Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 15 January 2026 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** • **13 November 2025**	Assurance	Report	09.05
5.	**Matters arising**			
6.	**Questions from the public**			09.10
7.	**Staff 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 Heather Gallagher, Interim Director of Midwifery*	Assurance	Report	09.55
11.	**General Perinatal and Maternity update** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Oral	10.05
	GOVERNANCE			
12.	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Report	10.15
13.	**Strategic Risk Report** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.25
14.	**Integrated Governance Report – Legal, Regulatory and Policy Update** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.40
	BREAK			
	PERFORMANCE & QUALITY			
15.	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Report	11.10
16.	**Integrated Performance Report** ***Al Sheward- Chief Operating Officer*** ***Matthew Holdaway – Chief Nurse.*** ***Mark Pietroni – Medical Director.*** ***Claire Radley –Director for People and Organisational Development.***	Assurance	Report	11.20

	Karen Johnson – Director of Finance			
17.	**Safer Staffing Report** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Report	11.40
	PEOPLE			
18.	**People and Organisational Development Committee Report** *Marie-Annick Gournet, Non-Executive Director*	Assurance	Report	11.50
19	**Equality, Diversity and Inclusion Overview: staff network development** *Claire Radley, Director for People and Organisational Development*	Assurance	Report	12.00
	FINANCE			
20.	**Finance and Resources Committee Report** *John Cappock, Non-Executive Director*	Assurance	Report	12.15
	STANDING ITEMS			
21.	**Any other business**			12.25
22.	**Governor observations**			
	Date and time of next meeting: Thursday 12th March 2026 09.00-12.30 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 13 November 2025, 09:00-12.30, 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
	Sally Moyle	Non-Executive Director
	Kaye Law-Fox	Gloucestershire Managed Services Chair/Associate Non-Executive Director
	Raj Kakar-Clayton	Associate Non-Executive Director
	Andrew Champness	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
Attending	James Brown	Director of Engagement, Involvement and Communications
	Sarah Favell	Trust Secretary
	Heather Gallagher	Interim Director of Midwifery
	Shona Duffy	Homeless Specialist Nurse, Safeguarding team
Apologies	Marie-Annick Gournet, Non-Executive Director John Noble, Non-Executive Director Al Sheward, Chief Operating Officer	
Observers		
Governors	Douglas Butler, Mike Ellis, Andrea Holder, Gwyn Morris, Deborah Balkwill and Emma Mawby	
Other	Shawn Smith, Members of the Phlebotomy team, Nikki Evans (CQC)	
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 alongside phlebotomy colleagues. Those attending were reminded that this was a meeting of the Board in public as distinct from a public meeting.
2	**Apologies for absence**
	Apologies were received from those listed above. It was hoped that Al Sheward, Chief Operating Officer would be able to join the meeting after his meeting with Gloucestershire Fire Service. 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 Board reviewed the minutes of the public board meeting held on 11th September 2025 with no amendments to the minutes. **RESOLVED:** The Board APPROVED the minutes of the meeting held on 11th September 2025.
5	**Matters arising**
	In respect of Action 21/July it was confirmed that the safeguarding training report had been considered by the Quality and Performance Committee (October meeting). This action was now complete.
6	**Questions from the public**
	Two questions had been received from Bren McInerney: Question 1: Within the last 2 years what have been the number of complaints, concerns, and what may be termed as near/avoidable misses for maternity care in Gloucestershire Hospitals NHS Foundation Trust maternity services for Black Asian and Minority Ethnic women. What assurance and re assurance does this board have that there is proper and accurate recording measures taken and analysed of all of these matters for internal and external purposes? Question 2: How does the Gloucestershire Hospitals NHS Foundation Trust actively address hate crime in the Trust. What policy(s) does the Trust have in place to address hate crimes, and what measure(s) and approach(s) are used to do so. How many hate crime incidents have been reported in this Trust since April 2023? What assurance and re assurance does this Trust's board have in regard to the prevalence and action taken to address hate crime? These questions would receive a written response from the respective Trust teams.
7	**Patient Story**
	This presentation was made by Shona Duffy, Homeless Specialist Nurse, Safeguarding team on behalf of a patient Alan. Alan had chosen not to attend the board meeting but had confirmed that he was keen to share his story with the board and provide the team working with our homeless community an opportunity to highlight the work with this vulnerable cohort of service users. Shona described how Alan had first come to the attention of the team in 2021 through frequent presentations to the Emergency Department. Following his loss of employment and the breakdown of his marriage Alan had become homeless, moving into his works van on an industrial estate. Van life was very difficult for Alan, particularly during the pandemic and his use of alcohol had increased but he was reluctant to ask for help, feeling shame at his situation. He became part of the 'unseen homeless' finding it difficult to access health and social care support and therefore forced to access healthcare support via the Emergency Department During one of his attendances at the Emergency Department he was assessed by a member of the homeless team but was initially reluctant to take up the offer of support. Over time trust was built and the team were able, working with social services and Gloucestershire Health and Care Trust colleagues, to offer Alan safe space accommodation. Over time he managed

	to reduce his alcohol use and moved into shared accommodation. With the support of the team and other agencies Alan continued his recovery journey, moving into single occupancy accommodation. He is now sustaining his recovery, training for marathons and cycling and is enjoying life with a new partner and improved relationships with his family. His improvement has been such that his health and welfare needs are now supported by his General Practice and he no longer requires the support of the Safeguarding team or to access healthcare via the emergency and urgent care route. Alan, through Shona, expressed his thanks for the support he had received. The board continued a discussion regarding the health inequalities facing individuals and communities within Gloucestershire with Will Cleary-Gray, Director of Improvement and Delivery confirming that this area of work would be regularly before the Quality and Performance Committee and this would be a primary area of focus across all aspects of services, recognising the importance of health inequalities work as a 'golden thread' within the Trust's Strategy. Deborah Evans, Chair, commented on the importance of working with system partners to put health inequalities work at the centre of the provision of healthcare within Gloucestershire, noting that as an acute provider much of the Trust's work would be done in support of community partners but that we must remain vigilant to the opportunities to intervene and support when vulnerable people access Trust services.
	Chair's Report *Deborah Evans, Chair*
	Deborah Evans, Chair, presented her report (taking the report as read), highlighting a recent visit to meet with senior Unison representatives regarding the ongoing industrial action by phlebotomy colleagues. She assured phlebotomy colleagues in attendance at the meeting that the Trust continued to focus its efforts on resolving the dispute and hoped to see them back at work soon. Recognising that October had been Black History month she described some of the sessions she had attended to hear from colleagues, and she particularly commended Dr Anita Takwale for her positive commitment to the Trust. The work of the inclusion networks within the Trust were highlighted, with each network linked with a non-executive director and with frequent opportunities for her and non-executive colleagues to meet with network chairs to improve understanding, communication and championing of issues affecting our staff community. Other visits included a visit to surgical services at Cheltenham General Hospital in support of the recent national elective hub accreditation process and also a visit to estates facilities within Cheltenham hospital to witness the excellent work of the Gloucestershire Managed Services team in managing the challenges presented by an aged estate. She commended Gloucestershire Managed Services colleagues for their work over the past year on staff development and support, particularly relating to issues of equality, diversity and inclusion and the 'hate has no home' campaign within the Trust. Kevin McNamara, Chief Executive, commented that since the visit the Trust had learnt that it had been successful in its application for accreditation as a national elective hub with Deborah Evans congratulating the teams who had worked to achieve this. Finally, the recent meeting of the non-executive directors with the Trust's Freedom to Speak Up Guardian, Louisa Hopkins, was an excellent opportunity for board colleagues to hear some

	of the lived experiences of colleagues using the service. Importantly non-executive colleagues had also undertaken the online training provided by the National Guardians Office, recognising the importance of this work throughout the Trust. **RESOLVED:** The Board NOTED the report for information
9	**Chief Executive's Report** *Kevin McNamara, Chief Executive*
	Kevin McNamara, Chief Executive, presented his report to the Board, taking items as read but highlighting the response of the Trust and system colleagues to the recent rise in racially motivated incidents within Gloucestershire communities generally and aimed at healthcare staff. Having spent a day with a community outreach colleague it had been challenging to hear of her experiences when endeavouring to connect with communities. Kevin McNamara was clear that such behaviours would not be tolerated on behalf of colleagues, and he encouraged staff to utilise reporting mechanisms to raise issues of concern and encouraged staff to actively support affected colleagues. He acknowledged the planned industrial action by resident doctors, represented by the British Medical Association and the ongoing industrial action by phlebotomy colleagues. He thanked the clinical teams for the significant amount of planning put in place to minimise the impact of the resident doctor industrial action, with the aim of keeping cancellations of service to a minimum. Echoing the comments of Deborah Evans, he spoke of recent meetings with representatives of phlebotomy colleagues and outlined the recent offers made by the Trust with the hope of bringing the dispute to a resolution. He acknowledged that these had been rejected by Unison but that he remained hopeful that the ongoing offer to refer the job evaluation to the national panel for determination would be a route that would be acceptable to the phlebotomists. It required the engagement of all parties and an agreement to be bound by the outcome of the panel evaluation. He expressed the hope that discussions would continue and lead to resolution. He advised that the service impact assessment of the industrial action would be considered at the next meeting of the Quality and Performance Committee but confirmed that there had been no decrease in performance, with the Trust achieving the best performance figures in the South-West region for pre-noon discharge and with no safety incidents having been identified consequent to the industrial action. Kevin McNamara referenced the small fire incident the previous week at Gloucester Royal Hospital and commended the staff, both Trust and Gloucestershire Managed Services, for their response to their incident and the support provided to patients. He confirmed that fire safety remained a primary focus of the Trust's senior team, with work ongoing to achieve structural and system improvements, noting this necessitated a complex patient services decant programme, ensuring wards were vacated without disruption to clinical services. He noted that Al Sheward, Chief Operating Officer, was meeting with key members of Gloucestershire Fire Service instead of being in attendance at the board meeting. The final item highlighted in the written report was a pilot being undertaken in conjunction with the Integrated Care Board to explore new ways of running community theatre services. The pilot would necessitate some changes to services at the various locations and would include suspension of theatre activity at Cirencester hospital for a six-month period. The concerns of

	those within the Cirencester area were recognised and, in addition to regular communications with Gloucestershire County Council there would be regular communications with stakeholders in addition to board briefings. It was commented that this 'test of change' process is likely to be used for other changes, particularly as the Trust and system partners worked closely in collaboration to achieve the principles outlined in the NHS 10-year plan, with the shift to a smaller acute healthcare footprint and more services within the community. In addition to items within the written report Kevin McNamara asked Matt Holdaway to comment on recent developments within Maternity Services. The National Maternity and Neonatal Investigation team, led by Baroness Amos, would be visiting the Trust on 4th and 5th December. The indications received were that the focus would be on systemic issues across national maternity services, including regulatory oversight. This was welcomed by the Trust as providing a clear framework for individual Trusts to work to. It is anticipated that each Trust will receive a report, together with an overarching report as to national maternity services. The original timetable had been for the investigation to be completed by the end of 2025 but it was likely that the report(s) would be released in Spring 2026. The recent departure of Lisa Stephens, Director of Midwifery, was acknowledged by Matt Holdaway, Chief Nurse, who expressed his thanks to Lisa for undertaking the role in challenging circumstances. Heather Gallagher has taken up the post of Interim Director of Midwifery and comes with extensive experience with a focus on the improvement agenda. Kevin McNamara confirmed that he and Matt Holdaway, together with Heather Gallagher, had recently met with colleagues from the community home births service to discuss their concerns regarding capacity within the service to meet increased demand for home births, particularly the rise in complex births and those 'outside of medical guidance'. It was a very constructive conversation with individuals who are clearly committed to their patients and the service but held safety concerns regarding capacity. These issues would be fully considered, including an initial risk assessment, to ensure the safety of the service for both patients and staff. This required an initial suspension of the service with it being recognised that a more detailed assessment was likely to require a longer pause in the service. The safety of the service and patients was paramount. Existing patients who had indicated a wish for a home birth were being contacted individually, with a focus on how to support their birth experience. The issue would remain a continued focus for the executive team and wider board. The decision of Claire Radley, Director for People and Organisational Development, to leave to take up a role in the West Midlands was shared with the meeting and on behalf of the board Kevin expressed his thanks to Claire for her work over the past four years to both stabilise and make real and substantial cultural improvements within the Trust. **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, a key element of the continued focus on maternity services. He was supported in this by Heather Gallagher and by Vareta Bryan, non-executive maternity champion.

	The report provided an update on progress/compliance against the s31 Enforcement Notice issued in May 2024. The report was taken as read with highlights as follows: The team continued to make progress against the individual improvement project workstreams with the Trust rating seven of the eight conditions as blue (complete and compliance sustained). Within the report one item remained amber (post-partum haemorrhage) whilst the team continues to monitor both risk assessments and the management of the risks relating to this condition. Matt Holdaway confirmed that, following assessment and since the report was prepared, this item had now progressed to a green rating with the team focused on embedding the improvements to achieve a blue rating. This marked the achievement of compliance in all required areas of improvement and reflected the hard work of the team. Suzie Cro, Director of Quality Governance would be working with the CQC team to initiate a formal review of progress against the s31 Improvement Notice, with a view to it being discharged. **RESOLVED:** The Board NOTED the content of this report for assurance.
11	**Perinatal Quality Surveillance Q2/25 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 July to September 2025 inclusive. The majority of the report was taken as read. It was confirmed that the report had been previously reviewed in detail by both the Perinatal Oversight and Assurance meeting and divisional board, with the following key information highlighted for the attention of the Board. It was confirmed that the Service continued to make good progress against the action plans put in place as a response to the recent external reviews with oversight of progress being monitored by both the Perinatal Oversight and Assurance meeting and the Trust's Safety and Experience Review Group. The following alerts were highlighted to the board: • During Quarter 2 there were 16 babies 'born before arrival' (a birth that occurs outside of the planned birth location before the arrival of midwifery/obstetric staff). The Trust is currently flagging at 1%, above the national average of 0.5%. A senior team review had been undertaken to better understand the themes informing the data but no themes were identified that could have avoided these birth experiences. One incident had been previously identified as a safety incident with all relevant investigation and learning undertaken. • In July the Unit flagged as an outlier for neonatal readmissions. A review identified that most readmissions related to feeding issues and an improvement plan has been put in place. • There were 7 perinatal deaths during the Quarter, all of which have been subject to a multi-disciplinary review and presented via the Patient Safety Review Panel, with professional duty of candour completed where necessary. Matt Holdaway, Chief Nurse, confirmed that the challenge facing the team in undertaking the perinatal death reviews was the availability of obstetric colleagues to support the reviews. This was now the focus of a piece of work being undertaken by Heather Gallagher, Interim

	Director of Midwifery, focusing on how to support medical teams to address the backlog of detailed reviews. The role of the Maternity and Neonatal safety champions remained key with the board safety champion meeting the Perinatal Quad regularly. There was a planned meeting with the community midwifery team to explore a broad range of issues, including potential solutions to the concerns regarding the home birth service. This was confirmed by both Vareta Bryan and Sam Foster, Non-Executive Directors. Matt Holdaway confirmed that the Trust was currently non-compliant in terms of the requirements of the Maternity Incentive Scheme for Year 7 (Safety Actions 1,4 & 8). An action plan was being put together to achieve improved compliance before year end with a briefing being brought to Quality and Performance Committee to outline all of the areas of potential non-compliance and associated actions. The report will then be brought to board for review. Heather Gallagher has been tasked to take a refreshed approach to Maternity Incentive Scheme compliance and would be recommending a refreshed report to Board, focused on the key areas of required oversight. Deborah Evans, Chair, and Sally Moyle, Non-Executive Director attended a recent Quality Improvement Academy presentation on the work being done on the maternity early warning observations scoring in obstetrics and had been impressed with the quality of the presentation and the work being undertaken. Kevin McNamara, Chief Executive, commented on the proposed new report to board, which was part of the new national review programme and highlighted the focus on mental health and maternity mortality by way of suicide. He acknowledged that the Trust's primary focus was appropriately on clinical safety but that the treatment of all aspects of a patient's condition was important. The Trust would be looking at working in partnership with Gloucestershire Health and Care Trust to focus on the mental health care provided to maternity patients. Matt Holdaway and Heather Gallagher provided the board with more information on this area of focus with a focus on the need to support the safeguarding team in this work as they can be resource limited. The board then discussed the provision of ultrasound services. There had been progress made during the year but work to provide a more permanent solution continued as part of the maternity safety improvement programme. This remained an identified but improving risk for the service. Matt Holdaway confirmed that the division, led by Alex Holland, had worked hard to bring in the external provider, working within the Trust's governance processes, and this had led to a marked improvement in productivity (including weekend working). This was a particular area of focus for patients who reported reduced foetal movements who were now able to undergo ultrasound scanning within 24 hours. Vareta Bryan, non-executive director commented that the service was also improving its internal provision with the training of 4 midwifes to undertake scans. This was a key development in terms of forward planning for both the service and development of staff. This was key in addressing one of the top risks within the service (slide 13) i.e. the provision of an ultrasound scan within 24 hours for women presenting with persistent reduced foetal movements from 28/40 weeks. The Board then considered the top five risks for the Service (slide 13) with Mark Pietroni, Medical Director, commenting on the risk relating to the inadequate number of consultant

	Obstetricians. He confirmed the Trust had funded some new substantive posts rather than fixed term as it was felt that substantive roles were more likely to benefit from improved calibre applications. The decision to fund these posts had been made 'at risk' as the business case was sitting with the Integrated Care Board but it was felt essential to both improve the multi-disciplinary obstetrics service and to provide increased capacity for caesarean sections. Karen Johnson, Director of Finance, and Kevin McNamara had met with the clinical and financial colleagues at the Integrated Care Board to focus on the funding requirements of the service. Matt Holdaway, Chief Nurse, outlined the actions being taken in respect of risk 490 (the risk of detailed review, identification and treatment for pregnant women attending triage) The service was receiving mandated support for this area. The factors for the risk were identified as multi-factoral, with the condition of the estate impacting capacity. Work was ongoing with Gloucestershire Managed Services colleagues to address the estates issues. Another factor was staffing levels within triage, with increased staff being made available in recent months. The issue continues to be an area of focus for the Oversight meeting. Sally Moyle, Non-Executive Director, raised an issue regarding the Maternity Early Warning Scores/Observations which had been the subject of a presentation at the Quality Improvement presentation she had attended. Sam Foster, Chair of Quality and Performance Committee confirmed that New Early Warning Observation Scores was a continued area of focus for the Quality and Performance Committee. She acknowledged the work that had been done in the previous year and that there was an improved line of sight across the delivery and governance committees. Kevin McNamara was also able to confirm that a Chair of the Maternity and Neonatal Voices Partnership had now been recruited, and this was very much a positive in terms of achieving a stronger level of engagement with mums and birthing families. Finally, there was a general discussion regarding the trust and confidence of mothers and birthing families in maternity services, both as a result of issues such as the suspension of the home birth service but also the recent tragic coroner case in Manchester regarding the deaths in delivery of both mother and child, which had resulted in a Report to Prevent Future Deaths. Both Deborah Evans, Chair and Sam Foster, Non-Executive Director, commented on the need for the Trust to assure itself of the safety of its home birth service in line with national guidance. It was noted that the suspension of the Service would be impacting a small number of individual patients, but it had also been impacting staff whose welfare was key to the delivery of a safe and effective service for those patients. From social media comments seen by Board members it was clear that the Trust had to ensure clear communication with affected patients, communities and staff about the rationale for the suspension/review and the timescales if the Trust was to retain patient trust and confidence in the service. This would be a focus for the Chief Nurse and senior Maternity team. John Cappock, Non-Executive Director, commented that he saw it as a positive that staff had felt able to bring their concerns to the senior management team. He asked if the issues that had been raised were specific to the service or could be of wider application across other clinical services. Heather Gallagher, Interim Director of Midwifery, advised that the issues were specific to the home birth service and were complex, relating to capacity and the complexity of births. She commented that the Service was based on a model designed for

low-risk births but over the last decade there had been an increase in complex homebirths and patient requests for births 'outside of guidance'. The Manchester Inquest had crystalised and triggered the stronger articulation of concerns, both nationally and locally. Kevin McNamara, Chief Executive, acknowledged the issue of wider application and commented that had the issue arisen in a ward or Emergency Department location the senior management team would know on a daily basis, but community-based services often manage their own risks, which were less visible. It had been a useful prompt for the senior management team to look at escalation process for services more widely.

Matt Holdaway confirmed that the provision of a safe and effective homebirth service was complex. Whilst it was important for midwives to be able provide choice for their maternity service users, it was necessary to balance that desire for choice alongside patient safety and the resources available. He commented that he did not think there was enough done nationally to inform women of their choices (and associated risks) and to support midwives to feel able to flag birth plans 'outside of guidance'. He expressed a desire to work with key stakeholders, both within the Trust and the wider community to explore what services were right for the local population and the anticipated Maternity Health Needs Assessment would be vital in that review. Vareta Bryan, Non-Executive Safety Champion for maternity services commented on the review of the homebirth services and the difficulties faced by midwifery colleagues in endeavouring to provide personalised care in situations where those patient choices were not in line with clinical guidance. She urged a continuing focus on supporting both patients and staff during the period of the review.

Turning back to the body of the main report Jaki Meekings-Davis, Non-Executive Director, commented on the claims data provided and asked if it would be possible to extend the data criterion to a longer period and against a recognised peer group. Matt Holdaway, Chief Nurse confirmed that the Service was undertaking a piece of benchmarking work but it was difficult to identify correct comparator organisations due to the size of single claims and other variables.

In response to a question from Kaye Law-Fox, Non-Executive Director, regarding the extensive data available and whether this would continue post the completion/withdrawal of the s31 notice, Matt Holdaway, Chief Nurse, confirmed that the team was beginning to explore the granularity of data sets for future Trust board reporting.

A final comment was made by Vareta Bryan, Non-Executive Director, that she would welcome more detailed reporting on the impact of health inequalities on the service received by mothers and birthing families. Matt Holdaway confirmed that the Health Inequalities team were preparing a paper on both maternal and neonatal health inequalities which, together with the Health Needs Assessment being undertaken with the Gloucestershire Integrated Care Board, would inform discussions as to future service provision, reflecting one of the Trust's key Strategic Aims.

RESOLVED:

1. The Board NOTED the Perinatal Mortality Review Tool report for Quarter 2 (slide 10-11) and NOTED that these reports were discussed with the Board Safety Champions at the Perinatal Delivery Group on an ongoing basis (noting there was an omission in that the Quarter 4 Perinatal Quality Surveillance Report was not presented to the Board with action plan in place to improve timeliness of reviews). **Safety Action 1**

	2. The Board NOTED and APPROVED the action plan for rotational medical staffing (Slide 17). **Safety Action 4** 3. The Board NOTED that the Service met compliance with British Association of Perinatal Medicine standards in relation to neonatal medical workforce and neonatal nursing workforce standards. **Safety action 4** 4. The Board NOTED and confirmed with the Board Safety Champions that they continue to meet with the Perinatal Leadership Team (at least bi-monthly) and Maternity and Neonatal Voices Partnership (slide 29). **Safety Action 9** 5. The Board NOTED the progress with the perinatal culture improvement work (Slide 29). **Safety Action 9** 6. The Board NOTED the Claims Scorecard and that it has been reviewed and the data triangulated with incident and claims data. **Safety Action 9**
12	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*
	John Cappock, Chair of the Audit and Assurance Committee presented this report following the September meeting of the Committee with much of the report being taken as read. He flagged the key red risk which was the high volume of out-of-date Trust policies and confirmed that a report from the relevant team had been requested for the Committee's November meeting. The Committee would be looking for assurance as to the process and the management of the backlog. He also brough the Board's attention to the recent Internal Audit report on the Patient Deterioration which had provided limited assurance as to design effectiveness with two high priority recommendations. It was noted that the Actions had been agreed by Management teams with the report to be considered by the Deteriorating Patient Group, Quality Delivery Group and oversight of the action plan to sit with the Quality and Performance Committee. He commented on the annual cyber report received by the Committee and noted that it was scheduled for consideration by the Board in the confidential board meeting. Overall, the report was a source of assurance but the remained two key areas of risk – the number of systems within the Trust approaching or at end of life (no longer supported) and the roll-out of Multi-factor Authentication. An Internal Audit report on cyber security would be considered by the Committee during its February meeting. **RESOLVED:** The Board NOTED the report as a source of assurance.
13	**Strategic and Operational Risk Report** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance presented this report. Before summarising the report, she flagged to the Board an error in the version of the report in the pack, confirming that the Finance and Resource Committee had reviewed Strategic Risk 13 (Digital) with an updated score, since the last board report but this was omitted in the board pack. It had been corrected post circulation of the board papers. Kerry Rogers confirmed that it had been a conscious decision of the board to delay the refresh of the Trust's Risk Appetite Statement to align with the new Trust Strategy. The Board had recently undertaken two board workshop sessions on risk management following the finalising of the Trust Strategy. The Risk Appetite Statement within the pack reflected the output from

	those workshops and represented the levels of risk the Board is willing to accept to achieve its objectives. It was confirmed that the Risk Appetite Statement had been reviewed at Risk Management Group and was supported by the Group. It was recognised that there was a need for additional training for risk managers and a communications plan. Work had been started by the Risk team to reclassify 700 plus risks under new categories, update divisional and service risk registers and escalation processes. The impact of the risk appetite statement would be the subject of close monitoring over the next six-month period as it was recognised that it could have unintended consequences for the management of both Trust and operational risks. A formal review of the effectiveness of the new approach would be undertaken in April 2026. The current Trust Risk Register was included within the report with it highlighted that there were 40 risks recorded, with 63% scored at 15 (red) or above. The key risks were largely estate related risks; fire safety, asbestos and window safety. This was consistent with the reports received by the Health and Safety Committee and reflected the ongoing focus on fire safety issues. Clinical 'red risks' included Emergency Department overcrowding and radiology workforce with action plans in place. The board were aware that, with the focus of the two recent workshops having been primarily on risk appetite, it was now necessary to focus on the strategic risks against the Trust's approved Strategy. It was intended that this would be the focus of the December board seminar, and that Executive Directors would be reviewing their strategic risks to ensure they were aligned with both the Strategy and the risk appetite statement. The initial work undertaken had demonstrated that the current strategic risks were not outliers against those of Trust's rated as 'good' or 'outstanding' and were not inconsistent with thought leadership guidance on NHS risks but they required updating and realignment against the Trust's new Strategy. Work would be undertaken during December to review all Strategic Risks with the aim that these would be presented to the Board in January 2026 and be utilised by both Executive leads and Board Committees to manage risk from Quarter 4. The current position ('business as usual') of the respective Board Assurance Framework risks was referenced as set out within the report with most strategic risks having been reviewed by the relevant Board Committees in the period September to November 2025. John Cappock, Non-Executive Director commented on the positive progress, with clear building blocks on which to set the future tone of risk management across the Trust. He acknowledged that there was a significant number of risks that would require review against the new risk appetite and this would require vigour, but he expressed the view, as Chair of Audit and Assurance Committee, that the approach to risk management had significantly improved over the course of the past 18 months. Kevin McNamara, Chief Executive led the discussion regarding the overcrowding of the Emergency Department and the work that was being undertaken with South-West Ambulance Service to both ensure quality data was available and to provide tangible action plans to address the risk, including increased integration of urgent care services and encouraging improved use of the 111 service. A report was anticipated from South-West Ambulance Service and the Trust was committed to continue to support various initiatives to reduce inappropriate attendance at Emergency Departments. The impact of these initiatives would be reviewed by Quality and Performance Committee as appropriate.

	It was acknowledged that there had been considerable progress in identifying and scoring health and safety risks with an effective Framework now in place for the monitoring of those risks and associate action plans but it was acknowledged by Deborah Evans, Chair, there was still work to be done **RESOLVED:** 1. The Board NOTED the assurance on the adequacy of the risk management systems and the ongoing improvements following the launch of the new Trust Strategy, including noting the challenge where current levels of assurance was weak. 2. The Board APPROVED the new Risk Appetite Statement, tolerance levels, thresholds (Appendix 1) with a review in six months to test its application and any need for adjustment. 3. The Board NOTED the implementation plan for the new Risk Appetite across the Trust. 4. The Board NOTED the revised Risk Scoring Matrix (Appendix 2) to align with the new Risk Appetite 5. The Board NOTED the Trust Risk Register profile (Appendix 3) 6. The Board NOTED the system performance matters in the divisions (Appendix 4)
14	**National Health Service Provider Licence** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance, summarised this report to the Board, confirming the annual process, effective from April 2023, requiring healthcare providers to meet rigorous conditions to enhance patient care and meet challenges such as climate change and system integration. Through a process of self-certification, the Board confirmed that the Trust complied with the requirements. These included various governance requirements including ensuring board members met the Fit and Proper Person Test requirements (Condition G3), systems for compliance with Licence Conditions (condition G5) and the Trust's adherence to governance standards (as set out in NHS1 &2). As a provider of services designated as Commissioner Requested Services there is a requirement to self-certify against Continuity of Service Condition 7; that the Trust has a reasonable expectation of required resources for the next 12 months. This was confirmed and was considered by the Audit and Assurance Committee and reflected in the Annual Report. This was endorsed by John Cappock as Chair, Audit and Assurance Committee. **RESOLVED**: 1. The Board RECEIVED assurance that the Trust is compliant with the NHS Provider Licence and confirmed support for the source, robustness, and an appropriate degree of independence of the assurance; 2. The Board APPROVED the self-certification of 'confirmed' for each of the applicable Provider Licence Conditions: G3 an G5 of the NHS Provider Licence and requirements detailed in conditions NHS1 and NHS2. 3. The Board NOTED and AGREED the Chief Executive Officer complete and sign the Declarations required by Continuity of Service condition 7 of the NHS Provider Licence.
15	**2025-2030 Strategy Approval** *Will Cleary-Gray, Director of Improvement and Delivery*
	Will Cleary-Gray presented both the report and the Strategy document, together with the summary version intended for broad communications across the Trust and with stakeholders.

