committee. Data security, integration with ESR (Electronic Staff Records) and the criteria against which the ”go live” decision would be taken remain to be concluded.
GMS Sick Pay arrangements	GMS have agreed to offer a change of contractual terms and conditions in relation to sick pay to Agenda for Change contract staff. To date, GMS Band A staff had not received sick pay. The cost would be approximately £300k and has been included within GMS budgets. This improvement addresses some of the structural inequalities between GMS and Trust staff and is a positive step.	New sickness policy to be introduced.

Investments

Case	Comments	Approval	Actions
Hereford LINAC	The Committee APPROVED the placing of an order with Varian for £2,179,616 excluding VAT		

Impact on Board Assurance Framework (BAF)

SR 9 : Failure to deliver recurrent financial sustainability – This remains the biggest concern for the Committee. The framework has been extended to include a longer term, 3 to 5 years, perspective and be submitted to national level by the end of December. A new piece of work, intended to align contract income and costs with the main commissioner is underway. Gaps in controls as a consequence of out of date policies remain to be addressed.

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Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – OCTOBER 2025

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meetings are available. This report is a summary of discussions held at the meeting – a slightly different format as we move towards the new, Advise, Alert and Assure reporting approach.

Items rated Red

Item	Rationale for rating	Actions/Outcome
SRO9 Failure to deliver Recurrent Financial Sustainability and to date Financial Performance	- Although improving there remains a continued shortfall in delivery of recurrent FSP resulting in a deficit at year end - Overspending in certain Divisions – particularly staffing costs - Concerns over the impact of this and the depreciation shortfall on cash balances and longer-term balance sheet metrics - Potential for attracting an increased level of regulatory insight. The year-to-date position at month 6 is a deficit of £3.4m which is £36k adverse than plan. This has been achieved through release of reserves, unexpected additional depreciation funding and other one-off measures and cannot be sustained. At month 6 the ICS had a favourable position of £355k largely due to a positive performance at GHFT.	Forecast outturn position to be reviewed at next meeting. Peer review underway – to report to next meeting. Board to be requested to write to ICB/NHSE re the need for a more holistic and longer-term approach to financial performance.
Capital and Estates Programme Delivery	- A reworking of the programme highlighted the fragility of existing teams to deliver this complex and changing programme. - Continued identification of new risks as a consequence of Survey work e.g. asbestos – necessary information but with significant costs attached to them. - A new postholder, Portfolio Director of Estates and Delivery, has taken up office. To date, expenditure totalled £7.7m against a plan of £15.8m – a £8.1m variance.	Forecast outturn position including month by month analysis for next meeting. Assessment of the impact of capitalisation of Digital costs to future meeting. Board level discussion planned re the impact of the NHS Ten Year Plan digital priorities on the capital programme in future years.

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

	£36m of the planned £56m programme has received Business case approval – a welcome improvement.	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Integrated Digital Report	Governance is robust with monthly reviews and clear escalation routes. Confirmed that systems do not go live until joint sign off by Digital and Sponsoring Directorate. Sunrise upgrade planned for next quarter. PACs development on target and staff fully briefed re progress. Further improvements in coding quality highlighted.	Next report to include graphical representation of KPIs and include number if hours of "downtime". Improved mechanism for ensuring identification of benefits realisation targets to be identified.
Digital Risk Register	Evidence that risks are being managed in line with Trust Risk Policy. 33 active risks with 4 escalated to the Trust level Risk Register. Growing concerns around the Electronic Health Record which depends upon a patchwork of systems and providers. Staffing remains a risk area, and many positions are covered by contractors. National benchmarking identifies the Trust as one of the stronger NHS providers for Cyber Resilience and Information Governance.	Report focussed on this issue to a future meeting, including proposed next steps.
Items	**Comments**	**Actions/Outcome**
Items rated Green		
Business Planning 2026/27- and Five-Year Medium Plan	A new approach has been adopted with 2026/27 planning at specialty level with a particular focus on identifying where demand outstripped funding. Working assumptions regarding the Medium-Term Plan included a 2% efficiency target, a 7.8% savings programme and a rebasing of the contract with the ICB.	Updated draft of both documents to the November Board meeting. To include a first draft of the allocation of the capital programme between Estats, Digital and Medical Equipment.

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Estates Strategy Update	An up-to-date strategy would be available in draft by Q 4. This report detailed the extensive preparatory work undertaken in advance of this project which was a risk based and would explicitly link to the upcoming Clinical Strategy.	
Research and Innovation Report	The report highlighted significant pressures in recent months in this area – financial, staffing and closure of the Pharmacy Manufacturing Unit. The service was now breaking even and had a stable core staff. Collaboration with outside academic and other partners was progressing.	
Climate Risk Vulnerability Assessment	A report commissioned by the County Council which provided an evidence base for understanding climate risks in different services e.g. health implications of a rise in temperature.	

Investments

Case	Approval	Actions/Outcome
Data Centre and Infrastructure Cloud Strategy	The Committee APPROVED the migration of its data centres to a hybrid cloud solution hosted at Crown Hosting.	The report would go forward to Board for final Approval.
Pathology Roche Direct Award	The Committee APPROVED the direct award, noting that the further information on the Value for Money and Vat implications would be received in due course.	The report would go forward to the Board for final approval.
CTC Scanner Approval	The Committee noted that GMS Board approval was being sought alongside this request. The Committee APPROVED the appointment of Canon for the supply and turnkey. installation of the Cardiac CT scanner up to the sum of £ 1,969,858.20 excluding VAT plus £100,000 contingency. Total cost £2,069,858.20	
Lithotripter and Urology services	The Committee APPROVED the appointment of Beard Construction as the principal contractor to undertake construction works for the Lithotripter and Urology Assessment Unit on the former Acute Care Unit C estate at Cheltenham General Hospital for the sum of £1,639,726 ex VAT, with an additional ex. contract contingency of	

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	£500,000, making a total contract envelope of £2,139,726 excluding VAT.	
Impact on Board Assurance Framework (BAF)		
SR 9: Failure to deliver recurrent financial sustainability – This remains the biggest concern for the Committee. The framework has been extended to include a longer term, 3 to 5 years, perspective and be submitted to national level by the end of December. A new piece of work, intended to align contract income and costs with the main commissioner is underway. Gaps in controls as a consequence of out-of-date policies remain to be addressed.		
SR12: Cyber Security – The RAG rating remained at amber – there had been positive assurance around a number of issues e.g. Microsoft defender score and whilst Cyber security would always remain a high-risk issue there was a clear focus on the issue.		
SR13: Digital Systems Functionality – The risk score had been increased to 20 (from 12) as a consequence of the recent issues at the data centre (see Business case above). Some 36 systems are at end of life and there are concerns about the availability of adequate staff to undertake this task. A workforce plan is in development and would be presented to a future meeting.		
SR 14: Research Activity – Failure to enable research active departments that deliver high quality care had been reviewed and now scored as an 8.		

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