	He expressed his thanks to both the board and wider consultees for their engagement with the revision of the Trust's Strategy – a strategy which had been able to incorporate the Trust's response to the NHS 10-year plan which had been published towards the conclusion of the initial consultation and drafting process. The board had several opportunities to contribute, alongside Trust governors, to the revised Trust vision and values alongside the key themes within the Strategy and to provide feedback on earlier iterations, which had been reflected in the final version Strategy. Will Cleary-Gray summarised the presentation and key elements of the Strategy, which was before the board for approval. The vision was 'we want the best care every day for everyone'. Alongside that vision were the four key values; caring, compassionate, inclusive and accountable. The Strategy reflects four key areas of focus: • Patient experience and voice; • People, culture and leadership; • Quality, safety and delivery • Digital first alongside the usual focus on estates and physical infrastructure These areas of focus reflected the importance of meeting the health needs of the community through listening and hearing our patients and community and the changing ways in which those needs would be met, through closer partnership working and a focus on core services. Also included was an improved focus on how research and development, particularly genomics, would inform service provision. Mark Pietroni, Medical Director, confirmed he was very supportive as genomics would transform medical care. Kaye Law-Fox, Chair of Gloucestershire Managed Services confirmed the subsidiary's Strategy would be consistent with the Group approach and the subsidiary's board was very supportive of the approach within the Trust's Strategy alongside the Vision and Values. Sam Foster, Non-Executive Director, commended the realism of the Strategy and proposed that that the Strategy, as a living document, be embedded in the board's approach to all aspects of its work. Kevin McNamara, Chief Executive, confirmed that the Strategy would be informing key work items such as the Medium-Term planning process with the formulation of key delivery plans (clinical, digital, estates) now being the focus of the executive team. This was in addition to the refresh and realignment of the Trust's Board Assurance Framework and the revised risk appetite statement. **RESOLVED:** The Board APPROVED the Strategy.
16	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*
	Sam Foster, Committee Chair, presented the report detailing the assurance received by the Committee during the period September to October 2025. She confirmed that the Committee had received both the Patient Experience and Complaints Annual Reports with the Patient Experience report being commended for its content. It was also noted that there

	had been significant activity and improvement in the management of complaints during the year, but it remained an area which required continued improvement with the Committee supporting the drive for a 'stretch target' to further improve pace in the resolution of complaints. Alert items: Items highlighted for 'Alert' included the ongoing regulatory inspection and enforcement action for maternity services. This remains a primary area of focus for the Committee and was being highlighted to the board to ensure continued focus and transparency – the discussions in the earlier agenda items relating to maternity were noted to avoid duplication of minutes. It was also noted that there had been four 'never events' since March 2025 and these continued to be monitored by the Committee with recent investigation and action plans to be considered at a future meeting of the committee. The Committee had asked for additional assurance as to the work being undertaken to address the poor levels of safeguarding training, particularly amongst medical staff. It was believed that the rotational nature of the resident doctor workforce was relevant to the low compliance but the Committee had requested a detailed action plan to return to Committee. It was noted that the focus was on winter pressures and the consequent impact on clinical flow, particularly in emergency and urgent care with an increased risk of corridor care albeit that this was now confined to the Emergency Department. Eve Oliphant, Integrated Care Board, had attended a recent Committee meeting where the need for system collaboration to meet winter pressures had been discussed in some detail. A further update would be provided to the Committee in November meeting but the positive feedback from the Care Quality Commission on the culture and leadership within the Emergency Department was noted. Other positive items of note was the assurance as to the embedding of the Learning from Deaths process and the confirmation that Child Protection Medical Assessments were moving from 'special measures to business-as-usual oversight. Kevin McNamara, Chief Executive, commended the recent national inpatient survey results for the Trust, which had been the best in 20 years. **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*
	In the absence of Al Sheward, Chief Operating Officer, Mark Pietroni, Medical Director, presented the performance section of the Integrated Performance Report for September 2025. The Board noted the following key items: **Performance**

Urgent and Emergency Care

Overall positive performance in most domains and key indicators with one exception – there was an increase in 12-hour waits for patients (an increase of 60). Specific actions have been revised to mitigate this risk. There was a further decrease in ambulance handover delays with 100 fewer patients waiting over an hour. The data would be reviewed with South-West Ambulance Service colleagues as there were some anomalies, with majority of the delays recorded against high acuity pathways.

Ambulance performance will be monitored daily as winter pressures increase activity. It was noted that the Hospital Ambulance Liaison Officer (SWAS) had relocated to work more closely with the Emergency Department leads and the change was working well.

There continued to be a focus on maintaining performance within paediatric Emergency Department, with efforts focused on mental health attendances and shortening the period before such patients were seen by the relevant team. There will be closer scrutiny of paediatric four-hour performance from October 2025 onwards

Elective: 45 Week wait

There was a small reduction in the number of 45 week wait breaches. It was anticipated that this trend would continue.

Cancer RTT (referral to treatment) (Standard 85%)

The Trust continued to perform well, both regionally and nationally. With regards to 62-day data, there was achievement of the standard by testicular, breast and skin services during August 2025. There had been a significant improvement in urology with September unvalidated data showing 74.7% and an anticipated 74.5% against standard in October. This represented the most positive performance against target since July 2021. The backlog was as a result of consultant workforce issues within lower gastrointestinal and skin.

Against the 28-day Faster Diagnosis Standard of 80% the Trust's unvalidated data for September was at 77.8% which, whilst less than the national standard, was above the minimum expectation of 75%. Planned actions included new escalation processes to support earlier identification of concerns and bottlenecks and additional skin minor operations capacity to be delivered through Agile.

Diagnostics

It was noted that there was a small improvement of 1.14% compared to the previous month but a waiting list increase of 363 patients was noted, predominantly in Echocardiogram and Colonoscopy. The board was advised that there was a recovery plan in place for Echocardiogram.

Discharge ready patients (previously 'no criteria to reside')

The position was complex with a deterioration in terms of number of patients and total bed day delays but for individual patients there has been a recovery in terms of average length of delay. This was a significant area of concern due to the associated impact on clinical flow and the vital Gloucester Royal Hospital Tower Building fire risk mitigation plan which required capacity to decant wards for the works to be undertaken. Work was ongoing with system partners, with

a cross system executive level commitment to resolve and bring back in line the level of discharges achieved to the required trajectory. It was noted that other key factors in achieving this trajectory were the impact of both winter pressures and the impact of industrial action taken by resident doctors, with discharges likely to be delayed during periods of strike action.

Kevin McNamara, Chief Executive, advised that there was an emerging risk in respect of urgent and emergency care with a proposed change to the recording of attendance data. The change would impact the Trust as there is no other Urgent Care Centre within the system. It would become relevant in Quarter 1, 2026/27. It would not reflect a change in service provision but would alter the centralised scrutiny of the Trust's performance. This would be explored at a future Quality and Performance Committee meeting.

Quality and Safety Metrics

Matt Holdaway, Chief Nurse and Director of Quality, highlighted the relevant performance metrics with most of the report being taken as read but noting the positive improvements against Safety Priority (Pressure Ulcers Cat 3) with confirmation of no CAT3 pressure ulcers for three months. This followed a recent Quality Summit, focusing on quality improvement projects which will continue to be monitored. The Pressure Ulcer Improvement Group was relaunched in October to maintain and continue the improvements against this Safety Priority.

It was noted that the overall Friends and Family Test score had marginally decreased to 91.6% for September. This was a result of a decline in scores for maternity and all areas of in-patient care, with only the Emergency Department (Gloucester Royal Hospital) showing an improved score. Divisions would be reviewing all scoring and associated narrative comments received and would triangulate the data with other experience insight data to identify opportunities for learning and improvement.

Conversely Patient Advisory & Liaison Service (PALS) were performing well, with a maintained closure rate of 91% despite team sickness absence.

Mark Pietroni, Medical Director and Director of Safety, highlighted one of the Watch Measures – performance in terms of Venous thromboembolism (VTE) assessment compliance had dropped during September. This would be picked up by the VTE Committee.

The board were also advised that there was a concern with the timeliness of completion of Learning Response reports against the Patient Safety Incident Response Framework (PSIRF) which requires learning responses to be completed within six months. Mark Pietroni indicated that whilst timeliness was improving it remained insufficient. It was anticipated that this would be addressed by the imminent implementation of the Quality Governance Framework.

Raj Kakar-Clayton, Associated Non-Executive Director, commented on the performance of the Patient Advice & Liaison team (PALS) in the context of significant team sickness absence and the support available to the team. Matt Holdaway confirmed that this was a focus for the management team, and it was recognised that the work done by the team was challenging, dealing with patients and carers who were, at the time, often upset. To mitigate the impact of the stresses of the role it was proposed that staff would be rotated between front-line patient liaison roles and divisional liaison roles. This would have the dual benefit of addressing causes of stress but would also provide development opportunities for team members. It was

felt that the team was performing well but there was a desire to build in additional resilience and support.

Use of Resources/Finance metrics

Karen Johnson, Director of Finance, provided an update on financial performance as at Month 6. It was acknowledged that the figures reflected a good position, but this was largely because of a depreciation exercise which had worked in the Trust's favour. It was anticipated that by Month 7 the Trust would be deviating from its planned budget trajectory. There remained significant risks including the delivery of the Financial Sustainability Programme, with £5.6m unidentified schemes and a further £8.9m identified as high risk. The identification of recurring savings remained a Trust priority, but the organisation would need to focus on a transformation agenda to achieve such savings, recognising the need for the organisation to become more focused on core acute services consistent with the NHS 10-year plan.

Additionally, there were delays in capital schemes starting due to a lack of approved business cases and an impact on the Trust's ability to deliver approved schemes for reasons both within and outside the Trust's control, including planning permission requirements and changes to building regulation and control processes. This created significant challenges for the Trust to meet the requirement to spend capital within a 12-month window. This was a focus of regular capital planning meetings, involving both Trust and Gloucestershire Managed Services colleagues.

Karen Johnson, Director of Finance, confirmed the ongoing work on the recovery plan and that System partners were aware of the anticipated deviation from business plan, even though the current month plan was on track. She indicated there was some evidence that the recovery plan was gaining traction within the Trust, with tighter oversight of workforce vacancies and a move towards increased focus on non-pay items/discretionary spend. It was acknowledged that it would be important that staff understood the financial position of the Trust and the need for efficiencies and their role in achieving financial stability. Jaki Meekings-Davis, Non-Executive Director, commented that there was a need to act on discretionary spend as a priority and Kevin McNamara concurred, emphasing the need for effective internal communications about the importance of considered expenditure.

People

Claire Radley, Director for People & Organisational Development provided an update on the current workforce issues. An area of particular focus was sickness management (slide 44) and it was proposed that a more detailed report would come to a future board meeting. The sickness position had improved slightly in September, with a focus on mental health absence (the top reason for absence) being supported by the Well-being team and other resources available to staff.

Flu/Cold/Cough was the second highest reason for absence, so the focus continued to be on encouraging staff to receive the flu vaccine. Vaccine levels for front-line staff were at approximately 44%.

Appraisal compliance remained static but was at its highest level in over three years. Focused areas for improvement were corporate and estates staff.

	The spend on bank and agency staff was an area of continuing concern with the Trust not achieving its overall 'Whole Time Equivalent' reduction target of 15%. Medicine division remains the highest user of bank and locum staff, with the Emergency Department, Stroke, Care of the Elderly and Acute Medicine the highest using services. It was anticipated that the further implementation of the e-Rostering solution for medical workforce would deliver reductions in temporary staff use. It was acknowledged that medical workforce industrial action was having an impact on the management of temporary staffing as it was necessary to ensure safe staffing levels by using agency/bank staff. Matt Holdaway, Chief Nurse, commented on the positive reduction in nursing bank usage but also flagged that it had a negative impact on senior nursing colleagues who were finding it challenging to manage bank/agency spend whilst ensuring safe staffing levels and delivery of care. Deborah Evans, Chair noted the comment and suggested that this was an issue which should be explored in a focused meeting of the board. It was noted that this was not currently a safety risk but more an issue of engagement and morale for the impacted teams. Mark Pietroni, Medical Director commented on the work of the job planning team with all job plans now in date and the October 2025 target of over 60% of job plans being signed off achieved. The focus would now be on improving the quality of the job plans in place. At the conclusion of the report Deborah Evans, Chair, asked authors to again focus on the need to reduce acronyms in the Integrated Performance Report to ensure their accessibility to members of the public reviewing the reports. **RESOLVED**; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
18	**Learning from Deaths Report** *Mark Pietroni, Medical Director*
	Mark Pietroni presented this assurance report, utilising the Alert, Assure, Advise format. The report documented the Trust's compliance with national requirements regarding the review of deaths. <u>Assure</u> Structured Judgement Reviews are embedded across all divisions, with a notable improvement in timely completion – 73.6% reviews completed within 3 months during Q4 2024/25. The Trust's Summary Hospital-level Mortality Indicator (SHMI) returned to 'as expected' levels (1.04) with a sustained nine-month downward trend across both hospital sites. <u>Advise</u> The Trust should ensure that momentum is maintained on the coding improvement programme as this had significantly contributed to reductions in the Mortality Indicator scores (SHMI). It was considered importance that there should be no complacency as to the improvements made to date. The Mortality Insights visit in July had resulted in a commendation of the Trust's progress with additional recommendations as to integration of business intelligence, clinical and quality teams alongside improved training and the development of a mortality dashboard.

	Alert Reflecting commentary in other reports regarding the impact of delay in discharge of discharge ready patients it had been noted that there was strong national evidence of an increase in 30 day mortality associated with a more than 8-hour delay to admission in patients presenting to the Emergency Department. This was informing the ongoing work being led by the Clinical Vision of Flow programme. Learning from Lives and Deaths – People with a Learning Disability and Autistic People Reviews (LeDeR) continue to face delays, although not attributable to the Trust, and this is resulting in limited feedback being provided by relevant staff, which has a consequent impact on both timely learning and staff development but overall the feedback received was positive, particularly comments regarding the strong support provided to wards and families by the two Learning Disability nurses. An increase of still-births was recorded during Quarter 3 2024/2025 (9 cases) (noted in other maternity services reports) had prompted a comprehensive review and action plan which was being monitored by the Trust's Maternity Safety and Review Group. Kevin McNamara, Chief Executive, commended the report, commenting that a year ago the Trust's mortality data presented a significant challenge, but it was thanks to Mark Pietroni Medical Director, Charles Candish and the wider coding team for their work in improving the coding data which had contributed to the much improved position. Kevin also commented that the issues related to delay related harm (Admissions from Emergency Department, particularly for patients over 70) had been shared with system partners, in particular the Ambulance Trust, and he had confidence that this sharing of data will have an impact on efforts to improve discharge performance across the system. The board discussed the clinical summary within the report setting out the investigation and learning relating to a failure to pick up and act on a radiology report incident finding of a lung mass for a period of six months, delaying cancer treatment. When identified the mass was found to have progressed making curative treatment impossible. Sadly, the patient had since died Sam Foster confirmed that the matter had been considered at Quality and Performance Committee as part of a discussion regarding results follow-up processes. Mark Pietroni outlined the multi-faceted learning that had emerged from the investigation which had resulted in recommendations to improve the visibility and actioning of 'red-flag' radiology results, reduce alert fatigue and strengthen processes relating to imaging findings, including incidental non-bone pathology. The family had been involved in the learning process and supported throughout. It was intended that this patient's story would be used in a number of ways including raising awareness of safety issues in image reporting and staff training as to the human impact of clinical errors. **RESOLVED:** The Board NOTED the report for assurance and approved its submission to NHS England.
19	**Tower Decant Programme Update** *Mark Pietroni, Medical Director*

	Mark Pietroni, Medical Director, provided the board with an update on the programme to achieve essential fire safety works within the Tower block, Gloucester Royal Hospital, which necessitated a decant programme for several clinical services and multiple wards as it was necessary to clear the building floor by floor to allow the works to be carried out. The report was taken as read but essentially the decant was underway with neurology having been relocated to Cheltenham General Hospital with a proposal that the relocation become permanent. Three wards would be reconfigured to collocate Vascular and Endocrine wards alongside a General Medicine ward to release a ward to be used as the decant ward. The full programme of works, over a four-year period was as set out within the report with a long-term plan that high risk services (respiratory and others with patients with very limited mobility would be located on lower floors. It was confirmed that much of the work was dependent on creating the space to achieve a decant ward and that was proving difficult as a result of the system failing to meet the shared target in terms of discharge of discharge-ready patients requiring community-based services. Deborah Evans, Chair, reiterated the importance of the programme, particularly following the recent small fire incident and the expressed concerns of Gloucestershire Fire Service. In addition to continued dialogue with system partners she asked for assurance that internally the Trust had learned from its experience of ward moves during the pandemic and that we were ensuring that there was appropriate staff consultation and engagement with the programme. Mark Pietroni confirmed that all stages of the programme would involve staff consultation for substantive location moves. He confirmed that the staff consultation exercise for Wards 9a and 9b had just concluded with very positive feedback received from staff. He also confirmed that it was a central tenet of the programme that ward moves be kept to a minimum with the aim that a ward would only be moved once. It was acknowledged that there would be staff who would not welcome the changes to their environment and so effective communications and engagement would be key to addressing those concerns. Jaki Meekings-Davis, non-executive director confirmed that the importance of achieving the decant programme and the role of system partners in terms of supporting discharges was stressed at the recent Integrated Care Board strategic meeting. It was also noted that the risk relating to the fire improvement works was included in the County Council's risk register. **RESOLVED**: The Board NOTED the Briefing on the Tower Block improvement works programme.
20	**People and Organisational Development Committee Report** *Deborah Evans, Trust Chair*
	The report was presented with a focus on the items rated red/Alert and discussed at the Committee meeting. These were the ongoing industrial action by phlebotomy colleagues (on which the board had heard separately) and the risk to the workforce sustainability programme because of the failure to meet bank and agency staff usage reduction targets. This had been considered within the Integrated Performance Report, but the Committee proposed that further actions be taken, to include a divisional breakdown of bank/agency staff usage being brought to the Committee with relevant action plans and for the Trust Leadership Team to review existing action plans with a focus on achieving the necessary reductions in agency spend. Items rated as amber (Advise) included the need to include equality impact assessments on all key workforce projects, particularly the Workforce Change Model, a focus on system working to achieve the workforce change model and for the proposed new HR operating model

	to return to Committee with more granular detail on the model, including key deliverables and timescales. Deborah Evans highlighted that more support was needed for Inclusion Networks. It was identified that the Trust needed to articulate its aims to achieve a clarity of purpose and the deliverables sought from the equality work. A future report would be provided to the Committee. **RESOLVED:** The Board NOTED the report for assurance.
21	**Workforce Race Equality Standard and Workforce Disability Equality Standard Report** *Claire Radley, Director for People & Organisational Development*
	Claire Radley, Director for People & Organisational Development presented the report on the Trust's compliance with both the Workforce Race Equality and Workforce Disability Equality Standards. The report set out the Trust's compliance with the Standards and the action plans that were being developed, both short and medium term. It was acknowledged that the report was late in coming to board but a significant amount of work had been undertaken to ensure the action plan was robust, fit for purpose and meaningful. A draft Action Plan had been published to meet the submission deadline of 31 October 2025 but would be updated following the Board's approval of the Action Plan within the report. The governance route for the Action Plan was confirmed with the report having been considered and approved by the Equality, Diversity and Inclusion Steering Group, the People & Organisational Development Group and the People and Organisational Development Committee. Oversight and monitoring of the action plan would be maintained by the two delivery groups with progress also being tracked at divisional level to ensure continued focus on delivery. This was considered a key development with an increased emphasis of divisional analysis and ownership, with the focus moving from corporate Human Resources to divisional responsibility for the implementation of the action plan. Claire Radley confirmed the emphasis on the Inclusion Network refresh, noting the comments received from the People and Organisational Development Committee and Non-Executive Director colleagues. It was noted that the development of the networks over the past three years was a positive but there was a need to improve the aims and role of the networks. A recent workshop for network leads with Eden Charles, Equality, Diversity and Inclusion consultant working with the Trust had been very impactful. In addition, the launch of 'Report, Support and Learn, a reporting tool to support learning from inappropriate behaviours was intended to be a key tool in achieving compliance with the relevant workforce standards, encouraging staff to raise concerns and to be confident of the support and learning to emerge from the raising of those concerns. Kevin McNamara endorsed the recent workshop with Eden Charles and was clear that the board must remain focused on the equality, diversity and inclusion agenda utilising a strengthened framework for the staff networks. It was confirmed that the implementation of the Action Plans for both Standards would be monitored by the People and Organisational Development Committee on behalf of the board. **RESOLVED:** 1. The Board NOTED as assurance the proposed Action Plan for both the Workforce Race and Disability Equality Standards and APPROVED the publication of the final version (as per Board papers).
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 September and October 2025, focusing on the red risks and taking the majority of the report as read. The financial risk (failure to deliver recurrent financial sustainability) had, in addition to being explored at both the September and October Committee meeting, been discussed within previous board agenda items, in particular the Integrated Performance Report and would be considered by the Board in the November confidential board meeting. Other key items from the September meeting of the Committee included the need for a future board debate on the role of digital in light of both the NHS 10-year plan and the Trust's strategic aim of Digital First. The proposed delivery strategies would be key. The Committee had also considered the Integrated Care Board's delayed and caveated approval of the Trust's business case for its security services model with the caveat being that the Trustabsorb the increased costs. The Committee was clear that this delayed business case should be implemented as a priority as continued delay represents a risk for patients, staff and the Trust. Other key items from the October meeting, in addition to the focus on the financial sustainability programme and capital programme, was the report received on research and innovation. Noel Peters was commended for the work over the past year to address challenges within the team and provide a focus on future developments. Strategic Risk 14 (Research and Development) had been reviewed and was now scored 8 (Green) Additionally, the Committee had reviewed and approved a number of capital spend business cases with work progressing on an up to date estates strategy. A draft would be available by Quarter 4 for Committee review. Both Kevin McNamara and Kaye Law-Fox commented on the changes to contractual provisions for Gloucestershire Managed Services colleagues which, whilst carrying a degree of risk (including potential industrial action) was considered a positive step by the board of Gloucestershire Managed Services in line with the organisation's strategic review, undertaken in July. **RESOLVED:** The Board NOTED the report for assurance.
24	**Any other business**
	1. With the departure of Jaki Meekings-Davis there would be a change in Committee Chairs with Shawn Smith taking up the role of Audit and Assurance Committee Chair and John Cappock taking up the Chair of Finance and Resource Committee.
25	**Governor observations**
	Andrea Holder, Lead Governor, provided observations on behalf of the attending governor observers commenting on the 'no home for hate' campaign, offering the support of governors to colleagues affected. She commented positively on the Strategy and would welcome a discussion with Will Cleary-Gray, as the Executive lead, at a future Council of Governors as to the implementation of the Strategy and the supporting delivery plans alongside the NHS 10-year plan with a focus on the role of the governors. With the expectation of changes to the constitutional role of governors in foundation trusts she indicated that the Council of Governors would welcome reassurance of what role governors would have in the future of the Trust. **ACTION**

	Deborah Evans, Chair, responded by acknowledging the lack of central guidance from the Department of Health and Social Security as to the role of the Governors. She proposed that at the next Governor/Non-Executive Director workshop there should be a focus on what is very useful about how governors and Trust work together, how that can be harnessed to meet the Trust's Strategic Aims, particularly Patient Voice and Experience and the quality agenda.

Close: 12:30
Date and time of next meeting: 15 January 2026, 09:00, Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

ACTIONS/DECISIONS

Item	Action	Lead / Due Date	Update
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	Completed
25/Nov	Director of Improvement and Delivery to attend the next Council of Governor workshop. Workshop to have a focus on the future role of the Governor.	Director of Improvement and Delivery and Director of Communications	

Chairs report to January Board

1. Purpose

This report highlights some of my activities since the last Board meeting and those of my Non-Executive Director colleagues.

2. Visits

- I have continued to visit our maternity services (as in my Board report). These visits have included time spent with Joanne Cowan, our Head of Midwifery; a review of Freedom to Speak Up in Maternity with Louisa Hopkins; and a visit to the triage service in Gloucestershire Royal Hospital.

- Midwifery colleagues were keen to describe the improvement journey which the service has been on and the ways in which they have developed the triage service with feedback from families. However, the principal non-executive visiting programme is carried out by Vareta Bryan, our NED Maternity and Neonatal Champion, who makes regular visits during which colleagues, women, and birthing people can raise issues.

- Vareta has regular meetings with Matt Holdaway, Director of Nursing and Executive Maternity Safety Champion, jointly with the maternity 'quad' (leadership team).

- Patient Advice and Liaison Service – I visit the PALS service regularly to express my support for their work and to hear first-hand about concerns. This time we talked about cardiology waits and the orthopaedics service. We also discussed the transition to more automated outpatient booking processes and teething problems they can have.

- Visit to Anaesthesia – In my November Board report I noted that I had been asked to join a national visiting team who came to assess whether we were ready to be designated as an “Elective Hub”. I was pleased to be invited by Mark Eveleigh, our Specialty Director for Anaesthesia, to follow up with a visit to their department in Cheltenham, including a visit to the pre-operative assessment service and the Department of Critical Care. Mark is keen to sponsor a reduction in our cancellation rates.

- Health Overview and Scrutiny Committee – It’s always a pleasure to host a visit from local councillors and, on this occasion, to demonstrate improvements in ambulance handover times and patient experience, as well as our focus on colleague wellbeing.

- I visited the Tower wards at Gloucestershire Royal to meet night duty colleagues, in the company of Noel Peter, our Head of Research and Innovation, and Coral Boston our EDI lead. The focus of this visit was to understand more about the experience of colleagues who work at night, very many of whom are internationally trained nurses or who are Gloucestershire residents from ethnically diverse communities. We had consistent feedback around positive regard for their immediate management, that the Trust had listened to previous concerns about corridor care on wards and had stopped it and that they felt that their professional development was being supported. Ward colleagues reported that they had started taking patients' blood during the night shift without difficulty, resulting in earlier discharge for their patients. We were pleased to find that no one reported feeling unsafe or experiencing racism while travelling to and from work. However, we know that some people have had bad experiences recently, and the executives are working on our response to this.

- Quality Improvement Academy and Sepsis Care in the Emergency Department. At the most recent Quality Improvement Academy graduation, I listened to many impressive clinically led improvement projects, including one about the time taken to administer antibiotics where sepsis is suspected in Gloucester Royal Emergency Department. The improvement team, led by a registrar, reported difficulty in achieving the improvement thy sought. The Trust has a strand of work about deterioration, and after discussion with the Executive Triumvirate (Medical Director, Nursing Director and Chief Operating Officer), it has been agreed that they will support the Emergency Department with a Quality Improvement project on timely administration of antibiotics for suspected sepsis in 2026/27.

- Non-Executive and Governor visit to Spiritual Care. I was unable to join Non-Executive and Governor colleagues on the visit to Spiritual Care but have heard that it was very impressive, with a focus on pastoral care at end of life. The visit programme for the calendar year 2026 has been published and processes for feedback and action on visits have been strengthened and made more visible.

3. **Ambassadorial activities – a snapshot**

- We held the first of what may become an annual fundraising concert in Gloucester Cathedral, hosted by the Dean, Andrew Ziini, who is a member of our Big Space Cancer appeal Board. It included performances from our own Gloucestershire Hospitals choir and the Dementia choir.

- Maggies is a local branch of a national charity which supports people on their cancer journey. Their annual fundraising concert was held at Christchurch, Cheltenham on 9th December.

- Young Influencers Celebration – This was an inspiring celebration of the work of our diverse group of Young Influencers, held with their families and friends. One of the leaders has been Bryony Armstrong, who is a public Governor for Cotswolds. We thanked her and noted that she has graduated from being a young influencer, by virtue of having a recent birthday.

- BNSSG and Gloucestershire Integrated Care Board cluster - Our colleagues in the two Integrated Care Boards are working ever more closely, prior to an anticipated merger, probably from April 2027. I have had the first of what will be regular meetings with Jeff Farrar, the Chair of the ICBs and am also meeting regularly with Jane Cummings, who has been asked to ensure continuity from a non-executive perspective for Gloucestershire. The Non-Executive Directors' network is having regular meetings which are scheduled throughout 2026/27, and these have been well supported by our Non-Executive Directors.

4. The Future of Governors

- The NHS 10-year plan stated that in future "Advanced Foundation Trusts" will be created which will have similar freedoms to those originally granted to Foundation Trusts. They will not have governors as the NHS Plan intends to allow freedoms for Advanced Foundation Trusts to develop what they describe as more dynamic approaches to patient experience and community engagement.

- At Gloucestershire Hospitals Foundation Trust, we have enjoyed a good relationship with our Governors and will work with them to strengthen and develop their role in patient experience and community engagement, rather than monitoring the work of Non-Executive Directors, which are now very well scrutinised by Fit and Proper Persons requirements, NHSE and of course, myself as Chair of the Trust. We will co-design our next Governor/Non-Executive Director workshop to explore these issues.

- A programme of monthly joint visits to services has been published for 2026, and these are well supported by colleagues.

Chief Executive Report to Board – January 2026

1 Patient Experience

1.1 Resident Doctors and BMA Industrial Action

The British Medical Association held two further sets of industrial action in England, including five days between Friday 14 November and 19 November 2025 and Wednesday 17 to 22 December. The number of doctors on strike in December was an average of 36.75% across the five days, lower than in previous periods of action.

The union and government have been trying to resolve these issues since the last industrial action at the end of July and there have now been 14 sets of action time since March 2023. As part of the Trust's contingency planning, we reviewed all services to ensure that any disruption was kept to a minimum and that patients could continue to access care normally.

During the two periods of industrial action, 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 342 outpatient appointments from around 4000 scheduled appointments, and 83 of over 1000 planned operations, and our teams worked to reschedule affected patients.

1.2 Phlebotomy Industrial Action

There have been several productive discussions between the Trust and Unison regarding the ongoing strike by phlebotomists in November and December, including formal ACAS (Arbitration and Conciliation Advisory Service) meetings.

Through the meetings, two proposals have been presented and Unison and phlebotomists will vote on the option they wish to follow, and the vote is expected to take place in early January. The two proposals are:

- That the current Band 2 phlebotomy role be submitted to the national Job Evaluation Group (JEG) for an independent and objective evaluation of the role.

- A new Band 3 Phlebotomy and Outpatient Health Care Support Worker, which would include higher pay, payment to reflect the length of the strike, protection of current enhancements for weekend working (for a period of time whilst the new weekend working arrangements are established), more training and better facilities.

The offers made to our phlebotomy teams will also ensure that improvements made in the services and for patients during this strike are maintained and built on, which includes improvements in discharges before midday, as samples now reach the labs much earlier. This is improving flow and ultimately care for patients throughout the hospital, and contributing towards the improvements in ambulance handovers.

We consider this a positive offer that will result in more pay to bring an end to the strike and look forward to the outcome of the ballot.

1.3 CQC Maternity Survey

The Care Quality Commission's (CQC) National Maternity survey was published on 10 December 2025 and highlighted a significant improvement for our Trust, and we were one of just six trusts in England to emerge as 'better than expected'.

The CQC Maternity Services Survey asks women a wide range of questions about their experience of choice, continuity of care and the support they receive in hospital maternity services.

Our maternity services are on an ongoing journey of improvement. Over the past three years we have acted on CQC findings, taken part in the NHS England maternity safety support programme and brought in independent experts to help review and shape our service plans. Colleagues across Gloucestershire Hospitals have been working hard to make meaningful changes, so we are pleased to see results that reflect the progress being made.

Headline results

- Our results were about the same as most trusts for 37 questions.
- Our results were somewhat better than most trusts for 10 questions.
- Our results were better than most trusts for 10 questions.
- Our results were much better than most trusts for 1 question

Our results did not change for most questions, but we did see a significant improvement in five areas, these are:

- Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- During labour and birth, were you able to get a member of staff to help you when you needed it?
- Did you feel that midwives gave you enough support and advice to feed your baby?
- Were you given information about your own physical recovery after the birth?
- In the four weeks after the birth of your baby, did you receive help and advice from a midwife about feeding your baby?

It is good to see the improvements seen in these five areas because they reflect the things that matter significantly to women and families during pregnancy, birth and the early weeks at home. Feeling supported, listened to and able to access help when needed are fundamental to safe and compassionate maternity care.

The progress in staffing responsiveness, emotional reassurance, feeding support and information around recovery shows that our teams are making a real difference at moments when people are most vulnerable. These results tell us that more women are experiencing the safe and personalised care we strive to provide every day and form an integral part of the improvements we continue to focus on.

1.4 16 Days of Activism against gender-based violence 2025

Gloucestershire Hospitals NHS Foundation Trust supported the 16 Days of Activism Against Gender-Based Violence, a global campaign that ran from 25 November, the International Day for the Elimination of Violence Against Women, to 10 December, Human Rights Day. This reflects our commitment to promoting equality, dignity, and respect for all.

Domestic abuse is a serious and complex issue that could affect anyone, regardless of age, gender, ethnicity, or background. While anyone could be a victim, women were disproportionately impacted and are far more likely to experience repeated and severe forms of abuse, including coercive control, sexual violence, and violence that resulted in injury or death.

By supporting the 16 Days campaign, the Trust aimed to raise awareness of gender-based violence, strengthen local partnerships to tackle abuse, working with staff and communities in signposting to support services.

2. People, Culture and Leadership

2.1 Staff Awards

We came together for our annual Staff Awards at Cheltenham Racecourse on 7 November 2025, and we received an incredible 940 nominations for staff and services. It was a privilege to celebrate the many extraordinary people who make Gloucestershire Hospitals such a special place. The room was filled with inspiring stories of compassion, innovation and dedication, and the event was linked to our Lions and Large campaign.

From those on the frontline delivering outstanding care to teams working tirelessly behind the scenes, each story highlighted the impact we have on the lives of our patients and the wider community here in Gloucestershire.

It was humbling to see so many of our staff recognised for going above and beyond. There was a clear sense of energy and positivity at the event, and indeed since, and I know many people felt as I did, that it was an opportunity to reflect on the work we all do to care for others and to be part of such talented and committed people that makes us all proud to work here.

You can find out more about the awards and see some of the winners here: www.gloshospitals.nhs.uk/about-us/news-media/staff-awards-2025/

3 Quality, Safety and Delivery

3.1 Home Births

The Board will be aware that in November the Trust took the decision to temporarily pause the Home Birth Service in Gloucestershire.

As part of our wider programme of work to strengthen and improve our maternity and neonatal services, we are reviewing our home birth service, reviewing best practice and ensuring any developments reflect both clinical evidence and the experiences of women, birthing people and families.

The decision to temporarily suspend the home birth service was not taken lightly and was made following safety concerns raised by midwives and a robust risk assessment. This decision was made after careful consideration to ensure the safety of women, birthing people, babies, and staff.

The decision was based on a combination of factors:

- Staffing and skill mix: While overall midwifery recruitment has improved, there is a high proportion of newly qualified, less experienced midwives who are not yet able to support home births as they require significant autonomy, and therefore a degree of experience. The Trust has also found it challenging to cover the on-call home birth rota without compromising staff wellbeing and safety, with staff being at risk of fatigue.

- Following best practice guidance: We have seen an increase in the number of home birth requests 'outside of guidance' however, there is currently no clear, consistent, evidenced-based national guidance for home births and in particular those 'outside of guidance'. The lack of national guidance means there are differing models of care, which is causing inconsistencies in clinical risk assessments, supportive informed decision making, birth planning and clear considerations of the ethical responsibility and proportionality of offering a home birth service particularly if considered too high risk, which can reduce the ability to provide safe care, ultimately increasing the risk of harm or death.

- Safety and national learning: Home births are intended for low-risk pregnancies and are safe when supported by experienced midwives. Recent national cases, including the tragic case in Greater Manchester in 2024, highlighted the need for all home birth service provision to be assessed for safety. The Trust is reviewing its processes in light of these lessons.

Women and birthing people have the right to choose where they give birth, the provision of home birth services is contingent on availability, service capacity but ultimately safety.

We recognise the disappointment and worry this will cause women and birthing people who had planned to have a midwife attend their home birth and we are sorry that we are unable to offer it at this time. The service continues to work with all women who had told us they planned to have a home birth to individually discuss their options.

Women and birthing people can continue to access midwifery-led care at Stroud Maternity Unit and Gloucester Birth Unit, both of which offer birth in homely environments and have ample capacity. For those who are assessed as requiring medical oversight, care is recommended within the central delivery suite at Gloucestershire Royal Hospital under the care of obstetric doctors and neonatologists, ensuring access to quick, appropriate and safe care.

The Trust's improvement journey and information about the support available to service users are regularly updated on our website: Improving our maternity services

3.2 National Maternity and Neonatal Investigation

Baroness Amos and the national team visited the Trust between 4 -5 December 2025, meeting with senior leadership and staff across the maternity and neonatal services and touring the facilities to meet families. The team also conducted interviews with selected colleagues, as well as requests for key documents for review as part of an evidence panel.

On 9 December, an interim report was published by Baroness Amos on the initial reflections from the national investigation into maternity and neonatal services in England.

The report itself is very clear that, although there are local investigations of specific Trusts, the investigation aims to identify systemic, national issues in maternity and neonatal care and make recommendations to address those.

The investigation is structured around five main areas: local investigations of selected NHS Trusts, a system-wide review including evidence from families and staff, a focus on inequalities affecting seldom-heard communities, a review of the legal framework regarding Coroners and compensation, and the development of a single set of national recommendations.

The report reflects on initial findings from extensive engagement with families, staff, community, and other stakeholders nationally.

Looking ahead, the investigation will continue site visits and evidence gathering into early 2026, including a national call for evidence launched in January. Engagement with national and international experts, regulatory bodies, and community organisations will continue, with the final report and recommendations expected in Spring 2026.

The full interim report can be read here: Independent Investigation into Maternity and Neonatal Services in England – Reflections and Initial Impressions

4 Regulatory

Alongside a busy winter period, which has included industrial action, the Trust is also in a phase of regulatory oversight which teams are responding to, and this includes:

4.1 Care Quality Commission (CQC) Inspection – Maternity Services

The Trust is awaiting two reports, following separate CQC Inspections of maternity services at Gloucestershire Royal Hospital and Stroud Maternity Hospital in September 2025. The reports are expected in early 2026.

4.2 CQC Inspection – Urgent and Emergency Care and Medical Care

The CQC undertook unannounced inspections of Urgent and Emergency Care (Gloucestershire Royal Hospital and Cheltenham General Hospital); and Medical Care (Gloucestershire Royal Hospital) on 8 and 9 December 2025

The CQC was chosen due to the wider system challenges as part of 15 Trusts inspected nationally. However, these inspections solely focus on acute services.

The inspection of the services focused on all five core domains: Safe, Effective; Caring; Responsive; and Well-led and initial feedback at the end of the visit highlighted some concerns around privacy and dignity and also noted positive improvements within the Emergency Department. We expect three separate reports to be published later in 2026.

We are also in the process of supporting further announced inspections due in quarter 4. This is alongside the National Maternity and Neonatal Investigation. Each of these requires significant work locally to support and provide the data and information returns to enable the inspections to take place, and I am grateful to clinical and non-clinical colleagues supporting this at a busy time for the Trust.

4.3 National Oversight Framework

In September 2025 NHS England published a new National Oversight Framework that ranks individual Trust performance in the form of league tables as part of the commitment to have greater transparency and accountability of services. The league tables are updated and published quarterly and mean our local communities can more easily to see how we are doing and how we compare with other NHS organisations.

There is a range of metrics within the framework to measure performance, including elective and urgent care performance, patient safety, quality, finance and both staff and patient experience. These metrics are then scored and combined to give each organisation a segment rating of between 1 (high performing) to 5 (recovery support).

In the latest quarter 2 update for December 2025, our hospitals have remained ranked 17 out of 134 acute Trust, although we have moved up into segment 1. This means that we are the highest placed Trust in the Southwest and the third ranked large acute Trust in the country.

This is a result of the significant effort and commitment of staff across our hospitals in reducing waiting lists and improving services and supporting our patients. The focus from colleagues on continual improvement is making a real difference to our patients and to one another on behalf of the Board we have thanked staff for their continued efforts.

The league tables are publicly available on the NHS England website here: Acute Trust League Table and the more detailed dashboard here: NHS dashboard.

Kevin McNamara
Chief Executive

Report to Board of Directors				
Date	15 January 2025			
Title	**Report to the Care Quality Commission - Section 31 Summary Reports**			
Authors **Presenter**	Director of Midwifery (Interim)– Heather Gallagher Director of Quality Governance - 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.

Position

Please note:

- We have rated 8 conditions (self-assessed) as blue (complete and compliance sustained).

Position	Self-assessment	Total 8
Conditions met	Fully met and sustained (condition)	8

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)

- Completing a continuous risk assessment process for postpartum haemorrhage throughout the entire maternity episode (antenatal, intrapartum and postnatal) enables proactive preparation and timely intervention which significantly reduces maternal morbidity and mortality.
- 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 35.83 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 on average 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 to escalate care appropriately.

As required by CQC, the enclosed Reports and the Maternity Dashboards were sent to the CQC by the deadlines. The December 2025 report will be prepared and sent to CQC by 9 January 2026 (extension requested and approved). The Trust are also providing assurance externally to the ICB Enhanced Oversight Group (EOG) (next meeting 12 January 2026). Progress continues to be made with the Maternity Senior Leadership Team preparing for applying to CQC for the conditions to be removed.

Recommendation

The Board is asked to note the contents of the table and receive assurance that a robust improvement programme of work is underway. The next steps for the Maternity Service is to apply to CQC to have the conditions removed.

Enclosures

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

Reading Room (board access only)

- November 2025

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>Targets met and sustained</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 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>487</td><td>487</td><td>100.0%</td></tr>
<tr><td>2025-06-01</td><td>501</td><td>501</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>574</td><td>574</td><td>100.0%</td></tr>
<tr><td>Grand Total</td><td>3179</td><td>3179</td><td>100.0%</td></tr>
</table>
<u>On admission</u>

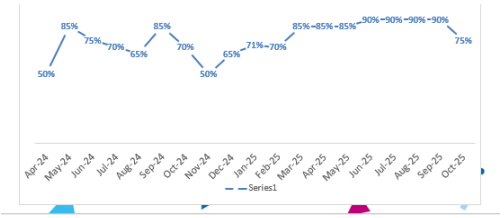
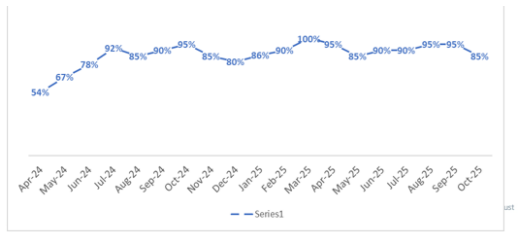
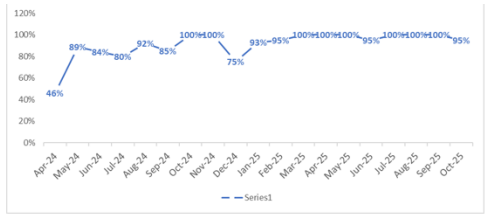
The on-admission risk assessment average is 100% (target 90%).

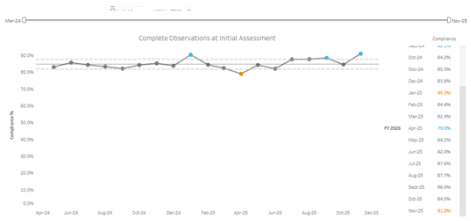
Management of PPH

REDUCE checklist completion is 85% (rolling average over the last 3 months with target of 85-90%).

Next steps

- Continue focus in obstetric theatres
- Review NICE guideline after update 14 November 2025 (Intrapartum Care)
- Four staged approach readiness, recognition, response and recording – focus now on further improving recording/documentation</td></tr>
<tr><td>2.</td><td>Ensure maternity staff at Gloucestershire Royal Hospital</td><td>Met</td><td>This month has seen a decrease in performance for peer reviews. The team are analysing why this is the case</td></tr>
</table>

Condition	Condition description	Met/ not met	Focus
	complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in line with national guidance.		to see if any changes are needed. Graph: Peer reviews 
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	To watch performance as slight decrease. Graph: Accurate interpretation  Graph: Escalation 
4.	Implement an effective system for ensuring staff at Gloucestershire Royal Hospital **complete and escalate maternity early obstetric warning score (MEOWS) charts** in line with national guidance during intrapartum	Met and sustained	Current compliance for "Act on Amber" sustained within 90-95% range for all clinical areas (intrapartum and postnatal). **Maternity triage** We have reviewed MEOWs completion (all parameters complete) at the initial assessment in Triage and this is now at 91% (target 90%).

Condition	Condition description	Met/ not met	Focus
	and postnatal care.		 **Next steps** 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	Next audit due January 2025. Guideline awaiting haematology review (Policy VTE M2014) review due 30 Nov 2025.
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. The 6 monthly Perinatal Workforce Report has been received by the Quality and Performance Committee in November 2025.
7 & 8	Monthly reports (to include PPH and Fetal Monitoring QI plan) Dashboard	Met	Monthly reports have been submitted to CQC, Trust Board, PDG and Q&P with the Perinatal dashboard demonstrating compliance.

Condition	Condition description	Met/ not met	Focus
			Progress is reported within the Division in the Perinatal Quality Surveillance Report.

Alert, Advise and Assure Report to the Board of Directors Meeting held on Thursday 15 January 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Quality and Performance Committee held on 18 November 2025
Board member lead(s)		NED Chair: John Cappock & Executive leads Director of Finance and Director of Integrated Governance
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	
	Discussion	
	Note	✓

PURPOSE OF REPORT

To present an update to the Board of Directors from the meeting of the Audit and Assurance Committee held on 18 November 2025.

The Audit and Assurance committee meets at least five times annually and is attended by members of the Board and senior managers.
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. Business transacted related to Internal Audit and Counter Fraud activity. These included Conflicts of Interest and Fit and Proper Person Process and budgetary controls internal audit reports and a report on salary overpayments by the Counter Fraud service. The Committee also met in confidential session and considered two reserved items of business. One had previously been considered, and excellent progress was noted. The second item, whilst of concern, had a clear and SMART action plan to address shortcomings by the end of the financial year

KEY POINTS

ALERT: matters that require the boards attention or action, e.g. non-compliance, safety concern or a threat to the Trust's strategy.
• *Nil to report*
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance.
• *Conflicts of interest and fit and proper persons* – In summary, satisfactory processes being ineffectively deployed. Recommendations agreed and action plans in place. • *Budgetary control* – satisfactory processes and effective deployment. Recommendations agreed and action plans in place. Specific recommendations around training and support to budget holders considered high priority. • *Counter fraud – updated policy reviewed and approved as detailed below. Salary overpayments position of concern. Policies have been updated and it will now be possible to hold more effectively repeat offenders to account.* • *Risk – Committee reported this as an amber item in September as the Trust risk appetite and profile had not been concluded. Whilst the score remains amber, the position has progressed and there is more focus on mitigations.* • *FOI SAR – A good report and current resourcing challenges are being well managed with a clear plan to address*
ASSURE: inform the board where positive assurance has been received
• include no more than 3-matters the Committee wants the Board to be assured of and which have been discussed at the Committee meeting. • Bullet point – concise descriptor. • *High quality and well-prepared papers* • *Satisfactory progress against annual internal audit plan, some reprofiling but at this stage all considered deliverable.* • *Clinical Audit assurance – applaud. Excellent work to bring a greater level of scrutiny and consistency of learning and application of good practice around clinical effectiveness*
APPROVALS: decisions made by the Committee
Updated Counter Fraud Bribery and Corruption Policy was approved

IMPLICATIONS

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	✓
People, culture and leadership	✓

Quality, safety and delivery	✓
Digital first	✓

BOARD ASSURANCE FRAMEWORK

BAF reference	**SR**

RECOMMENDATIONS

The Board of Directors is asked to take **assurance** from the report or **note** the report

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	15 January 2026
Report title	Board Assurance Framework Report
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance Sarah Favell, Trust Secretary

Purpose (confirm the appropriate box)			
For approval	**For discussion**	**For information**	**For Assurance**
X	X		X

Executive Summary	
• To provide the Board of Directors with an update on the realignment of the Board Assurance Framework against the Trust Strategy and seek the Board's approval of the Strategic Risks contained within. • To provide the Board of Directors with updates regarding the management of strategic risks, their primary controls and the range of assurances in place as detailed in the Board Assurance Framework.	
Previously considered by	Not applicable: New Board Assurance Framework developed within Board Development Seminars/Workshops during Quarter 3 2025/26.

Recommendations:

The board are asked to:

- Review and **approve** the updated Board Assurance Framework, new strategic risk descriptions and initial risk scorings, taking into account the Trust's revised Risk Appetite Statement (Appendix 3) and the Updated Board Assurance Framework.
- **Note** that Strategic Risk 1 (Quality and Safety) is subject to an ongoing review against the Trust's new Strategy and will be considered at the February meeting of Quality and Performance Committee.
- **Discuss** and explore the need to focus on the effectiveness of controls and sources of assurance.
- Delegate responsibility to Board Committees to comprehensively review those strategic risks within their portfolio during Quarter 4, emphasising a focus on the effectiveness of

controls and the levels of assurance with final version Strategic Risks to be confirmed prior to commencement of Quarter 1 2026/27
- Timetable a review of the Board Assurance Framework, alongside the Risk Appetite Statement at the May Board of Directors meeting.
- Note for assurance the review of current strategic risks during November and December 2025.

Strategic Aims (tick as appropriate)	
Patient experience and voice	✓
People, culture and leadership	✓
Quality, safety and delivery	✓
Digital first	✓

Impact on any Strategic Risks?
Report on Board Assurance Framework: all strategic risks

Implications on:	
Equality, Diversity and Inclusion	
Health Inequalities	
Finance and Resource	
Regulation/Legal	The report ensures and demonstrates compliance with the NHS Provider Licence, NHS Oversight Framework and UK corporate governance principles
CQC-Key line of enquiry	The report aligns with the CQC Well-Led domain by evidencing effective leadership, governance and oversight arrangements in respect of the management of both strategic priorities and risks to those priorities.
Green Plan	

Key Points
The Board Assurance Framework (BAF) provides details of strategic risks, the primary control framework, the assurances provided, and actions underway to mitigate uncertainty relating to the Trust's Strategic Aims.

New strategic risks have been developed by the Executive Team and the format and content of the Board Assurance Framework have been updated.

Enclosures

Appendix 1: Updated Board Assurance Framework Summary and key to Board Assurance Framework
Appendix 1a: Board Assurance Framework Summary – November 2025
Appendix 2: Three lines of defence/assurance model
Appendix 3: Risk appetite statement

FOI: Public

Report on the Updated Board Assurance Framework

January 2026

1. Introduction

1.1. As a statutory governance tool, the Board Assurance Framework supports the Board of Directors in fulfilling its responsibilities for oversight, accountability, and assurance by identifying and managing the principal risks to the delivery of the Trust's strategy.

1.2. Clear alignment between the Board Assurance Framework and the Trust's strategy is essential to ensure the organisation remains focused on its long-term vision, statutory duties, and commitments to patients, staff, members and stakeholders.

1.3. This report provides information and assurance to the Board of Directors in relation to the re-fresh and re-alignment of strategic risks which may impact on the realisation of the Trust's strategic aims, as set out within the recently approved Trust Strategy (November 2025).

1.4. Information regarding strategic risk is provided to the Board through the Board Assurance Framework (BAF). The Board Assurance Framework consists of strategic risks identified and managed by the responsible executive directors and their senior teams, with support from the Corporate Governance Team.

1.5. The importance of this stage in the realignment process is to; ensure the accuracy of the risk descriptions, the appropriate risk scoring, considering the Trust's refreshed Risk Appetite Statement (November board). It is also to be clear as to the controls environment and available assurance. The next stage will be to work with the responsible executives and assurance committee to strengthen the controls, address gaps and focus on the quality of assurance available.

1.6. It is proposed that, from Quarter 1 2026/27 the Board Assurance Framework will be reviewed and updated three times each year for approval by the Board of Directors. Board Committees will continue to review strategic risks within their remit on a regular basis and seek assurance as to the effectiveness of controls and the action plans in place to mitigate risk.

1.7. It is also proposed that the Board Assurance Framework will be reviewed by the Board in May 2026, alongside the Risk Appetite Statement to ensure that both are effective risk management tools. This will enable the Assurance Committees and responsible directors, with support from the Corporate Governance team to strength both controls and sources of assurance.

2. Trust Strategy

2.1. The Trust's strategy sets out its vision, values, and strategic aims which reflect both the needs of its local population and national NHS policy, including the NHS 10-year plan.

2.2. The Trust's strategic aims (from November 2025) are:

2.3. These strategic aims provide the framework against which the strategic risks have been identified and assessed within the Board Assurance Framework. This is an evolving 'live document' process if it is to be an effective risk management tool.

2.4. It is recognised that these strategic risks are likely to be relevant to multiple strategic aims, golden threads and enablers of success but for clarity in this first iteration of the new Board Assurance Framework we have specified a principal strategic aim for each risk. It is intended, as the Board Assurance Framework matures over the next 12 months, that this multi-faceted aspect of the Framework will be evidenced both in the work of the committees but also the documentation, with reference to other strategic aims, golden threads and enablers being referenced.

3. Board Assurance Framework

3.1. The Board of Directors requires regular assurance that the Trust is progressing to achieve its strategic aims in the expected way with the expected outcomes. This includes threats to achievement (risk), internal controls which have been put in place and the sources of assurance provided.

3.2. The sum of assurances received by the Board of Directors constitutes the Board Assurance Framework, the purpose of which is to:

3.2.1. Describe the Trust's strategic risks as identified by members of the Executive Team and approved by the Board of Directors;
3.2.2. Confirm the strategic themes which each risk is likely to affect;
3.2.3. Confirm the initial, current and target scores for each of the strategic risks
3.2.4. Identify how each risk is being mitigated (the primary controls in place);

3.2.5. Confirm the type of assurance offered for each control, its source, and the level of assurance that is provided;

3.2.6. Identify actions which will address weakness in or the absence of the primary controls.

3.3. The refreshed Strategic Risk template and Board Assurance Framework summary document have been developed and updated by Executives Executive Team, working with the Trust Secretary. These have been considered in Board development sessions and is now reported for approval and assurance to the Board of Directors. The updated version of the Board Assurance Framework Summary is included at Appendix 1. For comparator purposes the November 2025 Board Assurance Framework summary is included at Appendix 1A.

3.4. The Board Assurance Framework, and the strategic risks therein, are used as a live document to support effective Board and Board Committee oversight by informing strategic decision-making, highlighting emerging risks that may require changes to either strategy or delivery plans, supporting prioritisation of resources and investment as well as providing evidence of robust governance to regulators and stakeholders.

4. Alignment of the Board Assurance Framework with the Trust's strategy

4.1. Through the development workshops the Board was able to assure itself that, when compared to both peer and outstanding NHS Trusts and when considering relevant guidance, the Trust's previous strategic risks were not outliers from NHS best practice. Those risks focus on quality, safety, patient experience, financial sustainability, workforce, engagement of stakeholders, the digital and estates infrastructure. In refreshing the Trust's Board Assurance Framework much of those risks remains substantially unchanged, but now aligned to the Trust's new strategic aims, with more accurate risk descriptors but with transferred controls and sources of assurance.

4.2. <u>Strategic aims and principal risks</u>

The Board Assurance Framework explicitly links each strategic risk to a specific strategic aim within the Strategy, providing a clear line of sight from the Trust's ambitions to the risks that could undermine delivery. This ensures that all strategic priorities are reflected, that the most significant threats to strategy delivery are visible to the board and that board discussions are focused on strategic delivery rather than operational detail.

4.3. <u>Controls supporting delivery</u>

It is intended that key controls within the Board Assurance Framework will align to key Trust strategic programmes and enabling strategies in areas such as quality and safety governance, clinical service delivery, financial sustainability programmes, workforce models and strategies, capital, infrastructure and digital transformation programmes

4.4. <u>Sources of assurance</u>

The Trust is strengthening its assurance processes by re-emphasising the three lines of defence approach to assurance (see Appendix 2). By actively seeking evidence of assurance, both direct, internal and external or by identifying gaps in that assurance the

board and board Committees will be able to assess the effectiveness of both the controls and action plans in place.

4.5. Risk appetite and tolerance

The board has recently (November 2025) approved the Trust's refreshed Risk Appetite Statement (Appendix 3) and this will be utilised to score and monitor strategic risks, which in turn will ensure that the Trust's approach to risk management achieves a balance between supporting strategic ambitions whilst maintaining necessary safeguards.

5. Refreshed Strategic Risks

5.1. The below table sets out the proposed Strategic Risks within the Board Assurance Framework.

Strategic aim	Risk title and description	Initial Score	New Score	Target Score	Risk Owner	Committee
SR 1 Quality, safety & delivery	**Inability to deliver safe and effective services against regulatory and statutory requirements** The provision of safe, effective care that is responsive to the needs of patients is underpinned by statutory and regulatory standards and best practice guidance. Meeting these standards requires services to be well-led, with staff who are highly skilled, in an environment that acknowledges mistakes when they happen, and seeks to learn continually and improve through the implementation of effective governance arrangements Proposed Replacement for SR2 and SR5	20 5x4	12 To be confirmed	To be confirmed	CN/MD	QPC
SR2 People, culture & leadership	**Inability to attract and sustain a skilled, diverse and adaptable workforce may lead to skills shortages, reduced service quality, reduced operational productivity, and increased costs.** Attracting and retaining a skilled, diverse and adaptable workforce is fundamental to delivering high-quality	20 4x5	16 4x4	12 3x4	CPO	PODC

	services efficiently and sustainably, while supporting long-term organisational performance. Embracing our role as an anchor organisation is critical to strengthening our reputation as an employer of choice. Replacement for SR 17					
SR 3 People, culture & leadership	**Inability to retain a skilled, compassionate and diverse workforce that reflects the communities we serve because of a poor cultural environment and lack of development opportunities, impacting overall staff experience** The quality of patient care is intrinsically linked to the health, wellbeing, and morale of our staff. Prioritising the development and retention of a diverse workforce within an inclusive culture, where everyone feels valued and is treated fairly, we strengthen this connection Replacement for SR 16	20 4x5	16 4x4	12 3x4	CPO	PODC
SR 4 Quality, safety & delivery	**Failure to meet statutory and regulatory requirements to manage financial resources.** National mandates require us to contribute to a balanced net financial position for 2025/26 as an ICS. To achieve this challenging proposition, a financial sustainability programme needs to be achieved balancing efficiencies against the delivery of high quality, efficient and sustainable services Replacement SR9	25 5x5	25 5x5	Mar 26 5x4=20 Mar 27 5x3=15 Mar 28 5x2=10 Mar 29 5x1=5	DoF	FRC
SR 5	**Failure to provide timely access to services for patients.** National waiting time standards exist to support	n/a New risk - wider than	16 4x4	12 4x3	COO	QPC

Quality, safety & delivery	timely treatment of patients. Demand for NHS urgent and emergency care, elective care, cancer care and diagnostics have increased in recent years. NHS Providers are required to make substantial improvements to waiting times and productivity in line with NHS England targets New risk - Replacement for SR1	old SR1				
SR 6 Digital First	**Infrastructure & Cyber – Reliable Digital Foundations** There is a risk that the Trust's digital infrastructure and cyber security arrangements may not be sufficiently robust, resilient, connected, or up-to-date to support safe, effective, and continuous service delivery – including a solid platform for digital transformation. This could result in system outages, data breaches, or loss of critical services, undermining patient safety, increasing costs, staff wellbeing operational effectiveness, undermining public confidence and impeding delivery of the Trust's strategic objectives. Updated SR 12	15 3x5	20 4 x5	12 3x4	CDIO	FRC
SR7 Digital First	**Strategic Digital Risk: Digital Transformation & Culture** There is a risk that the Trust may not develop or sustain a digital culture, operating models, software architecture, skills, and leadership skills necessary to deliver digital transformation at scale and pace. Failure to build these foundations could result in inconsistent adoption of digital ways of working, limited capacity to embed new technologies and innovation, and widening inequalities in digital access	n/a	4x5 20	10 2x5	CDIO	FRC

	and patient experience. Collectively, these issues may prevent the Trust from realising its strategic ambitions and meeting expectations for a modern, data-driven NHS. New risk					
SR 8 Quality, safety & delivery	**State of the Estates** Risk of sub-standard asset condition and estate compliance position impacting safety and experience (staff and patients), historic and current capital investment insufficient to maintain NHS requirements, estates suitability and facilities not supporting high-quality care or optimal patient experience. Updated SR 10	4x4 16	4x4 16	4x4 16	COO	FRC
SR 9 Quality, safety & delivery	**Health and Safety risk** Failure to implement a robust health and safety governance framework which defines the role of the board and those in safety leadership, the structure through which the health and safety vision and commitment is set, safety objectives are agreed and the framework for monitoring performance is established with a view to ensuring compliance with legislation. New risk	4x5 20	4x4 16	3x2 6	DoIG	AAC
SR 10 Patient experience & voice	Failure to engage and involve patients, carers and communities in shaping services and experience. We build and maintain strong relationships with our communities and partners to understand the lived experience, improve the health and well-being of local people, improve access to services and shape healthcare services. Updated SR7	2x2 4	2x2 4	1x3 3	DoID	QPC

5.2. Specific items to note:

5.2.1. The proposed strategic risk for quality and safety reflects a change of focus from the previous strategic risk which was focused on clinical governance and this is the subject of continuing review by the Chief Nurse and Medical Director who have requested that it is first considered at Quality and Performance Committee for support and direction. It will be finalised during Quarter 4 2025/2026.

5.2.2. The strategic risk for research and development has been removed from the Board Assurance Framework. The risk scored low and was no longer considered a key risk. It also requires significant a refresh to properly reflect the Trust's new strategic commentary on research and development, recognising a shift in the strategy from the previous strategy. This risk will be reviewed during Quarter 4 2025/2026 and, if determined appropriate, a redesigned risk will be added to the Board Assurance Framework during 2026/27.

5.2.3. Strategic Risk 10 (Stakeholder engagement) primarily focuses on community and stakeholder engagement. There is ongoing discussion required as to the need for a separate risks relating to patient voice and health inequalities. This will be reviewed by the responsible executive directors during Quarter 4 2025/2026 and, if determined appropriate, a new risk will be added to the Board Assurance Framework during 2026/27.

5.2.4. Consideration is being given to a green plan/sustainability risk and this will be resolved during Quarter 4 2025/2026

5.2.5. This is a first iteration of the Strategic Risks within the Board Assurance Framework. There remains work to be done, including aligning relevant Trust risks to those strategic risks for which the Trust risk are key drivers. Following the approval of the new Trust risk appetite work is continuing to align all relevant Trust/Corporate risks and key risks will be added to the relevant Strategic Risks once that process is complete (during Quarter 4 2025/2026)

6. Next steps in respect of new strategic risks

6.1. The Committees of the Board will review the refreshed Board Assurance Framework and individual strategic risks within their remit for the first time during January and February 2026. In doing so each Committee will be asked to consider the following points with the Executive risk owner:

6.1.1. To confirm the risks are correctly identified as being within the purview of the Committee;

6.1.2. To review the context of each risk to identify any gaps in the assessment;

6.1.3. To discuss the rationale for the current score of each risk;

6.1.4. To discuss the planned mitigation and any barriers which may be present.

6.2. Executive Directors responsible for individual Strategic Risks will work with the Trust Secretary to refresh and update the strategic risks to reflect the feedback from the

Committees and to reflect the continued focus on the effectiveness of the control measures. A further iteration of the Board Assurance will be reviewed at the Board meeting in May 2026. The review cycle will then move to a 3 x yearly (financial year) board review of the Board Assurance Framework.

7. Executive and Board Assurance Committee review of existing strategic risks (November to December): Business as usual

7.1. There were no Committee meetings in December. The following Committees met since the last Board meeting (11 November 2025) and reviewed the following strategic risks:

Committee	Review	Current score
Finance and Resource Committee	SR9: Financial sustainability – update to action plans	5x5=25
	SR 10: Estates – general review of key areas of risk, controls and action plans	4x4=16
People and Organisational Development Committee	No review of strategic risks. Review of Corporate risks only	n/a
Quality and Performance Committee	SR 2: Quality governance – update to action plan and confirmation of full compliance against CQC conditions (maternity services)	3x4+12
Audit and Assurance Committee	Health & Safety risk was not due for review	n/a

8. Recommendations

8.1. Review and approve the updated Board Assurance Framework, new strategic risk descriptions and initial risk scorings, taking into account the Trust's revised Risk Appetite Statement (Appendix 3) and the Updated Board Assurance Framework.

8.2. Note that Strategic Risk 1 (Quality and Safety) is subject to an ongoing review against the Trust's new Strategy and will be considered at the February meeting of Quality and Performance Committee.

8.3. Discuss and explore the need to focus on the effectiveness of controls and sources of assurance.

8.4. Delegate responsibility to Board Committees to comprehensively review those strategic risks within their portfolio during Quarter 4, emphasising a focus on the effectiveness of controls and the levels of assurance with final version Strategic Risks to be confirmed prior to commencement of Quarter 1 2026/27

8.5. Timetable a review of the Board Assurance Framework, alongside the Risk Appetite Statement at the May Board of Directors meeting.

8.6. Note for assurance the review of current strategic risks during November and December 2025.

Sarah Favell
Trust Secretary
January 2026

Board Assurance Framework Summary : January 2026

Ref	Risk Description	Strategic Aim	Last Review	Lead	Committee	Current Score	Target Score	Risk Appetite
1,	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							
SR10	Failure to engage and involve patients, carers and communities in shaping services and experience		New risk	Director of Improvement and Delivery	QPC	4 2x2	3 1x3	Significant
2.	People, culture and leadership – our goal is to enhance staff experience and sustainability in an organisation where everyone can flourish.							
SR2	Inability to attract and sustain a skilled, diverse and adaptable workforce may lead to skills shortages, reduced service quality, reduced operational productivity, and increased costs.		Nov 2025	Chief People Officer	PODC	16 4x4	12 3x4	Cautious
SR3	Inability to retain a skilled, compassionate and diverse workforce that reflects the communities we serve because of a poor cultural environment and lack of development opportunities, impacting overall staff experience		June 2025	Chief People Officer	PODC	16 4x4	12 3x4	Open
3.	Quality, safety and delivery – our goal is to provide timely and responsive, high-quality, safe and effective services always for everyone							
SR1	Inability to deliver safe and effective services against regulatory and statutory requirements		Nov 2025	Chief Nurse/ Medical Director	QPC	12 3x4 To be confirmed	To be confirmed	Cautious

SR4	Failure to meet statutory and regulatory requirements to manage financial resources.		Nov 25	Director of Finance	FRC	25 5x5	Mar 26 - 20 Mar 27 - 15 Mar 28 - 10 Mar 29 - 5	Cautious
SR5	Failure to provide timely access to services for patients.		July 2025	Chief Operating Officer	QPC	16 4x4	12 4x3	Open
SR8	State of Estate - Risk of sub-standard asset condition and estate compliance position impacting safety and experience (staff and patients), historic and current capital investment insufficient to maintain NHS requirements, estates suitability and facilities not supporting high-quality care or optimal patient experience.		Nov 25	Chief Operating Officer	FRC	16 4x4	To be confirmed - under review	To be confirmed – under review
SR9	Health & Safety - Failure to implement a robust health and safety governance framework which defines the role of the board and those in safety leadership, the structure through which the health and safety vision and commitment is set, safety objectives are agreed and the framework for monitoring performance is established with a view to ensuring compliance with legislation.		Sept 25	Director of Integrated Governance	AAC	16 4x4	6 3x2	Cautious

4.	Digital first – our goal is to support patients and staff to be supported by technology and an innovative culture							
SR6	Infrastructure & Cyber – Reliable Digital Foundations There is a risk that the Trust's digital infrastructure and cyber security arrangements may not be sufficiently robust, resilient, connected, or up-to-date to support safe, effective, and continuous service delivery – including a solid platform for digital transformation		Sept/ Oct 2025	Chief Digital Information Officer	FRC	20 4x5	12 3x4	Cautious
SR7	Digital Transformation & Culture There is a risk that the Trust may not develop or sustain a digital culture, operating models, software architecture, skills, and leadership skills necessary to deliver digital transformation at scale and pace		Sept/ Oct	Chief Digital Information Officer	FRC	20 4x5	10 2x5	Seek

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
						SR4
	4	4 Rating	8 Rating	12 Rating	16 Rating	20 Rating
					SR2, SR3 SR 5, SR8, SR9	SR6, SR7
	3	3 Rating	6 Rating	9 Rating	12 Rating	15 Rating
					SR1	
	2	2 Rating	4 Rating	6 Rating	8 Rating	10 Rating
			SR10			
	1	1 Rating	2 Rating	3 Rating	4 Rating	5 Rating

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**

Appendix 2 : Three lines of defence Assurance Model

Appendix 3 - 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**

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	15 January 2026
Report title	Integrated Governance Report – Legal, Regulatory and Policy Update
Sponsoring Director/Author	Kerry Roger, Director of Integrated Governance

For discussion
Presented as a constructive stimulant to understanding of the potential impacts of new regulations or of breaches/failings of others being 'true for us'.

Executive Summary

This report provides an update to inform the Board of Directors on recent regulation and compliance guidance/policy issued by such as NHS England, the Care Quality Commission and other relevant bodies where their action/publications have a consequential impact on the Trust, or an awareness of the change/impending change is relevant to the Board of Directors. A section in the Addendum to pick up learning or stimulate curiosity around what's a 'True for Us' position is also included to support development/improvement activity and focus of the Board and its committees. Areas pertinent to the Trust's business will feature in future reports, so what is included this time is for illustrative purposes.

Proactive assessment is a core component of effective Board governance and enables early identification of risks and to stress test new rules to understand impact on the overall risk profile. With regard to the concept of 'True for Us' – post failure regulations often aim to increase accountability, often placing direct responsibility on directors.

The Board's active engagement sets a strong tone fostering a culture of integrity and accountability and learning from the failures of others and implementing the lessons helps the Board put in place stronger internal controls and oversight mechanisms, safeguarding the Trust from similar potential crises.

Previously considered by	N/A

Recommendations:

The Board of Directors is invited to

1. consider and note the content of the report and where relevant, members should each be satisfied through any additional enquiry, of their individual and collective assurances and reassurances that the internal plans and current controls in place to deliver or prepare for compliance against any of the Trust's obligations are appropriate and effective.
2. support Board Committee chairs and the Corporate Governance Team to ensure relevant focus of key risk areas in the report through Committee agendas and workplans.

Strategic Aims (tick as appropriate)	
Patient experience and voice	/
People, culture and leadership	/
Quality, safety and delivery	/
Digital first	/

Impact on any Strategic Risks?
Strategic misalignment – regulations and 'corporate' failure can clash with existing strategies, requiring difficult trade offs between national goals (e.g. reducing inequalities/reducing carbon footprint) and local service delivery. Any perception of organisational learning deficit damages public and staff trust and confidence.

Implications on:	
Equality, Diversity and Inclusion	No assessment in the context of this report content but specific items in the report may relate directly (e.g. sexual safety)
Health Inequalities	No assessment in the context of this report content but specific items in the report may relate directly
Finance and Resource	No assessment in the context of this report content, but often, increased complexity that comes with changing regulation/statute/policy reduces financial flexibilities. (e.g. Modern Slavery and new supply chain checks)
Regulation/Legal	The intention of the report is specific to the legal and regulatory context.

CQC-Key line of enquiry	Brief narrative e.g. The report aligns with the CQC Well-Led domain by evidencing effective leadership, governance and oversight arrangements by assessing how we manage strategic risks related to new regulations and historical failures. The shared direction and culture domain assesses how Boards translate national mandates into local vision that staff understand and support.
Green Plan	No assessment in the context of this report content but specific items in the report may relate directly to sustainability

Main Report

A. SITUATION

This report provides an update to inform the Board of Directors on recent regulation and compliance guidance/policy issued by such as NHS England, the Care Quality Commission and other relevant bodies where their action/publications have a consequential impact on the Trust, or an awareness of the change/impending change is relevant to the Board of Directors. A section in the Addendum to pick up learning or stimulate curiosity around what's a 'True for Us' position is also included to support development/improvement activity and focus of the Board and its committees. Areas pertinent to the Trust's business will feature in future reports, so what is included this time is for illustrative purposes.

Proposals regarding any matters arising out of the regular Legal, Regulatory & Policy Update report will where necessary be received by the Executive Team. This will ensure timely updates, to enable the Trust to respond as necessary to consultations and to ensure preparedness for the implications of, and compliance with changes in mandatory and best practice frameworks.

B. BACKGROUND

1. Patient care in temporary care environments

Temporary care environments – commonly referred to as 'corridor care' – are spaces not originally designed, staffed or equipped for patient care, such as waiting rooms, corridors, chairs on wards, ambulances outside emergency departments and other hospital areas not designed for inpatient care. There are widespread concerns about normalising their use and the impact on patients and staff. The Board has discussed this matter regularly and seen significant progress with avoiding it in the Trust notwithstanding the recent concerns in ED due to operational pressures. The HSSIB report urges healthcare leaders and NHS trusts to better understand and manage the risks that temporary care environments may present to patient safety. It includes a safety observation and a series of learning prompts to help NHS staff and organisations respond to this particular patient safety concern.

Patient care in temporary care environments

Trust position: The Board has previously discussed the importance of the definition of temporary care environments, known to vary across organisations. In the absence of consistent metrics or definitions it is difficult to evaluate the impact. Significant attention has been given to this area of patient care and patient and staff experience, evident in the success of reducing boarding across many areas of the Trust. The Integrated Performance Report to Board and discussions highlighted from the Trust

Leadership Team illustrate concerns regarding an increase of such situations more recently in ED. The Trust intends to use this report to examine its own systems and processes for managing the risks and the experiences of those impacted particularly when eliminating the use of temporary care environments will always be challenging in times of high demand.

2. **Data Security and Protection Toolkit 25/26**

In September the latest version of the Toolkit was published. The deadline for submission is 30th June 2026 and this version introduces new outcomes/assertions/evidence, stronger asset, supplier and training mandates, and Cyber Essentials Plus for suppliers (requiring supplier chain risks to be managed). For information, the CQC's Single Assessment Framework explicitly references the Data Security and Protection Toolkit and the Well Led Quality Statement tests that there are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems, and that information is used effectively to monitor and improve the quality of care. DPST is not just an IT or information governance issue, it underpins patient trust, legal compliance and operational resilience. For NHS Trusts, there are 9 mandated outcomes to be audited (listed below) with organisations selecting 3 outcomes of their choice.

A1.a Board direction
B1.a Policy, process and procedure development
B4.a Secure by design
B5.a Resilience preparation
B5.c Backups
C1.b Securing logs
D2.a Incident root cause analysis
E2.a Managing data subject rights under UK GDPR
E2.c National data opt-out policy

https://www.dsptoolkit.nhs.uk/News/DSPT-Changes

Audit links:https://www.dsptoolkit.nhs.uk/Help/Independent-Assessment-Guides

Trust position: The DPST is an annual self-assessment measuring compliance with the UK data protection law, NHS contractual obligations, and cyber security standards (including the Cyber Assessment Framework). Prior to the submission deadline in June 2026, the Internal Auditors will undertake an annual audit against aspects of our compliance with the Toolkit requirements and the Audit and Assurance Committee will receive a report on our recommended assessment. The Board is ultimately responsible for ensuring the Trust meets standards through its oversight of information governance, cyber security and risk management. Board should - be confident there are not any gaps in data protection or cyber security, ensure incident management and reporting are robust, monitor training and awareness on the same, and ensure the BAF is up to date with DPST risks. The A&A Committee will make recommendations to the Board in due course.

3. **NHS Oversight Framework – performance league tables**

NHS England has published segmentation and league table figures for Quarter 2 under the NHS Oversight Framework and will continue to do so quarterly. The dashboard provides a

view of how NHS trusts are performing in key services including urgent and emergency care, elective services, mental health and more. This is only the 2nd set of data published under the revised process so significant care needs to be taken when interpreting the information provided. As data builds, a better picture will emerge to understand 'normal' levels of performance variation etc (which a full year's data will in future support) however we can still draw some conclusions from this data with a degree of confidence. A total of 38 Trusts have seen a change in segment since Q1 and more Trusts were considered significantly off track against financial plan than in Q1. A total of 119 Trusts are subject to the financial override where the segment of any organisation determined to be in financial deficit is capped at no better than segment 3.

NHS England » NHS oversight framework – NHS trust performance league tables process and results

Trust position: The Trust has improved to Segment 1, remaining 17th overall out of 134 in the acute sector and 3rd position for large, non-specialist acute trusts. Two areas of patient safety metrics both from the staff survey (raising concerns and engagement theme sub scores) show the Trust 124th and 121st respectively. The Trust being scored first out of 134 in metrics regarding C.difficile and E.coli, and 1st out of 79 for over 52 weeks for community services. The position against the Trust's financial plan will be a key determinant of future segmentation outcomes. Provider oversight is now with NHSE who have set out our oversight arrangements for the holistic oversight of performance and regulatory interventions where required. The frequency of oversight meetings will be determined by our published NOF ratings based on consecutive frequency and published quarterly league tables. We are currently NOF segment one which requires an annual oversight meeting.

4. **NHS Finance Business Rules from 2026-27**

As set out in paragraph 6, NHS trusts will no longer be subject to the joint financial objective for each ICB and its partner NHS trusts to seek to deliver system financial balance from 2026/27. NHS England will require **each NHS trust to deliver breakeven in its revenue position in each financial year from 2026/27**, unless agreed otherwise with NHS England in exceptional circumstances. NHS trusts must continue to collaborate with ICBs to support the delivery of locally agreed priorities, as described in paragraph 8.

As part of the transition to the new accountability arrangements, where an NHS trust does not deliver its agreed plan position in 2025/26, NHS England may adjust NHS trust plan limits, including any associated deficit support funding, in 2026/27 as a consequence for not delivering the 2025/26 plan.

Similarly to the expectations for ICBs, NHS trusts are also required to ensure they have a robust approach to risk management in place. NHS trust plans should demonstrate a comprehensive understanding of financial risk and how these risks will be managed and mitigated. As part of the risk management approach, ICBs and NHS trusts should agree contract values in advance of the start of the year and ensure these are reflected as part of aligned plan submissions. The revenue finance and contracting guidance will provide more detail on the approach to risk management for the relevant financial period where required.

The 10 Year Health Plan sets an ambition for NHS trusts to move into surplus over the long term. It is anticipated, further information will be shared in due course on the proposed financial freedoms and flexibilities for new NHS foundation trusts, including access to prior-year surpluses.

NHS England » NHS finance business rules from 2026/27: guidance for integrated care boards and NHS trusts

Trust position: The activity being reported to, and governed by the Board and Finance and Resources Committee is cognisant of this guidance and accounts for the need for financial sustainability and system collaboration. The rules require robust financial planning with multi-year financial plans and modelling for risks and opportunities. The Board will need to ensure compliance with its statutory duties and understand the consequences of breaching them as well as being clear how financial risks are identified, shared and mitigated across the system. The increasing prevalence of Board Assurance Statements (BAS) and the consequence of breaching same, lays bare the processes the Board relies upon to make those assessments which will be open to scrutiny in the event of breach. An important consideration for the Board when it next reviews the Medium Term Plan BAS January/February Board sessions.

5. **Actions to prevent sexual misconduct in the NHS**

NHS England wrote in December to CEOs and CPOs in light of historic allegations of sexual assaults against young and vulnerable patients at Royal Stoke University Hospital and Russells Hall Hospital. Employers of NHS staff have been asked to take extra care in supporting staff or patients impacted.

The letter highlights results from a recent audit of adoption of the sexual misconduct policy framework which show progress with every trust and ICB now having a policy in place or in the process of adopting one. Seventy six percent have implemented anonymous reporting for staff who wish to speak up about sexual misconduct in the workplace. However, the audit also highlights that further focus and consistency are needed in some parts of the NHS and actions for all organisations delivering NHS care are set out. These include:

- Investigations training: two people professionals to undertaking national training following a train the trainer model
- Specialist investigators: Organisations should ensure that investigators of sexual misconduct allegations have specialist training, as set out in the national sexual misconduct policy framework. Trusts are asked to build a pool of medical/dental investigators specially trained and Responsible Officers should also be trained.
- Chaperoning: Providers are required to review their chaperoning policies to ensure specific principles are reflected.
- Review Groups: To strongly consider adopting review groups supported by safeguarding advice, to ensure sexual misconduct reports are robustly considered and investigated where appropriate
- Clarification on investigations involving resident doctors: For allegations against a resident doctor, there should be an initial discussion with the Postgraduate Dean as the doctor's responsible office to agree next steps. Any removal from work due to concerns about conduct that harmed a child or adult, or put them at risk of harm, then a barring

referral should be made. Failure of organisations fulfil this duty could result in police action.

- Sharing information: For police involvement in a case, employers are required to engage to understand which elements of the misconduct investigation can continue while the police investigations is underway.

NHS England » An update on actions to prevent sexual misconduct in the NHS

Trust position: : The Trust signed up to the Sexual Safety Charter this year and has a positive and comprehensive response to inappropriate sexualised behaviour in the workplace based on the NHSE guidance. In July, the Trust launched the Report, Support and Learn platform as an additional route for staff to report all inappropriate behaviours including those that are perceived to have a sexual motivation. The platform allows anonymised reporting which is an important aspect of the NHSE guidance and response to inappropriate sexual behaviour.

i. **Investigations training - the Trust will be nominating two members of staff to attend national sexual safety investigation training from March 2026 which will then be cascaded to others organisationally**

ii. **Specialist investigators – the Trust has a substantive investigator with a specialist background investigating sexual offences**

iii. **Chaperoning - additional advice on chaperoning has been shared with the Trust legal team to review and implement as they own the key organisational Consent Policy**

iv. **Review group should consider cases of inappropriate sexualised behaviour - the Trust is in a strong position with a weekly Case Review Meeting since April 2025 to consider all cases where formal investigation is required. The scope for this has been broadened to include cases of sexualised inappropriate behaviour regardless of the need for formal investigation**

v. **Clarification on cases involving Resident Doctors to involve the Postgraduate Dean - this is already in place organisationally and addressed through our Trust Case Assessment Framework and Case Review Meeting**

vi. **Restrictions and referrals: where staff have had restrictions placed upon them following concerns about their interactions with children or vulnerable adults, they should be subject to a DBS referral – this is not new and managed through the Safeguarding Team. The Trust has amended its guidance for those chairing the Case Review Meetings to ensure this is not missed if relevant**

vii. **Sharing information: an emphasis on information sharing and agreed timing of action where there is a police investigation which will also result in misconduct. This has been the subject of wider HR discussion and training to ensure that conduct matters are progressed concurrently where they can**

The POD Committee receives regular updates on progress against the Staff Experience Improvement Programme which underpins initiatives like Report, Support and Learn to foster a safe speaking up culture.

6. **Medium Term Planning Framework: Revenue finance & contracting guidance 2026/27 to 2028/29**

This guidance is to support integrated care boards (ICBs) and NHS trusts and foundation trusts ('NHS trusts') to develop multi-year revenue finance plans, as well as the agreement of

contract arrangements for 2026/27. It should be read alongside the medium-term planning framework, 2026/27 to 2029/30 capital guidance and ICB allocations for 2026/27 to 2028/29, as well as the draft 2026/27 NHS Payment Scheme (NHSPS) and draft 2026/27 NHS Standard Contract which are both subject to consultation.

As set out in the 10 Year Health Plan for England, ICB allocations will move towards their target distribution ('fair share') over the period of the NHS revenue settlement to 2028/29. Deficit support funding for ICBs and NHS trusts will also be removed.

To deliver on the ambitions in the 10 Year Health Plan, ensuring better care for patients and greater value for taxpayers, it is imperative a consistent and rigorous focus on driving improvement is maintained, cutting waste and getting value from every pound spent over each year of the multi-year planning period. To support this, the NHSPS consultation proposes to continue the 2% general efficiency factor in 2026/27.

This guidance sets out where the information required to complete plans is confirmed and where planning assumptions should be used. It also makes clear where information is available for 2026/27 only and separate assumptions should be used for 2027/28 and 2028/29. Throughout the guidance, NHSE distinguish between the actions that ICBs and NHS trusts should take.

In accordance with the requirement to manage a breakeven financial position, ICB and NHS trust boards must ensure they have a robust approach to risk management in place. Organisations will be required to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year, which must be assured by the board as part of the final plan submission process. Financial plan submissions will require organisations to have assessed risk and identified robust mitigations that are actionable within the control of the organisation. Risks and mitigations should be quantified in plans where appropriate. Where organisations go off plan in year, there will be a requirement to review the risk management approach and, where it is determined that the organisation did not plan for or mitigate risks as effectively as it could, improvements will need to be agreed and implemented.

As set out in the NHS Oversight Framework, NHS England will hold NHS trusts accountable for the effective delivery of services and hold ICBs accountable for the effective commissioning of services for the local population, including the delivery of these locally agreed plans.

NHS England » Medium-term planning framework: Revenue finance and contracting guidance

Trust position: The Trust has successfully launched the Medium-Term Planning Framework, moving away from short-term cycles to a structured, multi-year approach covering 2026/27 to 2028/29. This work has established a clear operating model aligned with national guidance, integrated financial, workforce, and activity plans, and embedded robust governance for assurance. Foundational activities included demand and capacity analysis, specialty-level deep dives, and engagement across clinical, operational, and corporate teams through workshops and programme boards. Our first submission, in December, set out trajectories for recovery of constitutional standards, transformation priorities, and financial sustainability, ensuring alignment with the Trust's five-year strategic plan and system ambitions. The Board approved the interim

Board Assurance Statement at its December development workshop subject to delegated authorities to finalise elements of the submission. A further iteration in advance of the February submission will be considered by the Board in January/February.

7. **Advanced Foundation Trust Programme – guide for applicants**

NHS England is inviting feedback on the Programme: guide for applicants. It will be a vehicle through which to reward and incentivise good performance. The intention is that by 2035 all providers will have become advanced foundation trusts, with freedoms including strategic and operational autonomy, a capability-based regulatory approach and greater financial flexibilities.

This consultation is open from the **12 November 2025 to the 11 January 2026**.

Following consultation, the updated policy and guide for applicants will be published and implemented in 2026.

NHS England » Advanced Foundation Trust Programme – guide for applicants **Board information:** NHS England » Advanced Foundation Trust Programme – guide for applicants: Annex 1 – assessment criteria, board statements and supporting evidence

Advanced Academy Part Two - The Advanced Foundation Trust Application and Assessment Process | Bevan Brittan LLP

Advanced Academy Part One: Introducing the Advanced Foundation Trust | Bevan Brittan LLP

Trust position: The CEO has asked the Director of Integrated Governance to review the guidance and bring a discussion to a future Board Development Session at which the Board will make determinations as to intentions with regard to applying for Advanced FT status. As referenced in this report, Board self-assessment capability is becoming increasingly critical in ensuring effective governance and organisational resilience during a period of significant transformation. Accurate assessments provide clarity on strengths and gaps, enabling targeted development and informed decision-making. Conversely, inaccurate or superficial assessments risk undermining strategic oversight, eroding confidence, and inviting regulatory scrutiny/intervention. It is essential that our future focus on robust self-assessment is not diluted or overshadowed by the demands of Advanced Foundation Trust Programme applications.

8. **Tackling Modern Slavery in NHS Procurement**

In December 2023, DHSC, supported by NHS England, delivered a review of risk of modern slavery and human trafficking in the NHS supply chains. The review covered a snapshot in time and showed that across 60% of spend on medical consumables, 21% of suppliers were identified as high risk for modern slavery and 16% were medium risk. The review highlighted the need for standardised risk management across the NHS and better data showing the extent and nature of modern slavery in NHS supply chains. The review also showed a significant amount of commitment from our suppliers to tackle modern slavery in their supply chains and made a recommendation to lay the regulations.

The National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 (the regulations) set out a requirement that all those procuring goods and services for the purposes of the health service in England will be required to assess the risk of modern slavery in their supply chains and respond by taking reasonable steps to mitigate that risk.

The regulations and guidance apply to new procurements only from the commencement of the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 and do not apply retrospectively to existing contracts. Where there is any doubt as to whether a procurement is in scope of the regulations, organisations should seek advice to determine the application or treat the procurement as in-scope and comply with the regulations and follow this guidance.

The procurement lead should consider the relevance and proportionality of the proposed reasonable steps within the context of each specific procurement and design an approach to managing modern slavery risk accordingly. The justification for any deviation from the reasonable steps set out in the guidance should be clearly documented. They are not making changes to how they rate at service level (or location level for acute trusts).

NHS England » Tackling modern slavery in NHS procurement (post consultation updated draft guidance)

Trust position: The Trust will adopt the national tool built into the procurement system to categorise the level of risk as low, medium or high. Where a competitive tendering procedure is being followed, processes will ensure a risk assessment is completed before the Trust publishes a notice inviting suppliers to participate as required. As allowed, the Trust will document and demonstrate any justifications of a change in approach through deviation from the minimum reasonable steps in the guidance. A proportionate response based on the value of the contract and the level of risk and challenges will be taken. Priority will be given to Framework award where the resource intensity of these checks will be mitigated as part of the Framework inclusion checks. This is where the highest volume of products is procured.

The Board should ensure it is assured of the prospective and proportionate application of this guidance when considering its next Modern Slavery Declaration which is published annually on our website.

9. CQC Report – State of Care 24/25

The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. The report summarises that there is unwarranted variation in people's experience of services across the country and inequality is particularly affecting people in the most deprived areas.

They see examples of innovation, excellent care and improvements in quality that are making a difference for people. Although there are many challenges in shifting the focus and resources to deliver services in the community, CQC have seen positive examples of pilot schemes and new initiatives that appear to support this change.

But their work also exposes issues about the readiness of the system for a shift to delivering neighbourhood care, as well as concerns for how some people experience care – such as for older people, people with dementia and people using maternity services.

Pressures in one part of the system are highlighted for their effect on other parts. This is true for hospitals, which are affected when there is a lack of access to preventative and community-based support. Examples include, delays in access to rehabilitation, reablement or recovery services were the biggest cause of delayed discharge for people who had been in an acute hospital for 14 days or longer (26%). And the 2025 GP Patient Survey found that 6.6% of people went to A&E when they could not contact their GP practice or did not know what the next stop would be – this was 4 percentage points higher for people in the most deprived areas.

Demand for urgent and emergency care services remains high, but the way in which people are accessing this care is changing. While there was a drop in the volume of calls to NHS 111 in 2024/25, calls to ambulance services have continued to increase, with the volume of 'hear and treat' responses also rising. The number of attendances at all types of urgent and emergency care services has also risen, with the biggest increases at single service facilities for specific conditions (type 2 services) and minor injury units (type 3 services).

And patients are still waiting too long in A&E: in 2024/25, 1,809,000 people waited over 12 hours from the time of their arrival until they were either admitted, transferred or discharged, which is 169,000 (10%) more people than in 2023/24.

Although the system is under serious pressure. In their assessments, CQC continue to see how good leadership can promote a culture of openness and learning.

The state of health care and adult social care in England 2024/25 - Care Quality Commission

Trust position: The report is designed to stimulate Board curiosity and reflection by highlighting failings observed in other organisations and comparing them against our own governance and assurance environment. This approach helps identify whether similar shortcomings could exist within our Trust and whether they are, in fact, "true for us" and should stimulate considerations of workplans for Board Committees.

10. Mental Health Act 2025

This report gives an overview of the key changes now the Act has received Royal Assent. It will be phased in over 8 years to allow a spending review and to enable services to prepare for the changes. A consultation on the Code of Practice is expected early this year.

Trust position: New detention criteria, exclusion criteria and others will have an impact on us as an acute Trust regarding training, documentation, governance processes, consent and treatment decisions and so forth. As more information becomes available, the Trust will respond to the changes required accordingly and work with our mental health partners concerning changes to places of safety and any capacity planning issues arising. The Board will want in due course to be assured that the Act compliance is embedded in governance frameworks (ligature risks, patient rights, statutory process adherence etc)

https://www.nhsconfed.org/publications/mental-health-act-2025-what-you-need-know

11. Safe Management of Controlled Drugs

This information is reported annually by the CQC and together with their regulatory activities under the Health and Social Care Act 2008, helps make recommendations to ensure the arrangements for managing controlled drugs safely in England continue to be effective. Whilst

issued in July 2025, the information is important for us as we manage controlled drugs and will be of interest to the Quality and Performance Committee workplan and deep dive focus. The CQC has long highlighted the importance of having board-level oversight of controlled drugs in designated bodies. To support this, they worked with NHS England Controlled Drugs Accountable Officers to deliver a webinar on considerations and good practice for boards.

Registered providers must tell CQC about certain safety incidents. The registered person should record the action taken on the relevant notification form. There is no requirement to notify CQC about medicines errors, but you must tell them if a medicines error has caused:

- a death
- an injury
- abuse, or an allegation of abuse
- an incident reported to or investigated by the police.

This includes where any of these have been caused by a controlled drug. CQC know that these incidents are not always reported and have encouraged services to report any instances associated with controlled drugs that meet these thresholds as soon as possible.

The report highlights good practice including:

- more efficient investigation and resolution of controlled drug stock discrepancies
- fewer controlled drug balance discrepancies
- more reporting on incidents, demonstrating increased awareness and vigilance
- improved communication and understanding of controlled drugs across all levels of nursing and pharmacy
- improved physical storage and management of controlled drugs
- increased engagement from all staff on the importance of safe and secure storage of controlled drugs, largely because of the multi-disciplinary team approach.

Recommendations include that findings from both inspections and prescribing data indicate that healthcare professionals are working outside their scope of practice, and in some cases, outside of the law. To ensure people receive safe care, all healthcare professionals must work within their scope of practice. All professional regulators have guidance on this.

Services should ensure they support this and do not encourage professionals to work outside of their scope of practice. Effective resourcing is a requirement under the 2013 Regulations. Many services don't fit the definition of a designated body. Although these services won't have a Controlled Drugs Accountable Officer (CDAO), many will handle, prescribe and administer significant volumes of controlled drugs. It's therefore vital that they have a controlled drugs lead, to ensure proper oversight and management.

The safer management of controlled drugs: Annual update 2024 - Care Quality Commission

Trust position: The Chief Pharmacist is the nominated person as a lead for controlled drugs. In recognition of the importance of relevant focus on governance and oversight of medicines safety and management, it is recommended that the QP Committee includes this in its schedule of deep dive activity in order to assure control systems for

safe prescribing, administration, storage, initiatives to reduce medications errors and audit and compliance process/outcomes.

C. CONCLUSION

The Board is expected to confirm that internal controls and governance arrangements are effective in meeting statutory, regulatory, and policy obligations. The report explicitly invites members to be satisfied that compliance mechanisms are robust and that any gaps are addressed through improvement plans or deep dives where necessary. It is aimed at ensuring external insights feed into internal reflection and then connect to governance tools like the BAF and Trust Risk Register.

D. RECOMMENDATION

The Board of Directors is invited to consider and note the content of the report and where relevant, members should each be satisfied through any additional enquiry, of their individual and collective assurances and reassurances that the internal plans and current controls in place to deliver or prepare for compliance against any of the Trust's obligations are appropriate and effective.

Lead Executive and Author: Kerry Rogers, Director of Integrated Governance

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Addendum

AWARENESS/LEARNING/'TRUE FOR US'/THOUGHT PIECES

CQC Inspections and updates

CQC publishes report on University Hospitals Birmingham NHS FT – Solihull Hospital
CQC, Report published 18 December 2025 Overall Good, Well Led Good
The report states evidence of a learning culture and patients were cared for in a safe environment. There were processes in place to assess the needs of the patients using evidence-based guidance. Staff provided patients with patient-centred care and treatment. There were governance processes in place which were effective, and staff knew their roles and responsibilities.
Assessment report template

Of interest/relevance:

What works in regulating health and social care
Kings Fund, 16 Dec 2025
The Care Quality Commission (CQC) as the main regulator of health and social care quality in England is currently rebuilding its regulatory model following several reviews that were critical of its approach, and The King's Fund is working with them to develop an evaluation that will support this work. This is an important signal of CQC's intention to bring evidence and learning into the development of its new approach.

As part of working 'in the open', this report shares findings from the first scoping phase of the evaluation, where they reviewed evidence, interviewed experts and engaged with CQC staff to understand what good regulation looks like. They worked with CQC to identify five challenges they are facing where evidence could help and have set out five key pieces of learning for CQC

to consider as it rebuilds its approach. They will continue to work with CQC over the next two years to share learning and evidence to support its ongoing development.
Evidence On What Works In Regulating Health And Social Care | The King's Fund

EPR systems – thematic review
HSSIB 27 Nov 2025
HSSIB received concerns about EPRs in some settings and identified incidents involving patient harm where EPRs have potentially contributed. The review found that EPR systems could contribute to the risks of patient care being missed, delayed or incorrect. These risks were persistent despite national recommendations and actions seeking to mitigate them. HSSIB has identified learning to help consider and mitigate risks around procuring, implementing and optimising EPR systems.
Electronic patient record (EPR) systems – thematic review

How to support partnership working: learning from the Health Communities Together programme.
Kings Fund, 4 Dec 2025
This report offers practical insights to support people who are seeking to develop partnership working within their local areas.
How To Support Partnership Working | The King's Fund
https://www.dekachambers.com/2024/02/20/judgment-handed-down-in-lewis-ranwell-v-g4s-health-services-others-2024/

How to support partnership working: learning from the Healthy Communities Together programme
Kings Fund, 9 Dec 2025
Rates of vaccination are declining in the UK. This research explores how Gloucestershire ICB has achieved some of the highest uptake rates in the country despite the challenges.
Approaches to vaccine delivery: learning from Gloucestershire ICB's Covid-19 vaccine programme

From diagnosis to delivery
Health Foundation, Nov 2025
This report explores current understanding of NHS system productivity and the reasons behind faltering growth. It sets out how our four-driver framework will guide future recommendations.
Improving productivity is integral to creating a high-performing and sustainable health service. Amid tight public finances and stalled progress in improving the nation's health, the NHS in England needs to seize opportunities over the next decade to deliver more and better care to patients for every pound spent. To assist, the Health Foundation has launched the NHS Productivity Commission to develop practical, evidence-based and ambitious solutions to improve productivity.
From diagnosis to delivery | The Health Foundation

HIGH PROFILE FAILINGS – LEARNING/'TRUE FOR US'

High profile corporate governance failures and/or weaknesses continually litter the headlines and the events that damage such organisations do not just happen. They are commonly linked to

boards being blind to the underlying risks that threaten their organisations and to the effectiveness of governance systems. Whilst these are predominantly headline news items with some containing allegations to be investigated – they will be routinely presented to the Board in this report to stimulate consideration of the importance of corporate governance (and of perceptions on reputation through trust and confidence) and to give due regard to there being any risk of it being 'true for us'.

We are developing a Framework to ensure that in a planned way we assess where any of these significant failings could happen at the Trust in order to learn and improve control environments accordingly, but regardless, each member of the Board should consider their individual responsibilities to 'be assured' and as such consider requirements to support attaining that position and consider as necessary what it might mean for GHFT.

For the purposes of illustrating to the Board what this will look like in future – I have used a previous example of when I was in the mental health sector. Going forwards, this section will include any more current failures more relevant to us as a large acute provider.

Edenfield – Independent Review of Greater Manchester MH NHSFT

The body of this Board report directs members to the results of an extensive review to understand what went wrong, how and why, with an ambition to help reduce the possibility of it happening again. Of direct interest to the Board and a number of its committees are some of the recommendations drawn out below.

The **independent review of Greater Manchester Mental Health NHS FT (Edenfield)** was published in 2024. Patients at the Edenfield Centre in Prestwich suffered appalling levels of abuse, humiliation and bullying. The NHS has experienced numerous opportunities to learn from adverse events. Reports are written, recommendations made, but this does not always lead to sustained improvement. The report seeks to report the realities of actual care provided versus care 'as imagined' by the Trust. It found a Trust that was not sufficiently focused on understanding the experience of patients, families and carers. The Board, while having many competing objectives, focused more on matters such as expansion/growth and meeting operational targets than it did on the quality of care it provided. The report highlights insufficient curiosity about the ongoing patient and staff experience across the Trust and limited focus on improvement.

Nursing levels had become unsafe, inadequate governance systems and the wider Trust culture contributed to the 'invisibility' of these deteriorations with an absence of an effective response to safe and timely care being severely compromised.

Board is encouraged to read page 63 of the report and the subsequent pages in terms of the Board's responsibilities which it is said had systems and processes which led to insufficient checks and balances to mitigate serious failings in care. Brief highlights specific for Board include:-

- A notable lack of the voice of the patient in governance processes and little focus on patient experience at meetings of the Quality Improvement Committee
- Board papers contained data aggregated to a very high level and no obvious way of identifying 'hotspots' and no visibility at a ward level of understaffed services.
- Senior staff authoring reports described expectations that papers to Board and its Committees were to be made 'palatable.'
- Board displayed a lack of professional curiosity and probing of information – e.g. Staff survey results were poor but no recognition of this at the People Committee or at Board nor any probing of how the Trust compared to others, or it intended to learn from the best nor what the results meant in terms of the Trust's prevailing culture.

- No identification or understanding of indicators of closed culture environments – low staffing, low morale, staff discrimination (race/ethnicity/physical violence), unempowered leadership, 'in groups' and cliques.
- concerns that learning was not taking place, e.g. those which were flagged by the coroner in Prevention of Future Death Notices.

The Trust's governance framework had not functioned effectively in raising serious quality concerns to the Board and its committees, including those from Edenfield, in a timely way, to support safety and improvement. The inquiry cites several reasons for this, including:

- a lack of helpful, relevant data and information available to frontline clinicians to help them understand the quality of care they were delivering;
- the absence of a culture of healthy escalation, with staff often too fearful to pass on 'bad news';
- unclear roles and responsibilities across committees, alongside a lack of grip;
- insufficient focus on quality at Board level; and
- insufficient rigour and probing of the information presented to key forums.

As would be the case for most NHS organisations, areas highlighted here have relevance for the Trust even if only loose connections, but it is important as a Board we remain clear of our weak/blind spots and where our quality improvement opportunities lie and what plans we are implementing to progress them.

Patients, families and carers need to be at the centre of strategy and service delivery and heard at every level of the organisation.

Leadership – Board disconnected from the realities of patient and staff experience and was excessively focused on external reputation and growth. Insufficient focus on quality at the Board and suppression of 'bad news'.

Clinical Leadership needs developing to ensure a strong clinical voice which must be heard and championed from Board to floor and in wider system meetings.

Culture – The Board allowed a dysfunctional executive team with a culture that valued operational/financial performance above clinical quality. The Board must develop and lead a culture that places quality of care as its utmost priority, underpinned by compassionate leadership from Board to floor, developing systems that encourage staff to report quality concerns and improvement ideas. (West et al, 2017):" *What leaders focus on, talk about, pay attention to, reward and seek to influence, tells those in the organisation what the leadership values and therefore what they, as organisation members, should value."*

A fundamental change in emphasis was described as being required to achieve this. The priority must be on people, on quality, and it must be on listening to those who use and work in their services. The review highlighted that much of the staffing at the Trust is too constrained to meaningfully change culture. The report amplifies that culture starts with the Board which dictates the tone of the organisation, what is important, the extent to which staff feel listened to, and the priority given to continuously improving services.

Workforce levels must be developed to adapt to and manage the safety challenges that a staffing shortfall may pose. The staff survey results were amongst the lowest for all MH trusts in England across many measures. The annual National Staff Survey gives every Board a window on the culture of the organisation and allows comparisons to be made with peer organisations regionally and nationally. It must be used to consider how the Trust is functioning so to formulate plans to improve any areas of concern.

FTSU Guardian - reviews of FTSU reports to the People Culture and Development Committee and Board found that information they contained was limited in how useful it might be in

understanding the Trust's culture. For example, rolling data for the number of cases raised is only provided in-year, and by quarter, so it is difficult to see how the volume of cases is rising or falling over a longer time period. There is little intelligence on the content of issues raised and where they come from in the organisation, nor how this is used alongside other workforce intelligence (such as turnover, grievances or surveys) to identify services potentially in distress. There is little information to tell the reader what has changed as a result of staff speaking up, or what the impact of the service is on the organisation's culture.

Estate – the Trust needed a better understanding of the quality of its estate and the impact of this on the delivery of high quality care, including providing a safe environment.

Governance structures had not been effective in escalating information in ways that are timely, clear or useful, with a poor use of data and intelligence to understand the current quality of services. The Board must ensure that its governance structures (including safeguarding and complaints), and the culture that this is applied within, supports timely escalation and that the right information can be used at the right level by the right staff.

It was recommended they urgently review how the Trust identifies safety concerns and initiates sustainable learning when people die unexpectedly while using inpatient services. It states the Board needs to immediately ensure it has an up to date and accurate view of the current levels of safety within each of the services and controls in place to address risks to safety and through a detailed review of deaths it maximises every opportunity to learn.

System - NHS England must review thresholds for information sharing and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. The role of the Trust as lead provider needs to be reviewed by NHS England.

Finally, the report authors were drawn to the words of Dr Bill Kirkup: "The first step in the process of restoration is to accept the reality of what has happened. The time is past to look for missing commas in a mistaken attempt to deflect from findings." (Kirkup, 2015). GMMH must adopt a similar philosophy and with this, positive change will come.

They hope the Trust will use this review to reflect on what has happened and to now focus on the future and the changes that need to be made.

Enclosures

None

FOI: Public

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on Thursday 15 January 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Quality and Performance Committee held on November 20th 2025
Board member lead(s)		NED Chair: Sam Foster & Executive leads CEO, COO, CMO, CNO
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	✓
	Discussion	✓
	Note	

Purpose of report

To present an update to the Board of Directors from the meeting of the Quality and Performance Committee held on 20th November 2025 – the committee met its quoracy needs.

This committee meets monthly and is attended by members of the Board and senior managers.

Key points

ALERT: matters that require the boards attention or action, e.g. non-compliance, safety concern or a threat to the Trust's strategy.

• **Fire Safety Risks Remain:** The recent compliance inspection noted significant improvements but highlighted key gaps, including **risks from lithium battery storage**, evacuation planning issues due to compartmentalisation, delays in fire door upgrades, and low staff training levels. Key risks related to access for fire appliances and infrastructure constraints in the tower remain, with delays linked to funding and procurement.

• **Maternity Incentive Scheme (MIS) Non-Compliance:** The Committee formally declared non-compliance with three critical MIS safety actions: Action 1 (Perinatal Mortality Review Tool completion), Action 4 (clinical workforce/locums), and Action 9 (oversight). This non-compliance is due to delays in reviews, workforce gaps, and missed quarterly board reviews.

• **High-Value Obstetric Claims:** The claims scorecard showed that while obstetric claims made up 13% of all trust claims, they accounted for **70% of claims by value**.

• **Perinatal Safety Incidents and Outliers:** The Quarter 2 Perinatal Quality Surveillance report noted that 16 babies were born before arrival at the trust, which is above the national average, with one potentially avoidable case reviewed as a safety incident. The unit was also flagged as an outlier for neonatal readmissions.

• **Corridor Care:** Bed closures for works had increased **corridor care in the Emergency Department (ED)**, which was flagged as a concern by the Chief Operating Officer. Staff were keen not to provide care in corridors

• **CQC Must-Do Requirements Not Met:** Appraisal rates in perinatal services were low (76% versus a 90% target), and mandatory training and appraisal monitoring issues were noted as **Care Quality Commission (CQC) must-do requirements** needing prioritisation.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance.

• **Home Birth Service Pause:** Home births were temporarily paused for at least six months due to community midwifery staffing concerns, increasing complexity of requests, and the need for a comprehensive risk assessment and skill mix review. The Chair acknowledged this was the right decision for staff safety and resilience.

• **Surgical Performance Deterioration:** Surgery's time to theatre metric dropped significantly from 63% to 30%, which has prompted divisional action.

• **Breast Screening Recovery Delay:** Sustainable recovery for the breast screening programme will not be achieved until **2028 without further NHS England investment**. This identified risk to women in Gloucestershire requires ongoing monitoring via a dedicated slide in the Integrated Performance Report.

• **Deteriorating Patient Audit:** The BDO audit of NEWS2 produced 8 themes and 16 actions, which are currently in progress. Although actions are underway, this area reflects assurance of improvement, not the absence of concern.

• **Cancer Performance Gaps:** Cancer performance is not fully compliant with all standards, although it remains above the recovery trajectory. Key challenges include maintaining the **28-day faster diagnostic standard** in some specialties.

• **Paediatric Emergency Department Challenges:** System-wide Urgent and Emergency Care performance remained slightly below target, and paediatric Emergency Department performance continued to be a key challenge under review.

ASSURE: inform the board where positive assurance has been received

• **Pseudomonas Action Plan Closure:** The action plan following the Pseudomonas incident was received as a record of its closure. Extensive corrective actions strengthened governance (including restructuring the Water Safety Group), and ongoing external scrutiny were detailed, confirming robust audit and reporting mechanisms are now in place.

• **Mortality Indicator Within Range:** The **Summary Hospital-level Mortality Indicator (SHMI) is now below one** for both sites, placing it well within the normal range.

• **Nursing Staffing Levels:** The statutory nursing safer staffing report found that wards were generally safely staffed, with **care hours per patient day above national and regional medians**.

• **Neonatal Staffing Compliance:** The organisation meets compliance with the British Association of Perinatal Medicine (BAPM) standards in relation to both the neonatal medical workforce and neonatal nursing workforce standards.

• **Complaints Turnaround:** Continued improvement in complaints turnaround was reported, with fewer than ten long standing complaints outstanding.

• **Elective Waiting Time Improvement:** The number of patients waiting over 45 weeks had improved, particularly in dermatology and Ear, Nose and Throat.

APPLAUD- Areas of exceptional positive performance, compliance achievement, or success noted by the Committee)

• **Maternity One-to-One Care:** The Committee noted and celebrated the recent achievement of **100% compliance** for one-to-one care in labour for the last two months.

• **Cancer Treatment Record:** The annual cancer report highlighted **record numbers of first cancer treatments (over 4,000)** and positive patient experience scores.

• **Ambulance Handover Improvement:** Ambulance handover times had improved to 22 minutes, placing the Trust **among the best in the region**, although the target remains 15 minutes.

APPROVALS: decisions made by the Committee

- Nil

Implications

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	✓
People, culture and leadership	
Quality, safety and delivery	✓
Digital first	

Board assurance framework

BAF reference	**SR:**

Risks discussed

The Committee discussed the following risks: Delivery of access targets, care quality across the system and delivery of required progress to meet MIS.

Recommendations

The Board of Directors is asked to take **assurance** from the report and note its contents.

Report to Public Board of Directors				
Date	15 January 2026			
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

RTT
The total RTT incompletes increased from 62,897 in October (69.34%) to 63,893 (69.80%), noting that the overall percentage improved from the previous month. The number of 45-week breaches has reduced in-month, moving from 822 in October to 634 in November.
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; November month-end performance for 52 weeks places GHFT top 10 best in the country. The November month-end position has been finalised with a total of 30 reportable breaches (compared to 29 in October). Of the 30 breaches, 6 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 24 breaches in month. The Divisional split was 4 for Medicine (+3 compared to the previous month), and 20 for Surgery (-1 compared to the previous month and inclusive of 7 GI inpatients impacted by Industrial action). There were no breaches for D&S or W&C divisions.

DM01
In November 2025, diagnostic performance improved to 24.55% (3,777 breaches out of 15,382 total waiting), representing a 1.7% gain compared to October's validated figure of 26.21% (4,116 breaches out of 15,701). While most modalities are maintaining or improving, Flexi Sigmoidoscopy has shown three consecutive months of deterioration, and MRI continues to fluctuate bi-monthly, highlighting insufficient capacity to consistently meet demand.
Notably, ECHO performance improved by 3.1%, signaling early success from the accelerated recovery approach. Additional Endoscopy weekend lists starting December are expected to reduce Flexi Sigmoidoscopy and Gastroscopy waits. However, reliance on short-term, non-recurrent initiatives remains a risk; therefore, a sustainability business case will be submitted in Q4 to secure long-term assurance of performance into 2026–27.

CANCER
The 62-day reportable backlog reduced to 149 from 165 in October, with Urology holding the largest share.

- Unvalidated performance for the 62-day standard is 75.1%, broadly stable month-on-month, though significant deterioration is noted in Head & Neck (-30%), Urology (-13%), and Lung (-9%).
- The 31-day standard declined to 90.5% (-4.7%), driven by Lung (-16%) and Gynae-Oncology (-9%).

- The 28-day Faster Diagnosis Standard stands at 74.9%, a slight deterioration (-1.3%) and just below the 75% compliance threshold, impacted disproportionately by small sites such as Haematology (-33.4%) and Non-Specific Symptoms (-13.4%).

To maintain compliance and progress toward the new 80% FDS target, actions include: implementing a new escalation and coordination process for early bottleneck identification (impact expected from October 2025), increasing Skin Minor Ops capacity via Agile, and demand-and-capacity modelling for first outpatient appointments aligned to Best Practice Timed Pathways.

SCREENING PROGRAMMES

Screening programme performance in November 2025 showed significant challenges, particularly in breast screening. The service remains under an NHSE Performance Improvement Plan (PIP) due to failure to meet the required standard, driven by a severe shortage of mammography staff. Backlogs have grown, with delays of up to 22 weeks, and modelling indicates the backlog could peak at 1,250 women by early 2028 without further intervention. Recovery actions include short-term funding from NHSE and Cancer Alliance, recruitment of additional staff, and plans for extended hours and external capacity at Nuffield Cheltenham, though long-term sustainability depends on recurrent funding support. It is likely compliance will return by June 2026.

Diabetic Eye Screening achieved an attendance rate of around 80.5%, below target, with 2,799 patients invited and 2,253 attending routine digital screening. Workforce constraints and equipment issues were noted as contributing factors. Cervical screening received confirmation of recurrent funding for drop-in clinics over three years, with monthly monitoring in place.

Governance oversight flagged screening performance as a key risk in the November Integrated Performance Report, highlighting the need for continued focus on recovery plans and sustainable solutions across all programmes.

QUALITY

Patient experience

The overall Friends and Family Test (FFT) score has increased by 0.3% to 92.4% for November compared to the previous month. Notably, increased scores were seen in Outpatients and the Emergency Department, decreased scores were seen in in-patient wards, SDEC and Maternity.

Patient Advice and Liaison Service (PALS)

The PALS team have closed 80% of concerns in 5 working days, the volume of cases has reduced to 323 throughout the month. 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 54% in November 2025. There is a slight dip in performance this month due to temporary staff absence. However, the improvement trajectory 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.

Safety incident management

PSII/AERs

81 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 6.6 per month. 1 new Patient Safety Incident Investigation was declared in November 2025, 2 After Event Reviews, 1 Multi-professional reviews. There were no Never Events this month.

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 We are just above the national average for our PPH at 41.3 per 1000 births. We have reviewed the electronic patient record and have decided the general risk assessments are the more appropriate PPH risk assessment and we have 100% compliance with women being continually risk assessed. The CQC S31 enforcement notice remains extant and reports to the Maternity Delivery Group.

SHMI

There is a continued fall in the 12m rolling SHMI. In/Out of hospital deaths and weekend admissions now all fall within the expected range. Latest NHS Digital SHMI = 1.04.

FINANCE

At the end of month 8, the Trust is reporting a year-to-date deficit of c£0.3m which is c£3.3m adverse to our planned position. This position is utilising underspends in corporate areas and slippage in reserves to mitigate emerging pressures in various areas. These pressures pre-dominantly relate to the non-delivery of our financial sustainability schemes, staffing pressures (e.g. Worked levels and unfunded maternity cover costs) and non-pay issues (e.g. Consumables, fire safety costs, non-pass through drug costs which don't receive additional income).

The forecast position for the full year continues to contain a material level of risk to delivering the planned breakeven position. Several schemes and opportunities have been taken forward to mitigate some of the risks identified in the August position statement, but further challenges remain.

The Trust's capital spend at the end of October was c£12.5m against a planned position of c£26.2m. The total level of capital resources is still forecast to be utilised by year end, and this represents an operational challenge to deliver these schemes in the latter part of the year.

The current cashflow forecast of the Trust is based on the current run rate position of the Trust and the assumption of full capital resource utlisation. This current position shows that the number of days of operating cash held by the Trust will significantly reduce as the year progresses - however successful delivery of recovery schemes, and alterations to the timing of capital payments, will improve the balances held. Subsequent to the timing of the writing of this report, the Trust has been informed that it has been successful in its capital cash allocation bid and will receive a cash injection during quarter 4.

WORKFORCE

The workforce section this month reflects where there has been a deterioration in performance across the standard people metrics; with focus this month on appraisal compliance, sickness absence 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 given, as part of the requirements laid out in the NHS Operating Plan this year.

Approved by: Chief Operating Officer	**Date:**

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:**

Integrated Performance Report (IPR)

November 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	Oct-25	Nov-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%	22.3%	22.7%
		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%	9.2%	10.1%
	Elective Care	Total elective activity undertaken compared with 2019/20 baseline		111%	106%	111%	110%	107%	118%	108%	106%
		Total diagnostic activity undertaken compared with 2019/20 baseline		146%	142%	157%	140%	147%	149%	137%	142%
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	*No Target*	161	160	125	135	144	152	152	115
		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%	6.70%	4.76%
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	82%	83%	86%	84%	80%	78%	77%	75%
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	356	362	343	333	339	379	295	202
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		109.93%	104.98%	109.45%	110.14%	106.42%	120.16%	109.14%	107.45%
	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%	97.41%	97.43%	97.47%
	Safe Care	Summary Hospital -level Mortality Indicator	*No Target*	1.137	1.127	1.095	1.083	1.045	1.038	1.010	0.993
		Summary Hospital -level Mortality Indicator Limits		Within	Within	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	51.5	40
		E. coli bloodstream infection rate per 100,000 bed days	*71*	21.5	17.5	22.4	25.3	17.1	26	38.6	48.9

Watch Measures

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Watch Measures	Urgent Care	Total hours lost to ambulance handovers		1820	1099	910	753	668	489	547	524
		Average ambulance handover time	*< 40 minutes*	34	19	16	13	11	8	9	8
	Elective Care	78ww RTT	*0*	1	0	1	1	2	0	0	0
		65ww RTT	*0*	3	3	2	3	2	1	0	0
		52ww RTT	*0*	94	75	47	40	37	36	29	31
		Short notice (within 72h) cancellation rate – total	*<9%*	9.4%	8.7%	9.6%	10.7%	10.7%	15.9%	12.3%	11.1%
		Short notice (within 72h) cancellation rate – for clinical reasons	*<3%*	2.4%	2.0%	2.5%	2.7%	2.9%	2.5%	2.3%	2.8%
		Last minute cancellations for non-clinical reasons		64	64	60	75	84	53	92	62
		Cancellations not rebooked within 28 days		7	12	14	9	25	11	28	16
		Angiogram Waiting List Position		293	288	274	280	265	231	220	216
		Histopathology 10-day reporting	*90%*	56%	56%	49%	63%	63%	58%	52%	41%
	Flow	G&A Occupancy - CGH	*92%*	88%	89%	88%	86%	85%	87%	87%	86%
		G&A Occupancy - GRH	*92%*	95%	94%	92%	94%	94%	94%	95%	95%
		Daily Average of boarded patients	*0*	4	3	1	4	2	3	3	3
	Safe Care	VTE Assessment within 14 hours (%)	*95%*	92%	91%	92%	86%	90%	88%	88%	89%
		VTE assessment completed - excluding short stay (%)	*95%*	96%	96%	96%	91%	94%	93%	93%	94%
		Number of Category 2 pressure ulcers acquired as inpatient		15	19	11	11	21	11	24	11
		Smoking Status Compliance (%)	*95%*	97.11%	97.16%	97.09%	97.12%	97.54%	98.40%	98.55%	97.95%
		Severe Harm from Patient Medication Errors	*0*	2	1	0	0	1	0	0	0
	Cancer - Breast Screening	R/Length		13%	37%	26%	29%	46%	28%	18%	
		SCR to RR		93%	99%	91%	99%	99%	99%	99%	
		Technical Repeat		2.2%	2.3%	3%	3%	3%	3%	3%	
		Technical Recall		0.20%	40.00%	0.20%	0.20%	0.00%	0.21%	0.07%	
		DOFOA		73%	95%	90%	87%	100%	100%		

UEC: Performance

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

Highlights

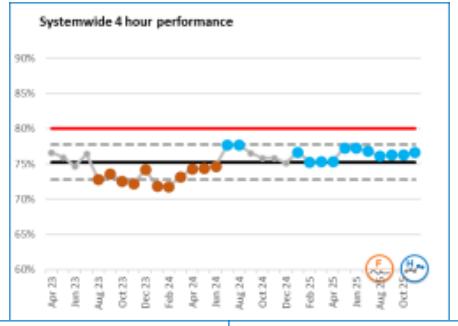
- 4-hour performance ay highest level of last two years in November at 64.2%
- 12-hour performance deteriorated very slightly, from 90.9% to 90.0% in the same month

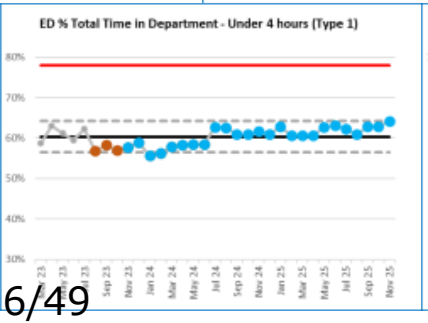
Areas of Concern

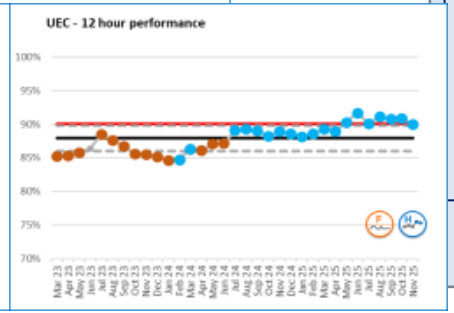
- Improvement trajectories set for performance across CGH, Paediatrics and Non-Admitted
- Only achieving at CGH at present; high volume of attendances creating issues in Paediatrics

Looking Forward

- Beginning of QI Project across Minors intended to drive performance across Non-Admitted pts
- Focusing additional Matron time at CGH continues to yield dividends







Technical Analysis

Overall, 12-hour performance has stabilised at ~ 90% over last couple of months. Need to continue to focus on de-congesting the department so that staff can see the wood for the trees.

Planned Actions

Ongoing closer working between Operations and Nursing teams continues to drive improvements in CGH performance.

A similar approach has been planned across Paediatrics; however, success slightly undermined by patient attendance volumes with average daily attendances up by 12 per day.

Recognition that to materially impact on performance across Non-Admitted patient group we need to improve processes across Minors area; Quality Improvement project initiated through second half of winter with a view to driving process improvements.

UEC: Performance

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

Highlights

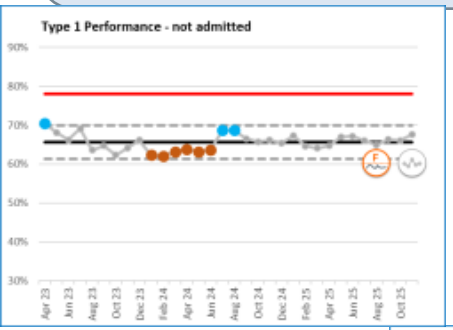
- Non-Admitted performance has gone up from 66.1% in October to 67.5%
- Admitted performance has also improved in November, from 53.4% to 53.6%

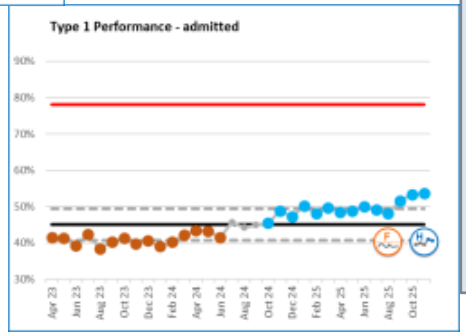
Areas of Concern

- Decision to close Ward 6B is not being compensated for by a fall in NCTR patients
- High levels of influenza presentations are driving a higher level of ED attendances

Looking Forward

- Winter planning launched and framework action plans in place – effectiveness will be assessed as we go through the season





Technical Analysis

Performance improvements across Admitted and Non-Admitted patients have supported overall improvement in four-hour performance through November

Planned Actions

Quality Improvement project started in November

Additional Matron presence at CGH is delivering and will be maintained

Ongoing review and update of ED Escalation SOP will continue with dedicated Action Cards to identify the actions from key senior nursing roles within the department will continue

UEC: Performance

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

Highlight

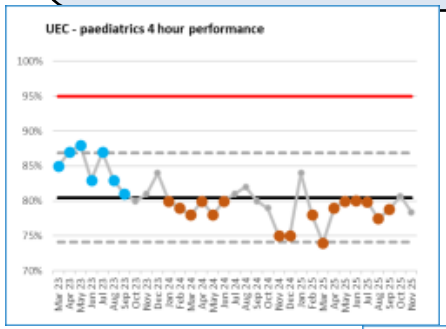
Volume of paediatric attendances has grown dramatically over last two months; December so far (8 days) 17% higher than November and a third higher than 2024/5

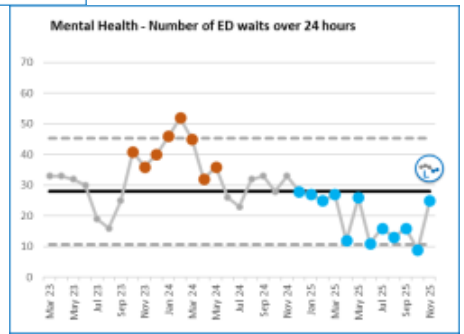
Areas of Concern

Significant challenges remain around getting patients into PAU in the numbers and at the speed required by demand for these services

Looking Forward

Update on actions to address shortcomings in respect of the paediatric services have been discussed at Mandated Support meetings





Technical Analysis

As part of the ongoing review of paediatric patients in our ED, we will look to base-line our activity, notably the number of patients requiring Mental Health input and the time elapsed before they are seen. Four-hour performance deteriorated to 78.4% in November, compared with 80.7% in October.

Planned Actions

- Longer-term objective to develop staffing model to have s dedicated SDM within Paediatrics in ED; discussed at Mandated Support meetings
- Closer scrutiny of Paediatric four-hour performance through December

UEC: Average Handover Time

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

Highlights

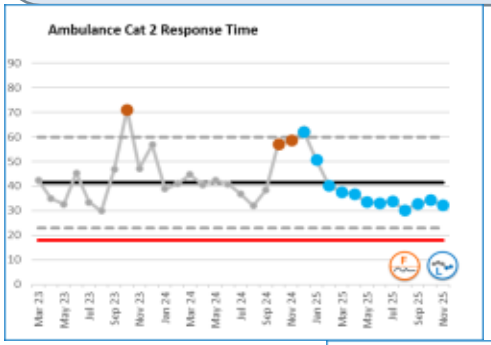
Ambulance handover times have stabilised at 22 minutes on average through the months of September. October & November

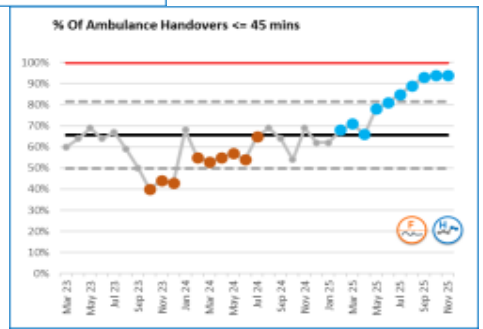
Areas of Concern

Focus on offloading ambulances against higher demand for our services means that we are increasingly having to nurse patients in corridors in ED – need to ensure that response to this is built into the ED Escalation SOP

Looking Forward

Continue to review the Escalation SOP across ED, embed new Action Cards and refine and include approach to flexible staffing as we find ourselves having to nurse patients in corridor spaces





Technical Analysis

Average ambulance handover time improvements are well-established and have stabilised at 22 minutes over the last three months

Planned Actions

- Audit and confirm that Action Cards for Co-ordinator roles in ED are being used and are effective in escalating at times of pressure in the department
- The ED Escalation SOP needs to be reviewed and updated with the agreed responses to reflect the actions that need to be taken when we find ourselves needing to nurse patients in corridor areas of ED

% RTT & 1st Outpatient Appointment within 18 Weeks

The number of patients who are seen and those who receive a first outpatient appointment in 18 weeks.

Highlights

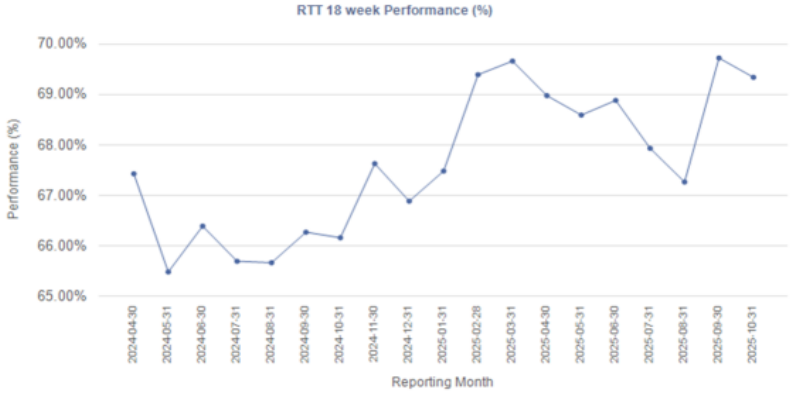
RTT performance improved from 69.34% in October to 69.80% in November (0.46%). The total incomplete waiting list increased from 62,875 to 63,893 which represents a deterioration of 1,018 patients compared to the previous month.

Technical Analysis

Incompletes under 18 weeks grew by 998 patients in November compared to the previous month. There has been a marginal rise in the >18 week waiting list (20 patients). The improvement in performance comes from the list composition shifting slightly back towards <18-week pathways (mostly within the 45 weeks cohort).

Planned Actions

- Review outpatient polling ranges at sub-specialty level to assess the proportion of services who are currently not able to offer a 1st OPD within 18 weeks. Divisions to provide a capacity plan to carve out additional new slots and reduce follow ups.
- Maintain a clear focus on 45 weeks+ elimination



Treatment Function Code	Number of Pathways	Average Time Waiting	Median Time Waiting	Maximum Time Waiting
330: Dermatology Service	2,912	20.5	19	52
120: Ear Nose and Throat Service	4,199	18.8	18	48
400: Neurology Service	2,290	16.3	13	47
110: Trauma and Orthopaedic Service	4,323	14.0	11	45
502: Gynaecology Service	2,252	14.0	11	49
140: Oral Surgery Service	2,091	11.4	10	40
130: Ophthalmology Service	2,447	11.6	8	43
320: Cardiology Service	4,170	12.2	8	46
101: Urology Service	1,411	8.5	6	46
420: Paediatric Service	1,389	8.2	6	46

Ten specialties make up 43% of the Incompletes waiting list (as of 31st November 2025). Focus on these ten specialties will make a significant difference to both >45 weeks elimination and to the % RTT pathways completed within 18 weeks.

Elective: 45 Week Wait

Highlights

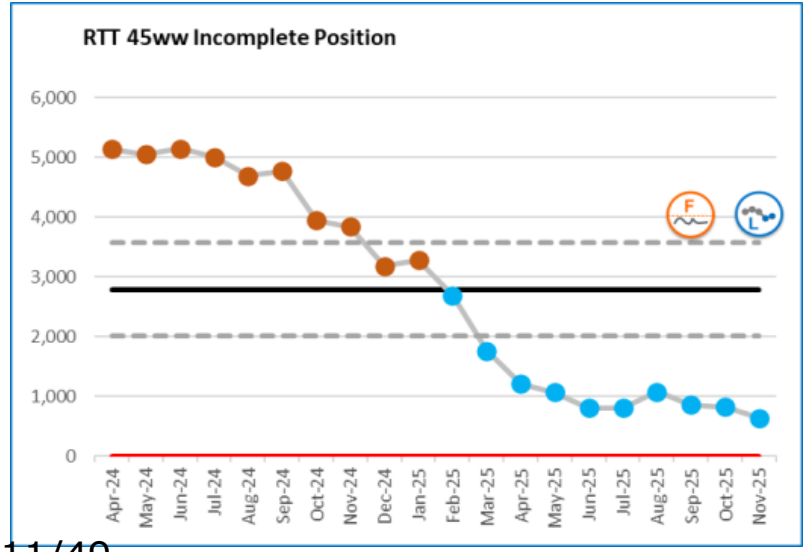
The number of 45 weeks has reduced significantly since last month, moving from 822 in October to approx. 636 in November (unsubmitted). This is the lowest for several years..

Areas of concern

Dermatology, Orthopaedics/Spines and GI services remain the most challenged services (albeit in-month reductions made) with services impacted by staffing shortfalls; cancer & P2 demands, and Industrial Action

Looking forward

Within bank holidays and leave in December, coupled with further Industrial Action, reductions in the over 45wk cohort are expected to be small. Uncertainty exists with the impact of Industrial Action, which will result in lost capacity.



Technical Analysis

The November month-end position will be submitted mid-December, with an anticipated position around 630. Many specialties have made reductions, with the most notable being Dermatology due to the transfer of patients to Modality Health (from 299 in Oct to 188 in Nov); Orthopaedic/Spines due to the transfer of patients to the Nuffield (from 164 in Oct to 107 in Nov).

Planned Actions

- Activity continues to flow to the new independent providers; Health Harmonie, Optimised Care, Modality Health and Pastel Health.
- Dermatology are continuing to IPT out to Modality Health which will continue into the New Year. Approx 150 transferred to date.
- Orthopaedics/Spines continuing to transfer patients to the Nuffield
- A 3rd validation sprint commenced 3rd November and will cease 14th December

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

Standard: 85%

Highlights

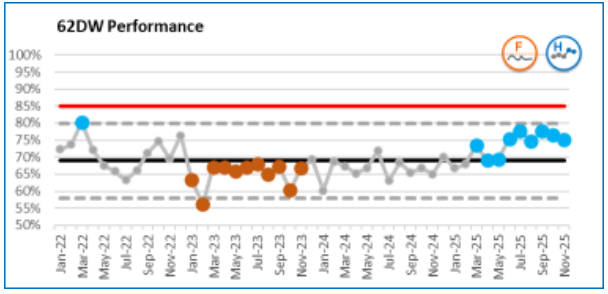
Achievement of 85% by Testicular and Breast in October-25.
We have also seen a massive improvement in urology. October is showing at 88.5% attainment!

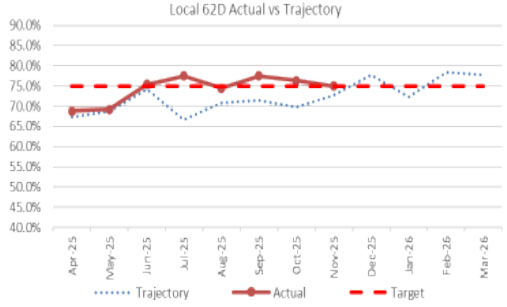
Areas of concern

Validated 62 Day standard for October is currently at 76.4% and so we will miss the national target however we will meet the minimum requirement of 75% for 62 day
Ongoing concerns continue to be linked to late diagnosis and limited surgical capacity for first treatments
November-25 unvalidated is showing a 75.2% performance

Looking forward

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

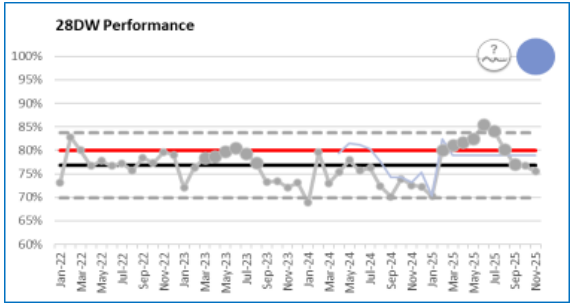
Continued increase in Urology 28-day performance

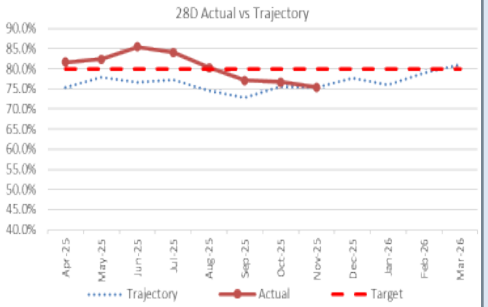
Areas of concern

Skin 28 day has continued to decline over the past few months due to seasonal demand and operational capacity issues
Breast is currently booking first OPA's at day 35+ and is a real risk to overall Trust compliance with 28 day performance as similar to Skin, Breast equates to around 18% of all Trust 28 day activity

Looking forward

Breast and Skin to present recovery plans ant timeline trajectory of compliance at Cancer Delivery Group 11/12 however we recognise that performance will be impacted within December





Technical Analysis

Unvalidated 28 Day standard for November 2025 is currently at 75.6% and we are likely to not meet the national standard of 80% and will also miss the minimum expectation of 77%

Planned Actions

To 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

- 149 on backlog as of 07/12
- Improved compliance in Urology and Gynaecology

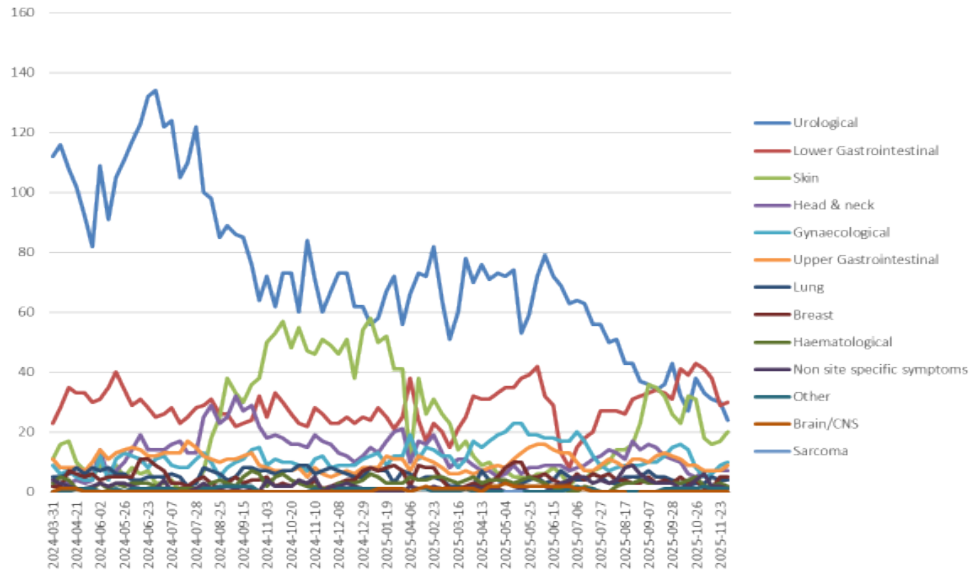
Areas of concern

- Lower GI has seen a large increase in backlog position due to capacity issues within the surgical aspect of the pathway, complex patients and operational pressures
- The same is found in Skin as the MOPS and OPA capacity doesn't meet the demand with season 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

Most of this cohort is held by Lower GI 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 – November is unvalidated

CWT Metrics – 3 prev. months position (excluding Breast. Symptomatic referrals)

CWT Standards	Two week wait			28 Day FDS			31 Day Treatment			62 Day Treatment		
	Sep-25	Oct-25	Nov-25	Sep-25	Oct-25	Nov-25	Sep-25	Oct-25	Nov-25	Sep-25	Oct-25	Nov-25
Acute leukaemia										100.0%	100.0%	100.0%
Brain/CNS	100.0%	100.0%	92.9%	75.0%	83.3%	100.0%	100.0%					
Breast	81.6%	12.6%	8.7%	97.2%	90.7%	86.1%	98.0%	98.8%	92.5%	93.3%	93.9%	90.6%
Gynaecological	94.0%	86.9%	87.2%	69.7%	65.8%	53.8%	86.5%	93.4%	84.6%	65.6%	52.9%	76.5%
Haematological	100.0%	90.5%	88.9%	50.0%	91.7%	58.3%	100.0%	97.1%	100.0%	77.8%	63.2%	94.4%
Head & neck	89.5%	85.2%	92.8%	77.7%	84.4%	84.8%	95.5%	97.7%	93.1%	58.3%	81.8%	53.3%
Lower GI	92.6%	95.6%	92.2%	76.5%	81.8%	77.5%	94.7%	77.3%	70.3%	67.7%	46.8%	40.4%
Lung	100.0%	100.0%	96.4%	80.0%	93.8%	92.3%	98.2%	98.1%	82.8%	61.5%	63.6%	54.2%
Other					0.0%		100.0%	100.0%	100.0%	40.0%	81.8%	100.0%
Sarcomas							100.0%	100.0%	0.0%	0.0%		0.0%
Skin	70.4%	51.4%	71.2%	61.1%	54.2%	62.1%	94.4%	92.4%	92.9%	79.9%	83.1%	90.0%
Non site specific symptoms	22.9%	12.5%	8.3%	19.0%	36.1%	22.7%						
Testicular	66.7%	91.7%	100.0%	100.0%	100.0%	100.0%				100.0%		
Upper GI	98.9%	97.6%	98.4%	89.2%	92.4%	94.7%	95.7%	97.9%	92.6%	84.8%	73.1%	76.9%
Urological	93.2%	97.0%	94.7%	60.5%	60.5%	59.4%	94.4%	96.2%	93.3%	76.9%	87.8%	74.8%
Trust Total	85.9%	70.7%	72.7%	76.3%	76.2%	74.9%	95.7%	95.2%	90.5%	77.7%	76.5%	75.1%

Cancer: Breast Screening

Highlights

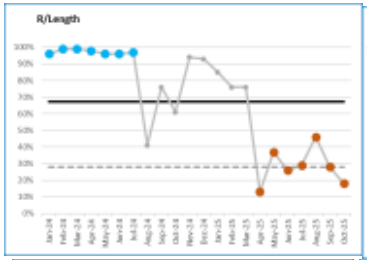
- Reduction of 1,600 patient from Nov to Dec in the backlog.

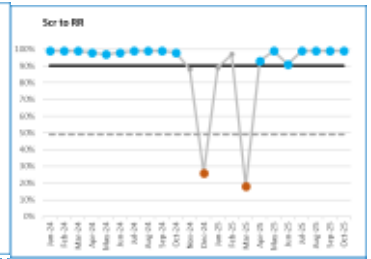
Areas of concern

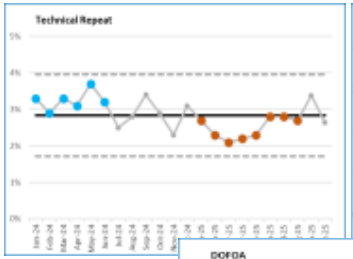
- Limited capacity due to inadequate numbers of radiographers
- One US out of use, and there is a risk to the rest of the US due to no service contract which will reduce the capacity. Work being completed with procurement to resolve this.

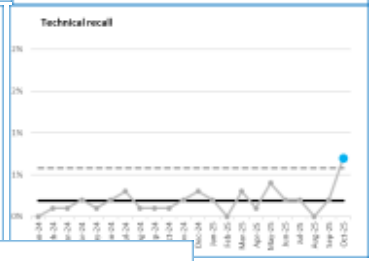
Looking forward

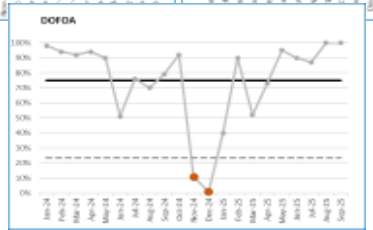
- IS working with the Nuffield, minimum gain of 30 slots per week
- Recruitment of a B6 Mammographer approved by Exec Tri
- Final review by NHSE of the long term sustainability business case











Technical Analysis

- Current backlog is 8,500, which is a reduction from last month.
- Current round-length is up to 36 months + 22weeks depending on area.
- Recovery is projected for October 2026 pending approval of the business case, though this could be brought forward with on-going actions

Planned Actions

- Room rental at the Nuffield in order to deliver additional appointments – funding to be sought from NHSE.
- Appointment of a B6 Trained Mammographer, will deliver 240 additional appointments per week once trained.
- Development of a static site at Stroud Hospital, which will support with health inequalities, and once the NHSE business case is approved will deliver an additional 540 slots per week once the staff are trained.
- Running a 7-day service with CTF funded Sunday clinics, which have supported with accelerated recovery of the backlog, pending an additional 500 appointments in Jan.

Diagnostics: Performance Trend

Highlights

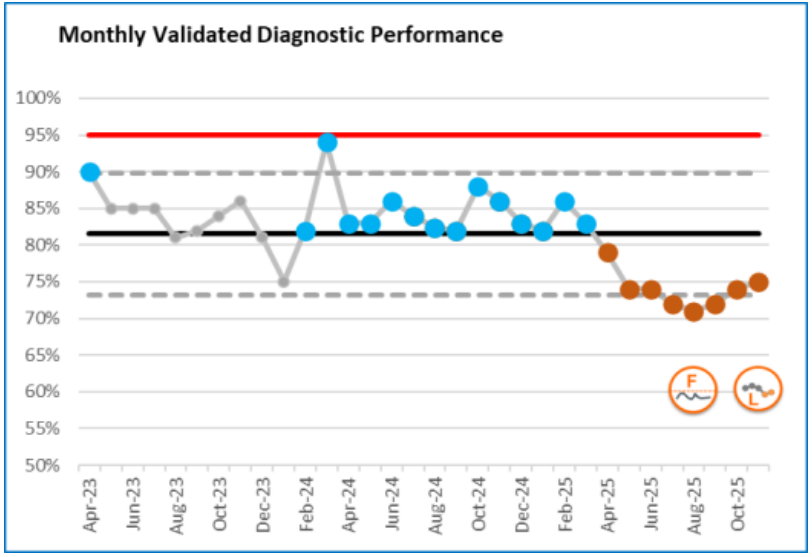
Improvement of 1.7% compared to M7.
Waiting list reduction of 319 patients.
Improvements predominantly in CT (-137), ECHO (-235) and Neurophysiology (-102)

Areas of concern

ECHO performance has begun to improve (3.1% reduction in breaches)
Endoscopy improvement in Gastroscopy (2.1%) offset by deterioration in Flexi Sigmoidoscopy (3.2%) and Colonoscopy (0.7%)

Looking forward

Cystoscopy will continue to improve.
ECHO recovery acceleration begins 17th November '25, which will become a sustained performance improvement from January 2026 onwards
CT performance will continue to fluctuate between 10-13% over the next quarter.



Technical Analysis

November '25 performance has moderately improved compared to the previous month. One modality has had three months of consecutive deterioration (Flexi Sig) and one modality has alternating improvement and deterioration swings bimonthly (MRI) demonstrating capacity is insufficient to consistently meet monthly demand. All other services are maintaining or improving.

Planned Actions

- **Cystoscopy** improvement plan submitted September 2025 to ECPB; additional recovery generated through Cancer Transformation Funding in December 2025 mobilising via PSR.
- **Endoscopy** - Additional recovery funding generated through Cancer Transformation and Community Diagnostic Centre funds. Additional weekend lists commencing in December 2025. A sustainability business case will be submitted through trust governance in Q4 as the waiting list reliance on non-recurrent short-term initiatives does not provide assurance of performance into 2026-27

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	2025-10-01	2025-11-01
Audiology - Audiology Assessments	99.38%	98.98%	99.22%	99.22%	98.27%	99.76%	99.66%	99.65%
Barium Enema	83.55%	99.08%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cardiology - echocardiography	47.08%	33.24%	28.80%	22.98%	29.40%	19.63%	23.41%	26.52%
Colonoscopy	67.16%	72.55%	64.09%	51.96%	45.87%	48.34%	51.27%	50.60%
Computed Tomography	92.83%	91.28%	90.81%	89.75%	86.15%	88.47%	89.11%	87.28%
Cystoscopy	45.18%	38.97%	33.40%	28.29%	36.31%	28.36%	32.75%	36.93%
DEXA Scan	100.00%	100.00%	100.00%	99.77%	100.00%	100.00%	100.00%	99.82%
Flexi sigmoidoscopy	74.47%	61.40%	51.05%	45.05%	40.29%	42.34%	41.69%	38.54%
Gastroscopy	86.10%	80.38%	75.00%	77.54%	74.81%	73.63%	71.75%	73.81%
Magnetic Resonance Imaging	77.59%	76.09%	85.26%	91.42%	99.17%	98.90%	99.10%	97.84%
Neurophysiology - peripheral neurophysiology	40.88%	43.82%	35.68%	53.05%	56.86%	60.87%	62.28%	75.14%
Non-obstetric ultrasound	99.68%	99.93%	99.49%	99.18%	99.40%	99.47%	99.64%	99.91%
Respiratory physiology - sleep studies	98.26%	90.38%	96.73%	96.43%	97.90%	94.22%	96.27%	99.22%
Urodynamics - pressures & flows	76.09%	100.00%	75.81%	87.50%	100.00%	100.00%	100.00%	100.00%

Flow Summary

Highlights

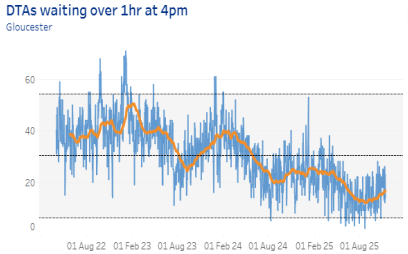
October half term and BMA IA saw a significant reduction in discharge performance across all discharge pathways P0-P3. The recovery period was slower than expected

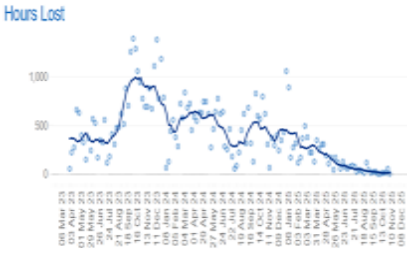
Areas of concern

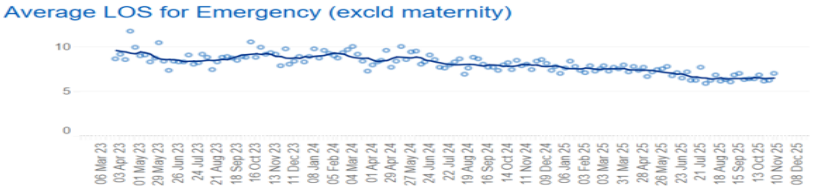
Ability to sustain performance heading into the winter surge period without further improvement in DRD numbers.

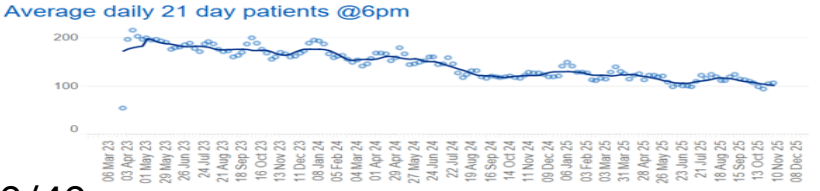
Looking forward

Ongoing improvements being driven through CVOF, system patient flow workstreams and system task force. Tower decant work to be achieved as a systemwide responsibility









Technical Analysis

All internal key trajectories around flow showing positive improvements outside of the 10days of school half terms. Performance has recovered post, although still needs further improvement in line with trust and system improvement trajectories. There has been a generalised decrease in simple discharges, P0 discharges. This is currently under investigation and challenge. There has also been targeted analysis and action with community partners which has highlighted a deficit in commissioned capacity; further contractual changes have had an impact the organisation have impacted on performance

Planned Actions

Ongoing work via the CVOF and wider patient flow programmes to support further reduction in LOS, delays and further enhance RCRP. System Task force implemented to support realisation of tower decant plan and overall reduction in DRD numbers.

Discharge Ready Summary

Highlights

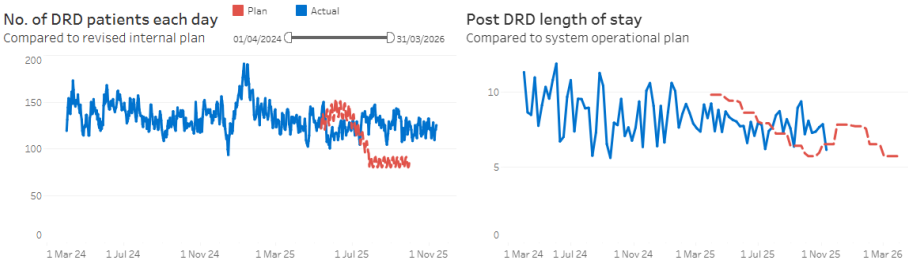
Number of DRD patients remains stable but above the system trajectory, however associated bed days is now below trajectory. This indicates more flow within P1-3, but demand has increased.

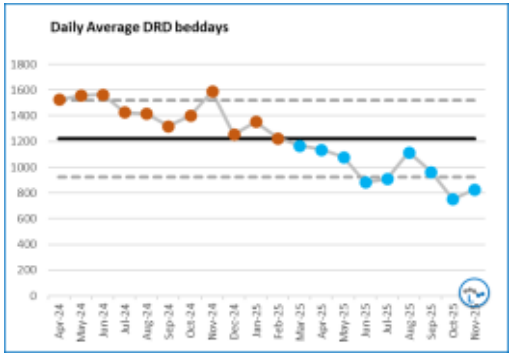
Areas of concern

Increase in number of patients being referred for onward care alongside ability to sustain improved flow through surge periods.

Looking forward

System Task force initiated to support delivery of the DRD reduction plan linked to the tower decant.





Technical Analysis

Although at an individual patient level, average delays have seen a recovery back within plan, the overall impact of the volume of patients now delayed means the impact on flow and bed occupancy remains static. This links to increased demand through the IFH and need for onward care. IA has had a modest impact on stable referral flow meaning some surges experienced in recovery which remedial action has been taken ahead of December IA

Planned Actions

System task force has been set up to deliver on the system DRD reduction plan and identify sustainable ways to maintain the level of flow required to keep DRD numbers below 100 and closed to the 87 identified within system planning.

Delay Related Harm Summary

Highlights

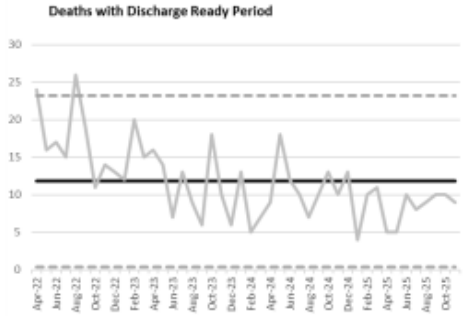
The number of patients reverting to CTR having DRD has remained below the overall average, but did show an increase over the past 2 months. Deaths remain lower and within a consistent variation month to month.

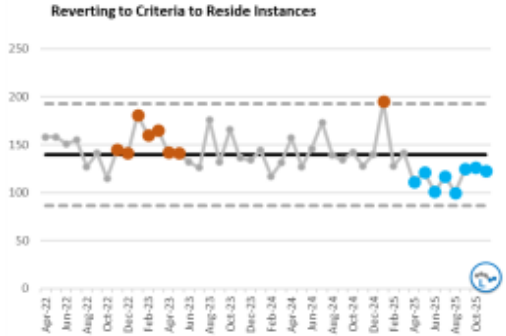
Areas of concern

Delays within the discharge pathways still causing delay related harm for patients waiting for both P1 & P2. Average DRD days for P1 remains main focus.

Looking forward

System Task force initiated to support delivery of the DRD reduction plan linked to the tower decant. This will reduce delays as much as the number of DRD patients.





Technical Analysis

Both deterioration and deaths have remained at a similar level to the previous month, although that was up on the month before.
Further analysis needed to understand how quickly post being made DRD patients deteriorate to understand the difference between true delay related harm and a potential variable clinical condition. This along with driving down average bed days associated with DRD will support further reduction in occurrences.

Planned Actions

Links directly to DRD recovery plan and system task force which is reviewing delays overall as well as a specific focus on the CHC processes and delays. Twice weekly LLOS DRD meetings implemented alongside wider IFH work on flow and delayed discharges.

Quality Metrics

(Safety, experience and effectiveness)

Quality of Care: FFT Positive Response

Highlights

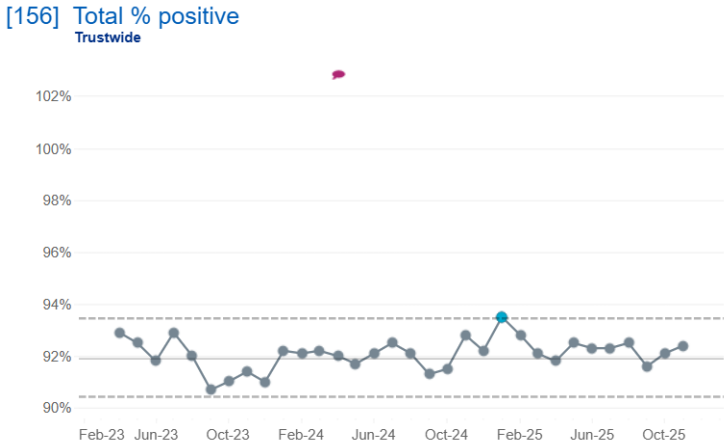
FFT positive score remains above average at 92.4% and is very slightly up on the previous month. This is slightly lower than our position at the same point in the previous year (92.8%).

Areas of concern

We have seen a decrease in positive score for Maternity with a significant decrease specifically in the Maternity Ward.
There is a significant and increasing difference in score between each of our ED's.

Looking forward

We would anticipate that our overall position will be maintained through to the end of the year in line with previous trends. Current pressure in GRH ED may lead to a reduction in their score.



Technical Analysis

The overall Friends and Family Test (FFT) score has increased to 92.4% in Nov from 92.1% Oct remaining above average. This has been supported by improvements in score for 3 of 4 care types including Outpatients and ED. Although a slight increase in Inpatients care type this is due to an increase in Day case score but inpatient wards and SDEC saw a decrease. Maternity saw a decrease overall but delivery suite saw an increase, the significant drop for the maternity ward impacted their overall position.

Planned Actions

We are working with divisions to support the introduction of divisional experience of care meetings and the reporting required to support teams with reviewing their FFT data including comments in conjunction with other experience insight data e.g. PALS, complaints and National surveys. This work supports the quality governance review and delivery of our Trust five year strategy.
Work ongoing with the ICS to bring experience insight into a space to support decision making.

PALS

Highlights

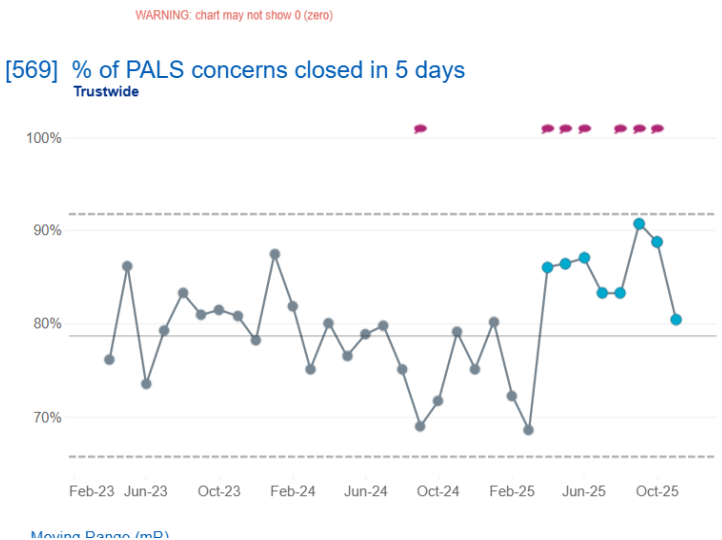
Closure rate maintained above target (75%) at 80%. Position remains positive.

Areas of concern

Volume of cases reduced to 323 through the month. Long term sickness continues with two members of the team currently off. Complexity of cases is proving challenging.

Looking forward

Trend data suggests that we will see a further slight reduction in cases through December, however, ongoing ED challenges with volume of patients and the impact on the wider flow through our hospitals.



Technical Analysis

The PALS team have reduced closure to 80% of concerns being closed in 5 working days and above the local target of 75%. PALS continue to work hard to close cases as quickly as possible working with teams to understand ongoing challenges to support swift responses to patients. 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 how issues are recorded 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 including support from the wider Patient Experience Team. A daily review of workload and response accordingly has led to the drop in service needing to be withdrawn and improve experiences of patients.

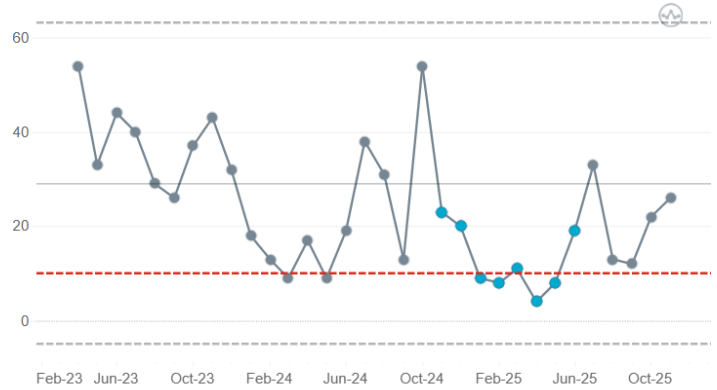
Patient Care: Mixed Sex Breaches

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

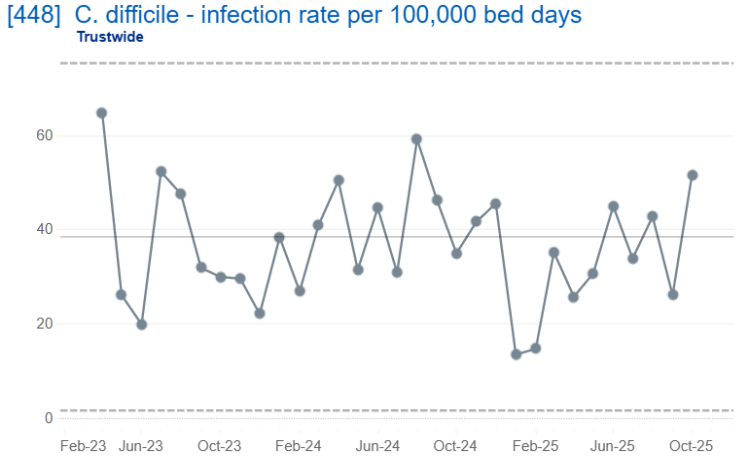
The annual CDI threshold for 2025-2026 has been set 97; we have had 68 cases since April 2025- November 2025; we are 3 cases above trajectory

Areas of concern

Ward/ environmental and equipment cleanliness e.g. mattresses and beds and estate condition, particularly floors continue to be an issue. There has also been a period of increased incidence of CDI across 7B; which has been managed by the outbreak management team and enhanced actions taken. More samples were also sent in response to increased Norovirus rates

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



Technical Analysis

For 2025-26 we have had 68 trust apportioned cases of *C. difficile;* we are currently above 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 continues with 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. Outbreak management team has met to support 7B with the CDI PII and enhanced action plan has been implemented

Safety Priority: Patient Falls

Highlights

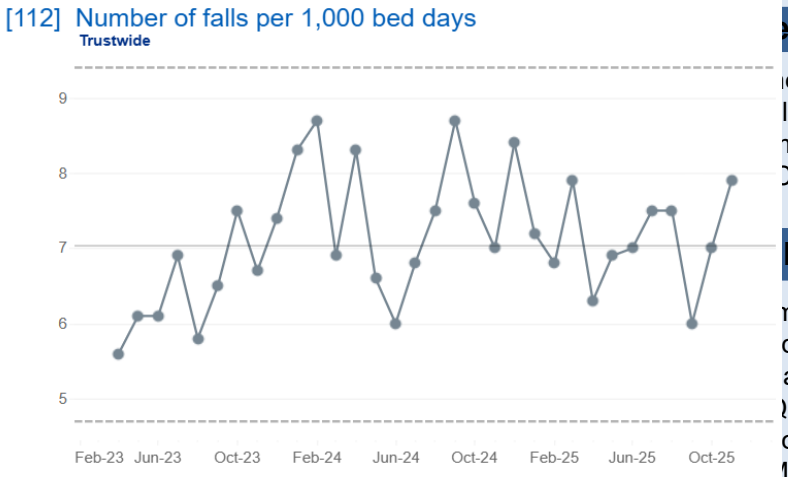
Number of falls within the trust remain static and number of falls of injurious falls also remains static. No falls resulted on fractured Neck of Femur

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



echnical Analysis

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

lanned Actions

mprovement focus is on specialist review of patients who have fallen twice during dmission, if appropriate. A comprehensive training package has been launched by the alls Team and is being very well attended; this is a key focus for us.
uality improvement programmes continue, with Datix development and EPR ocumentation near completion. Immediate Post falls forms for both Nursing and edical staff now live and in use – no data gathered thus far

Maternity Care: Postpartum Haemorrhage >= 1,500 ml

Highlights

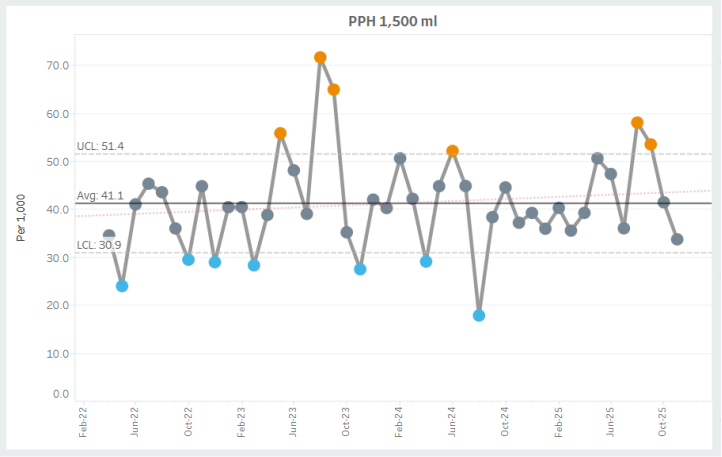
We have reviewed the electronic patient record and have decided the general risk assessments are the more appropriate PPH risk assessment and we have 100% compliance with women being continually risk assessed.

Areas of concern

We are just above national average for our PPH rates and this is a stable position.

Looking forward

The QI work continues with oversight reported to the Perinatal **Delivery Group**. The next focus is to review the clinical guidelines as they are nearly due for review.



Technical Analysis

We note this month there is common cause variation.

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

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

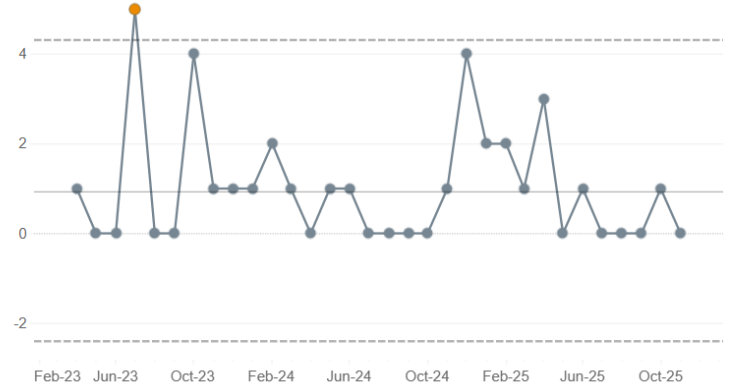
These serious pressure ulcers have remained a challenge for the Trust, whilst numbers appear low our ambition is to have lower than average cases and over the last couple of months cases are static.

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

Tslight rise in cat 3 pressure ulcers

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

PSIRF (Patient Safety Incident Response Framework) Learning Responses

Highlights

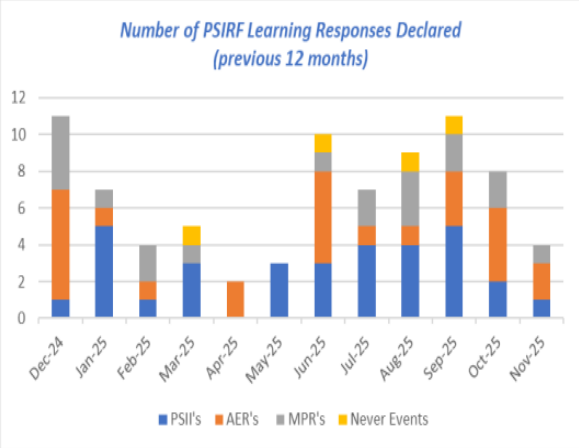
81 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 6.75 per month

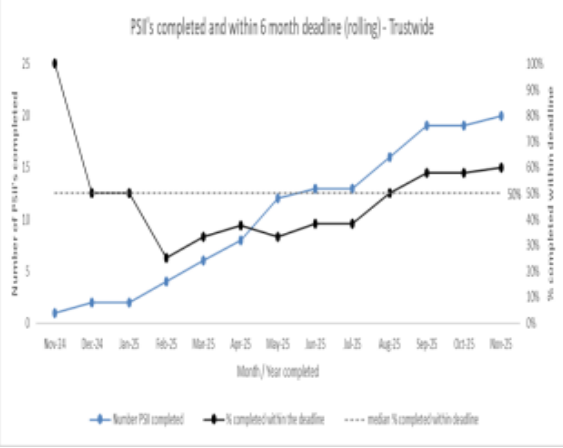
Areas of concern

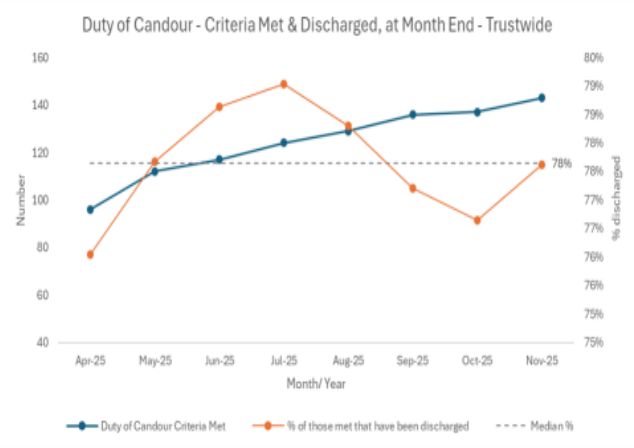
Timeframes within which learning responses are completed. Median on time for PSII's is 50%, for AER's 62% and MPR's 68%.

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

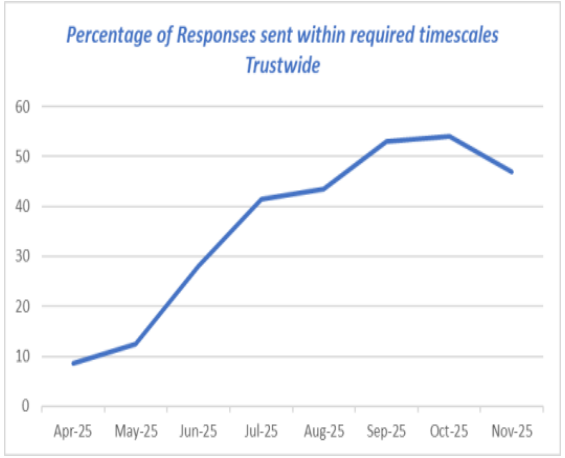
The Trust wide commitment to improve response timeframes has enabled a significant backlog to be cleared and the month on month upward trajectory in the percentage of responses being sent within required timeframes.

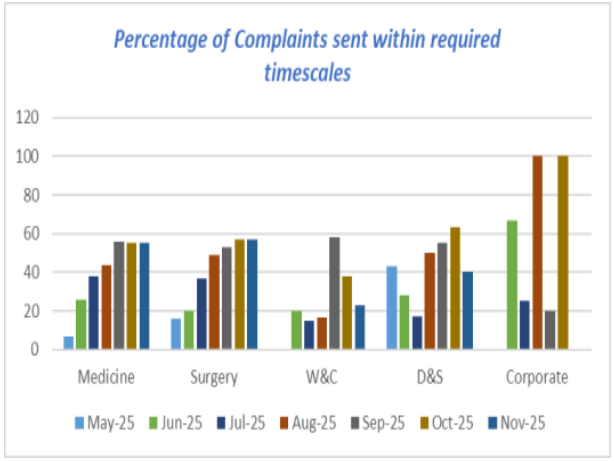
Areas of concern

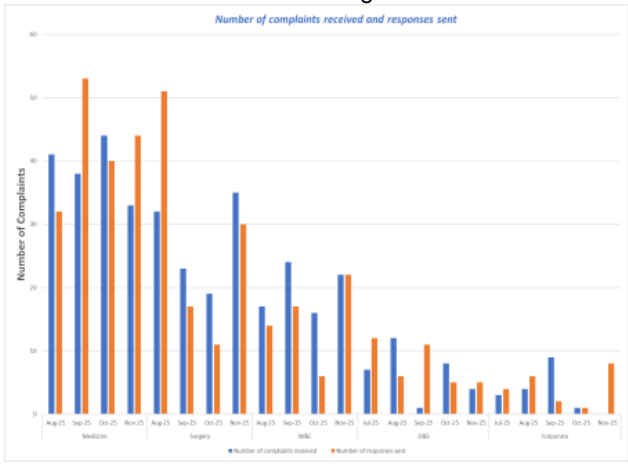
There are 4 complaints that have not had a response within 6 months. Whilst the response rate (figure below) continues to require improvement, significant progress is evident and is expected to continue month on month.

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 54% in November 2025. Performance dipped slightly in November 2025. Factors affecting performance are workforce (annual leave/sickness) and higher numbers due in November 25. 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 £3.3m adverse to planned deficit of £0.3m.
Agency spend is £0.5m higher than NHSE target.
Bank spend is £1.2m higher than NHSE target although this includes industrial action. FSP is £5.7m adverse to plan. Capital spend is £13.7m behind plan. The Trust is holding 16 days operating cash.

Areas of concern

FSP shortfall continues to be the main area of concern and is under-delivering by £5.7m. In addition, system savings targets aren't delivering.
Capital spend continues to be behind plan.

Looking forward

The unmitigated forecast is £28m deficit. Recovery actions totalling £21.4m have been identified to improve this. These actions reduce the forecast deficit to £6.6m. This deficit includes £1.1m industrial action costs and £4.7m system risk share.

	Metric	Month 5			Month 6			Month 7			Month 8		
		Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	-6,147	-8,167	-2,020	-3,455	-3,419	36	2,628	416	-2,212	-300	-3,607	-3,307
		0	0	0	0	0	0	0	0	0	0	0	0
	Agency spend against NHS	-705	-892	-187	-625	-909	-284	-530	-1,133	-603	-747	-248	499
	FSP	15,333	12,123	-3,210	18,808	15,293	-3,515	22,638	17,493	-5,145	26,418	20,708	-5,710
		41,775	41,775	0	41,775	41,775	0	41,775	41,775	0	41,775	41,775	0
	Capital vs budget plan	12,160	5,813	-6,347	15,459	7,492	-7,967	19,585	9,946	-9,639	26,191	12,520	-13,671
		55,638	55,959	321	55,638	55,077	-561	55,638	55,082	-556	55,638	55,082	-556
	Nos days operating cash	5	15	10	5	12	7	5	19	14	5	16	11
	BPP - nos invoices paid in	95%	99%	4%	95%	98%	3%	95%	99%	4%	95%	97%	2%
	Bank spend against NHSE	-3,086	-3,805	-719	-2,945	-3,808	-863	-2,900	-3,257	-357	-2,659	-3,840	-1,181

Risks

The Trust financial position is faced with significant risks including:

- FSP delivery. There remains £6.3m unidentified schemes at M8 with a further £5.3m rated as high risk. Total risk £11.6m, which is an improvement of £2.1m 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.

M8 Revenue Position

Highlights

The Month 8 in month position is £4m deficit which is £1m adverse to plan. The YTD position is £3.6m deficit which is £3.3m adverse to plan. The ytd plan is £0.3m deficit.

Areas of concern

- FSP £5.7m, of which £3.7m is pay
- System wide savings not being delivered £3.3m.
- Maternity cover (in addition to funded element c.50%) £1.5m

Looking forward

The Trust and ICS are reporting breakeven positions in line with plan for 2025/26.
The internal financial position is c£6.6m deficit against breakeven plan if recovery actions are implemented immediately.

Summary I&E Position (Trust only)	Current Month Budget	Current Month Actual	Current Month Variance	YTD Budget	YTD Actual	YTD Variance
	£000	£000	£000	£000	£000	£000
Income	(65,905)	(66,940)	(1,035)	(554,458)	(566,861)	(12,403)
Pay	42,105	41,457	(648)	339,184	341,451	2,267
Non Pay	26,727	29,505	2,777	215,575	230,387	14,812
(Surplus)/Deficit	**2,928**	**4,022**	**1,094**	**301**	**4,977**	**4,676**
Donated Assets/Impairments/IFRIC 12 Adj	**0**	**(1)**	**(1)**	**0**	**(1,371)**	**(1,371)**
Adjusted (surplus)/deficit	**2,928**	**4,021**	**1,093**	**300**	**3,604**	**3,305**

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.
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

The financial position continues to be under significant pressure. The unmitigated forecast indicated that the Trust was heading for a £28m deficit. A recovery plan was prepared and actions are underway to mitigate the forecast to £9m deficit. Further actions have been identified in M8 to improve the position to £6.6m deficit.

The £6.6m deficit is driven by a number of factors, including an FSP gap that has been mitigated through non recurrent measures. The deficit includes £9.175m system risk share targets, of which £1.3m has been offset by release of a provision and £3.15m should remain with GHFT. The remaining £1.885m includes £1.1m industrial action up to M8.

There are several high risk recovery actions which will need to be managed over M9-M12. There is potential for the forecast to deteriorate if these actions do not materialise. These include release of provisions and increase in GMS dividend which is dependent on capital spend.

Operational pressures may deteriorate the position including industrial action, winter pressures and the management capacity to deliver FSP when operational demands increase.

	£000	
GHFT Forecast Variance to Plan 25/26	**FOT**	**Risk of delivery for mitigations**
M7 Forecast Deficit Variance (likely)	**9,371**	
Changes to FOT in M8		
M8 training overhead (medical staffing)	(320)	Complete
M8 IA	542	Complete
Remove PP stretch target for FSP	500	Complete
Remove double count of GMS profit margin benefit	350	Complete
Pass through drugs income is lower than forecast	2,628	Complete
Pass through overhead risk due to aseptic unit closure	700	Complete
Reserves maternity recovery accrual	(188)	Low
Reserves enhanced care accrual	(392)	Low
Changes to FOT in M8	3,821	
Options to close position		
Accrue for overperformance that will be paid in 26/27	(1,000)	High
Provision release	(800)	High
Gen Med accrual from March 23 released	(500)	Amber
SABA bad debt	(3,398)	Low
Medicine accrual	(100)	Amber
GMS dividend increase if capital delivers £40m	(384)	High
Increase contract leakage to £800k	(200)	Amber
Ward moves	(500)	Low
DCC	300	Low
Total Additional Mitigations & Recovery Actions @ M8	(6,582)	
M8 Forecast deficit variance (likely)	**6,610**	
System risk carry forward	(5,300)	
System risk share	(375)	
System risk share	(2,000)	
ERF reduction	(1,500)	
Less water provision	1,300	
GHFT share 40%	3,150	
M8 Forecast deficit variance adjusted for system risk share	**1,885**	

M8 Pay

Highlights

Pay is overspent by £2.3m.
This includes £1.1m due to industrial action.

Areas of concern

Non delivery of FSP continues to be a significant pressure (£3.7m). The temporary staffing workstream and workforce change programme are behind plan.

Looking forward

Medical staffing costs are forecast to overspend if mitigating actions do not materialise. 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)	M8 YTD Plan £000s	M8 YTD Actuals £000s	M8 YTD Variance £000s
Infastructure	54,839	52,638	(2,201)
Medical & Dental	105,686	106,610	924
Nursing	132,388	132,888	499
Other Clinical Staff	50,325	49,143	(1,182)
Total (excl reserves)	**343,238**	**341,278**	**(1,961)**
Reserves (FSP & Other Staff)	**(739)**	**(84)**	**656**
Divisions (FSP target & vacancy factor)	(3,315)	257	3,572
Adjusted (Surplus)/Deficit	339,184	341,451	2,267

Summary Pay Variance (Trust Only)	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Total
Infrastructure	(2,741)	178	(0)	88	163	111	(2,201)
Medical & Dental	116	157	1,347	(802)	(57)	162	924
Nursing	72	(158)	3,077	(1,633)	(279)	(580)	499
Other Clinical Staff	33	(1,155)	(125)	94	(52)	22	(1,182)
Other Staff Sub	94	647	1,517	656	686	629	4,228
YTD Variance	(2,425)	(330)	5,817	(1,599)	461	343	2,267

Technical Analysis (further info on following slides)

Nursing overspend of £499k, of which £755k is due to unfunded maternity cover.

Medical staffing overspend of £924k of which £585k is industrial action and £1,127k is due to unfunded maternity cover. It also includes a one off £700k benefit from a proportion of the annual leave accrual dropping out.

Infrastructure underspend of c£2.2m, of which c£2.7m is within corporate, primarily CIO.

Planned Actions

Recovery actions are in place and being monitored at Executive Reviews.

M8 Nursing Pay

Highlights

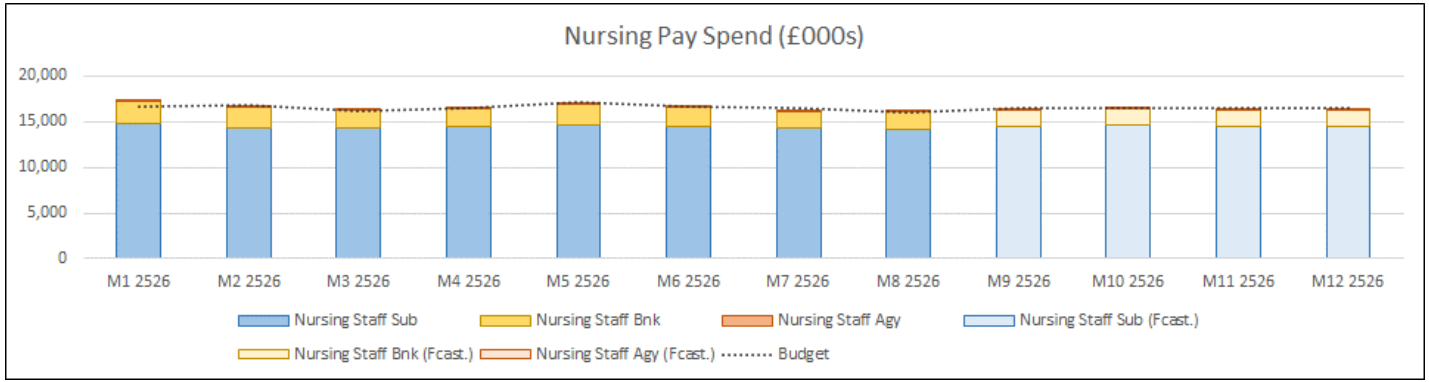
The Month 8 YTD nursing position is £499k overspent of which £755k is unfunded maternity leave cover. YTD spend is £132.9m against a budget of £132.4m.

Areas of concern

Nursing run rate has increased (deteriorated) by £47k when compared to M7. Agency has reduced by £45k but bank and substantive have increased. Bank is the biggest increase and is mainly in Medicine.

Looking forward

Nursing rate has increased within Medicine. The tight controls continue to have an impact but high staff sickness is resulting in higher bank spend.



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 includes specific nursing actions that are being discussed with Executives.

M8 Medical Pay

Highlights

Medical staffing overspend of £0.9m of which £1.1m is industrial action (IA). It also includes a one off £0.7m benefit from a proportion of the annual leave accrual dropping out.

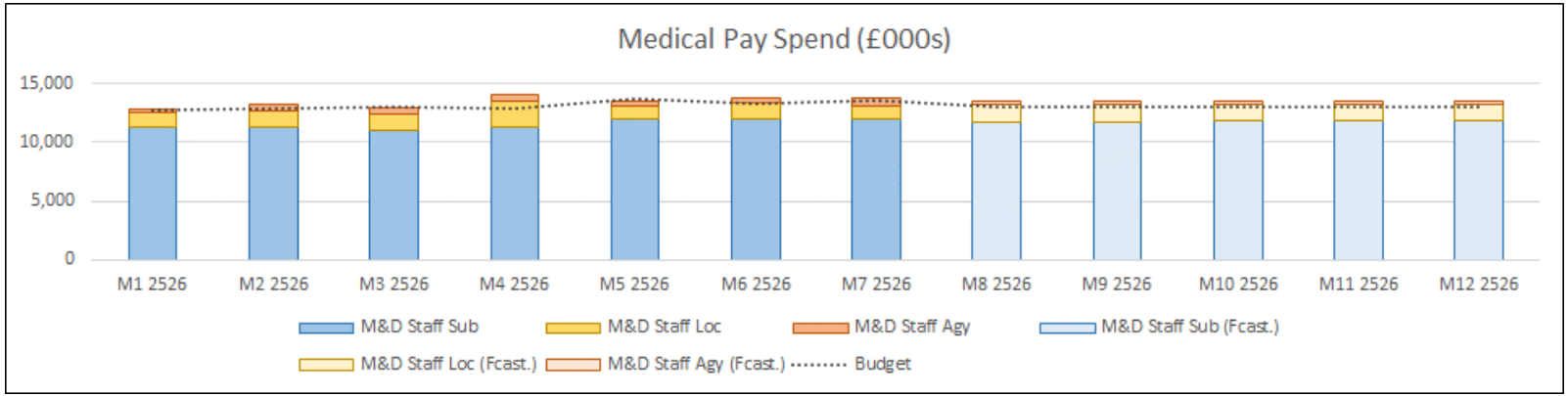
Areas of concern

Medicine continues to be the biggest area of overspend, driven by sickness, vacancy cover and WLIs.

Industrial action costs now exceed £1m which will grow in M9. There is no additional funding.

Looking forward

Medical pay is forecast to be c£3m 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.

M8 Non Pay

Highlights

The non pay position is £14.8m overspent, reducing to £6.6m overspend after excluding passthrough drugs and IFRIC12 & donated assets.

Areas of concern

System savings that aren't delivering are driving £4.5m of the non pay overspend although £1.2m has been delivered against income & pay. Non pass through drugs and supplies also continue to be a pressure due to ERF, and price increases.

Looking forward

FSP delivery continues to be a risk with the phasing of targets increasing each month for the remainder of the year.

Non Pay	YTD Variance			
	Divisions	Corporate	Reserves/ Central	YTD Variance
YTD Variance	14,770	-1,868	1,910	**14,812**
Drivers of variance				
IFRIC12 & donated assets		1,371		**1,371**
Pass through drugs and devices	6,588		169	**6,756**
System wide savings not being delivered			4,541	**4,541**
FSP gap	899	42	-422	**519**
Clinical supplies in divisions	1,280			**1,280**
Release of 3% productivity reserve			-705	**-705**
Non Passthrough drugs	2,063	77		**2,140**
Reserves slippage			-1,673	**-1,673**
Other	3,922	-3,359	19	**582**
Total YTD Variance	14,752	-1,868	1,910	**14,812**

Technical Analysis

Pass through drugs are driving a pressure, although partly offset by £3.6m income overperformance. In theory the costs of passthrough drugs should be completely recovered from commissioners. We are reviewing how the costs and income are flagged in the pharmacy system to ensure coding is accurate. We are, however, finding that some drugs are 'blocked' and some gainshare arrangements are not having a recurrent benefit to the Trust, both of which cause a pressure.

Other pressures caused by tariff drugs (£2.1m) and clinical supplies in divisions (£1.3m). The pressures have been mitigated by releasing balance sheet items and accelerating balance sheet releases but these are non recurrent. Advancement of schemes has supported the ytd position but presents a challenge for future months.

Planned Actions

Medical Grip & Control meetings have now been stepped up to meeting weekly, with drugs being discussed on a fortnightly basis, alternating with discussing staffing costs.

M8 Income

Highlights

The income position is £12.4m favourable to plan. This includes £3.6m pass through drugs & devices income overperformance, £1.2m API overperformance, £4.2m increased depreciation funding and (£2.6m) clawback of funding.

Areas of concern

Private Patient income continues to be below plan. Growth is assumed as part of FSP delivery plans and recovery of the financial position, but this is not materialising in the YTD 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	M8 YTD Plan £000s	M8 YTD Actuals £000s	M8 YTD Variance £000s
HEE Income	(13,226)	(16,557)	(3,332)
Other Income from Patient Activities	(13,129)	(13,496)	(367)
Other Operating Income	(17,659)	(18,759)	(1,099)
PP Overseas and RTA Income	(4,539)	(3,808)	731
SLA & Commissioning Income	(505,905)	(514,241)	(8,336)
Total Income	(554,458)	(566,861)	(12,404)

Technical Analysis

HEE income is £3.3m above plan and is covering pay costs.

SLA and Commissioning Income is £8.6m above plan due to £3.6m pass through drugs income, £4.2m unexpected depreciation funding and (£2.6m) clawback of funding, £1.2m API overperformance and £1m prior year income mainly from NHSE.

M8 Capital Position

Highlights

As at of the end of November (M8), the Trust had goods delivered, works done or services received totalling £12.8m, against a planned spend of £26.6m, equating to a variance of £13.8m 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 and no recent forecasts for several schemes

Looking forward

At M8, the Trust is reporting a breakeven forecast in line with the gross capital spend allocation of £56.6m. At M5, mitigations were agreed that overcommitted the programme by £0.2m on top of an expected high slippage risk of £4m.

Some of the high risks have materialised erased the overcommitment and reduced the slippage required to balance the programme to £1.1m. It is strongly believed that once formal updated forecasts are incorporated that this will not be the case and there it is likely that we are facing an underspend against our allocation.

in £000's	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	6,421	4,050	2,370	11,500	11,501	(0)
DIGITAL - IFRS16	0	0	0	101	101	0
MEDICAL EQUIPMENT	2,679	1,383	1,296	6,980	6,778	202
MED EQUIP - IFRS16	2,225	462	1,763	1,312	1,386	(74)
ESTATES	10,253	6,458	3,795	24,158	21,123	3,035
ESTATES - IFRS16	199	146	53	516	505	11
UEC INCENTIVE SCHEME	0	0	0	0	0	0
SLIPPAGE RESERVE	730	0	730	(4,040)	(1,144)	(2,896)
OVERCOMMITMENT OF PROGRAMME	0	0	0	(210)	0	(210)
NBV OF ASSET DISPOSALS	0	(265)	265	(265)	(265)	(0)
Total Charge against Capital Allocation (incl. IFRS 16)	**22,507**	**12,235**	**10,272**	**40,053**	**39,986**	**67**
NAT PROG: CIR FUNDING	1,616	50	1,566	9,710	9,783	(73)
NAT PROG: CDC PATHWAY OPTIMISATION	0	0	0	25	25	0
NAT PROG: CONST STANDARDS FUNDING - DIAGNOSTIC	1,585	0	1,585	1,242	1,243	(1)
NAT PROG: DIGITAL DIAGNOSTICS	249	0	249	783	776	7
NAT PROG: CANCER FUNDING	0	0	0	2,916	2,916	0
IFRIC 12	354	354	0	533	533	0
DONATIONS VIA CHARITABLE FUNDS	301	154	147	1,339	1,339	(0)
Total Expenditure against Additional Funding	**4,105**	**558**	**3,547**	**16,548**	**16,615**	**(67)**
Gross Capital Spend Total	**26,612**	**12,793**	**13,819**	**56,601**	**56,601**	**(0)**
Gross Capital Spend Total	**26,612**	**12,793**	**13,819**	**56,601**	**56,601**	**(0)**
Less Donations and Grants Received	(301)	(154)	(147)	(1,339)	(1,339)	(0)
Less PFI Capital (IFRIC12)	(354)	(354)	0	(533)	(533)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	236	236	0	353	353	0
Total Capital Departmental Expenditure Limit (CDEL)	**26,192**	**12,520**	**13,672**	**55,082**	**55,082**	**(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 of £57.1m. Since, the Trust has received additional capital of c£0.5m for digital diagnostics, a further £2.0m of system capital 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.

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

	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	Mar 27 £'000
Opening Balance	44,123	36,437	31,926	36,703	35,125	22,530	20,897	14,238	10,996	24,427	20,416	13,447	27,747	16,108	20,636	11,790	9,990
Receipts																	
SLA Income	63,925	63,673	62,436	66,946	67,257	62,415	65,017	64,179	63,249	65,124	63,249	69,740	62,568	63,549	63,549	62,429	66,685
Other NHS	941	3,095	6,014	12,647	1,871	18,771	3,578	3,745	25,283	3,215	3,017	23,446	2,155	2,371	5,161	11,080	2,313
Other Non-NHS	2,655	2,162	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	3,736
VAT	2,674	2,095	2,989	1,688	2,214	2,628	2,455	2,961	2,841	3,218	2,166	2,435	2,479	2,595	2,989	2,688	2,214
Total Receipts	70,195	71,026	74,213	83,891	74,079	86,624	73,553	73,439	94,450	74,159	71,111	98,394	69,602	70,610	74,375	78,806	74,948
Payments																	
Payroll - Direct payments	(27,485)	(28,421)	(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)	(28,545)
Payroll - On costs	(21,523)	(21,490)	(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)	(21,493)
Payables	(27,463)	(21,758)	(29,026)	(27,769)	(26,381)	(26,443)	(27,925)	(24,675)	(28,707)	(25,604)	(21,908)	(31,667)	(28,912)	(13,744)	(29,891)	(27,880)	(27,246)
Loan Principle & Interest	0	0	0	0	(1,142)	0	0	0	0	0	(1,125)	0	0	0	0	0	(1,100)
PDC Payments	0	0	0	0	(3,790)	0	0	0	0	0	(2,938)	0	0	0	0	0	(3,790)
Total Payments	(76,471)	(71,669)	(79,394)	(77,887)	(81,351)	(76,404)	(78,144)	(74,613)	(78,711)	(75,890)	(75,939)	(81,956)	(78,850)	(63,691)	(80,830)	(77,999)	(82,174)
Capital																	
Capital Funding Grants & PDC	0	0	15,244	6,274	6,253	0	0	0	0	0	0	0	0	0	0	0	0
Capital Payables	(1,411)	(3,868)	(5,286)	(13,855)	(11,576)	(11,853)	(2,068)	(2,068)	(2,307)	(2,281)	(2,140)	(2,138)	(2,391)	(2,391)	(2,391)	(2,608)	(2,608)
	(1,411)	(3,868)	9,958	(7,581)	(5,323)	(11,853)	(2,068)	(2,068)	(2,307)	(2,281)	(2,140)	(2,138)	(2,391)	(2,391)	(2,391)	(2,608)	(2,608)
Net Cashflow	(7,686)	(4,511)	4,777	(1,578)	(12,595)	(1,633)	(6,659)	(3,243)	13,431	(4,011)	(6,969)	14,300	(11,639)	4,528	(8,846)	(1,800)	(9,834)
Closing Balance	36,437	31,926	36,703	35,125	22,530	20,897	14,238	10,996	24,427	20,416	13,447	27,747	16,108	20,636	11,790	9,990	156
Number of days operating cash held	16	14	16	15	10	9	6	5	11	9	6	12	7	9	5	4	0

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.
- This includes £13m of 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 10 days.

Planned Actions

- Enhance recovery governance arrangements to secure improvements

Workforce

Workforce Performance Indicators

KPI	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Turnover	11%	9.30%	9.04%	8.78%	8.95%	8.71%	8.54%	8.40%	8.34%	8.64%	8.13%	8.03%	8.73%
Vacancy	8%	7.67%	7.25%	7.41%	7.21%	7.30%	7.34%	7.48%	7.45%	7.99%	6.85%	6.87%	6.96%
Sickness	4%	4.62%	4.87%	4.34%	4.19%	4.37%	4.37%	4.62%	4.39%	4.39%	4.40%	4.41%	
Appraisal	90%	80.60%	81.60%	81.37%	81.37%	82.37%	82.33%	83.00%	84.00%	84.00%	84.00%	83.00%	82.00%
Essential Training	90%	89.32%	89.48%	89.40%	89.81%	89.81%	90.01%	89.96%	91.00%	91.00%	91.00%	90.00%	90.00%
Agency FTE	-	74.00	85.52	81.50	108.26	94.46	90.35	84.28	73.39	85.37	58.13	46.85	49.53
Agency % of Establishment	2%	0.90%	1.10%	1.00%	1.30%	1.20%	1.10%	1.00%	0.90%	1.00%	0.70%	0.58%	0.61%
Bank FTE	-	570.92	536.54	637.20	639.27	650.71	572.59	568.92	546.37	577.37	562.28	515.46	505.63
Bank % of Establishment	7%	7.10%	6.60%	7.90%	7.90%	8.00%	7.00%	7.00%	6.70%	7.10%	6.90%	6.35%	6.25%

Sickness

		Trend				Division (Past 2 Years)					Top 5 Absence Reasons (Past 2 Years)**				
		Prev. 12m	Last 12m	Difference	Trendline	Corporate	D&S	Medicine	Surgery	W&C	Mental Health	Musculoskel	Respiratory	Gastrointest	Infectious
	Trust	4.2%	4.3%	0.1%		3.8%	4.1%	4.3%	4.3%	5.1%	24.0%	7.6%	13.3%	10.0%	2.6%
ESR Staff Group	Add Prof Scientific & Technical	2.9%	3.2%	0.3%		1.6%	3.2%	3.4%	2.5%	*	34.0%	2.2%	14.4%	9.3%	4.6%
	Additional Clinical Services	5.4%	6.4%	0.9%		5.7%	5.7%	5.6%	6.5%	5.6%	22.8%	8.6%	12.7%	12.5%	2.6%
	Administrative and Clerical	4.3%	4.2%	0.0%		3.7%	4.8%	3.8%	5.2%	6.0%	27.9%	6.4%	11.3%	8.0%	2.2%
	Allied Health Professionals	3.3%	2.9%	-0.3%		2.9%	2.9%	2.8%	4.1%	*	27.8%	5.3%	18.1%	11.3%	3.4%
	Estates and Ancilliary	6.7%	5.4%	-1.3%		*	6.0%	*	*	*	29.0%	17.8%	6.7%	8.9%	1.3%
	Healthcare Scientists	2.8%	3.4%	0.6%		*	3.2%	3.9%	2.1%	*	24.7%	7.6%	16.6%	8.9%	3.2%
	Medical and Dental	1.9%	2.1%	0.3%		0.9%	1.4%	2.4%	1.9%	1.8%	10.9%	3.7%	12.1%	6.0%	1.9%
	Nursing & Midwifery Registered	4.8%	4.7%	-0.2%		4.2%	5.5%	4.5%	4.4%	5.7%	23.7%	8.6%	14.3%	10.2%	2.7%

** Fewer than 20 assignments in past 2 years*

*** As a proportion of all absence*

- 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

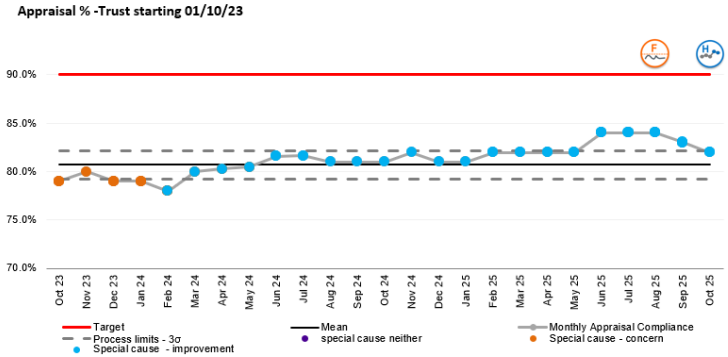
- Appraisal outreach very successful with teams who have high quality and high compliance appraisal scores, sharing a lot of learning and ideas.

Areas of Concern

- Increased reporting from managers of lack of awareness or understanding regarding new paperwork and process;
- Compliance lower than 70% in 97 cost centres, of which 34 are less than 50%.

Looking forward

- Internal Audit of Appraisals planned Q4
- Further engagement sessions planned in low compliance staff groups and service lines.
- New bitesize virtual training created to increase knowledge of appraisal paperwork and process



Division / Date	30-Nov-25
Corporate Division	73%
Diagnostic & Specialty Division	82%
Medicine Division	87%
Non-Division	47%
Surgery Division	85%
Women & Children Division	75%
GHT Total	**82%**

Staff Group / Date	30-Nov-25
Add Prof Scientific and Technic	84%
Additional Clinical Services	83%
Administrative and Clerical	74%
Allied Health Professionals	79%
Estates and Ancillary	77%
Healthcare Scientists	81%
Medical Staff - Consultants	91%
Medical Staff - SAS	77%
All Medical Staff	88%
Nursing and Midwifery Registered	85%
GHT Total	**82%**

Technical Analysis

The current appraisal compliance rate stands at 82%, a drop after consecutive months higher. Most staff groups show slight decline in compliance apart from estates and ancillary staff who have seen significant improvement with compliance now 77%, its highest for 5months. Divisional data shows minimal change, multiple service lines within corporate division continue to have compliance of less than 70% and non-division remain significant outliers.

Planned Actions

Collating learned themes from recent outreach programme to inform improvement in the low compliance and low quality departments.

Focused interventions in non division and service lines within corporate division with less than 70% compliance, which will include support to Service leads and enrolment to training if necessary.

Embedding the appraisal learning and development offering into the managers development programme

Development of point of need learning resource

Workforce - Bank

Highlights

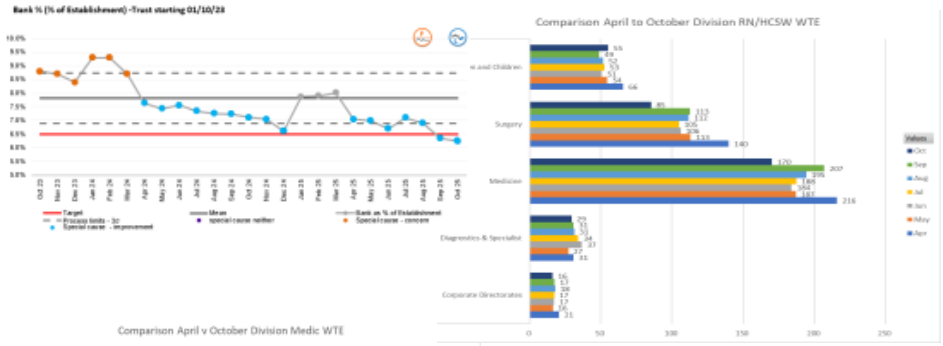
- Reduction of RN/HCSW (61 WTE) in M7 compared with M6. - 417WTE to 356
- M7 is 39 WTE lower than M7 for 24/25.
- Reduction in Medic Locum in M7 compared with M6 of 2 WTE
- Reduction of 11 WTE Meical Locum has been achieved since April

Areas of concern

- The Trust target of 6.5% has not been achieved in month 7.
- Overall WTE and £ use of bank is not yet at the trust reduction target of 15% in M7.

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 a reduction in temporary RN/HCSW Staffing of 61 WTE (M6 417 to M7 356 WTE).
- In comparison with M7 of 24/25 FY, there has been a reduction of 39 WTE RN/HCSW
- **Medicine** is the highest user of Bank & Locum staff.
- Top 3 users in M7 ED , COTE and Respiratory. However, all have reduced temporary staffing use compared to M6
- **ED** (79.64 to 65.86 WTE), **COTE** (41.74 to 29.41WTE) **Respiratory** (21.21 to 16.65 WTE)

- 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

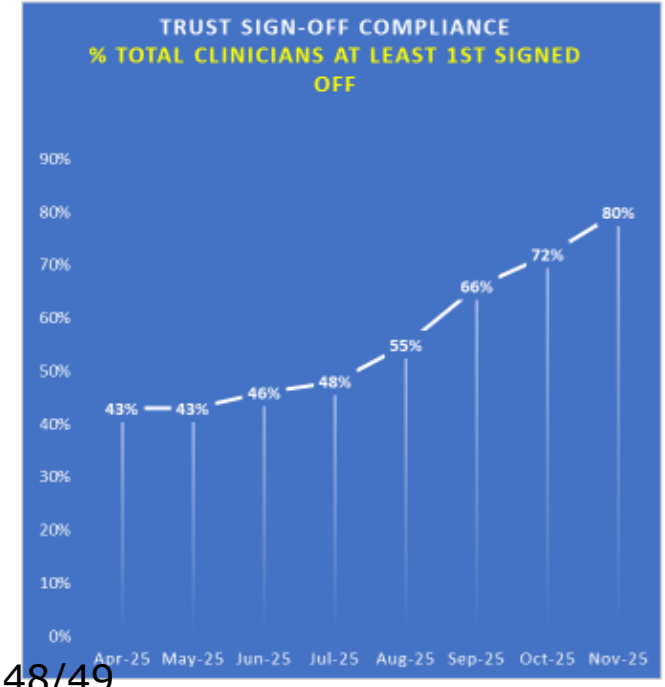
- Job Planning has this year been included in PWR reporting and is also an NHS England Improvement Programme
- The medical e.rostering work is providing a helpful lever as up to date job plans are required for e.rostering
- The October 2025 target of over 60% of job plans signed off by 1st October has been met

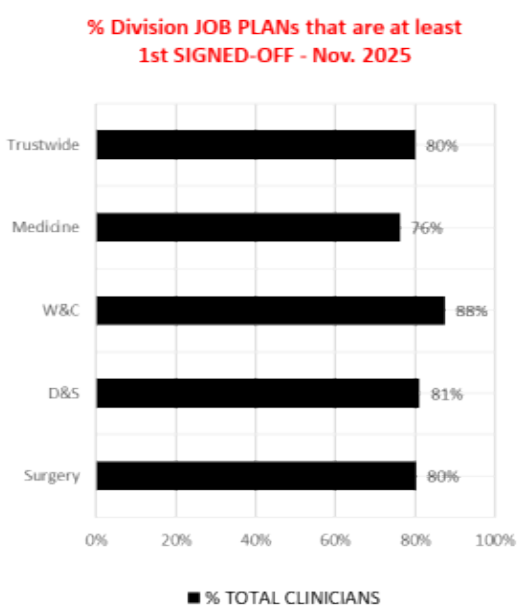
Areas of concern

- 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 594 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 has been renewed for a further year to allow time for review and procurement going forward





Technical Analysis

-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 weekly, showing their job planning performance and progress. Additionally, emails have been sent to leads where there are outstanding sign offs, to encourage and support their engagement with the process and also do individual doctors when signoff is outstanding.

-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

Continue weekly reporting to support SDs and CLs

The Job Planning department continues to support clinicians and leads with the process

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Thank you

Report to Board of Directors				
Date	15 January 2026			
Title	**Safer Staffing Report for Nursing (Annual)**			
Author **Director/Presenter**	Ana Gleghorn, Associate Chief Nurse for Workforce & Education Matt Holdaway, Chief Nurse and Director of Quality			
Purpose of Report		Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**		
Regulatory requirement		**To highlight an emerging risk or issue**		
To canvas opinion		**For information**		
To provide advice		**To highlight patient or staff experience**		

Summary of Report

The objective of this paper is to present the Quality & Performance Committee with a comprehensive assessment of nursing staffing levels at Gloucestershire Hospitals NHS Foundation Trust, as well as an evaluation of compliance with the Developing Workforce Safeguards (NHSI, 2018). This framework is informed by the National Quality Board (NQB) standards and the National Institute for Health and Care Excellence (NICE) guidance (DH, 2014).

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) provides Trusts with best practice recommendations for effective staff deployment and workforce planning, incorporating evidence-based tools and professional judgement to ensure appropriately skilled staff are available in the right place at the right time. This methodology supports the determination of safe staffing levels based on patient needs, acuity, and associated risks, enabling monitoring from ward to board. The Care Quality Commission (CQC) also endorses this triangulated approach to staffing decisions.

This report is distinct from previous iterations in that it is organised around three principal themes: Right Staff, Right Skills, and Right Place and Time, encompassing a review period of twelve months.

It should be noted that although several departments have been identified as potentially requiring further investment, these considerations have been deferred pending the reconfiguration of the wards within the tower, and likelihood this will mitigate those shortages. Equally there are a number of areas where the acuity and dependency of patients at the time of audit required less staff than established. The next biannual audit takes place in Q4 and will be reviewed to understand what movement of staff may be required.

Risks or Concerns

There are two Trust wide risks detailed in this paper - Risk 154 & Risk 722. Both are longstanding and both have a current risk score < 15

Financial Implications

As described above, there are no financial implications described.

Recommendation
The Board is **asked to note and accept assurance** that the Trust has **effective systems and governance in place to ensure safe nurse staffing**, in line with national guidance. The Board is further asked to **acknowledge that current staffing levels, escalation processes, and establishment review mechanisms provide appropriate assurance** that risks relating to nursing workforce capacity and capability are being **identified, managed, and mitigated**.
Enclosures
There are no enclosures in this report.

Gloucestershire Hospitals
NHS Foundation Trust

September 2025
Safer Staffing
Report for Nursing

1.1 Purpose of the paper

The purpose of this paper is to provide the Quality & Performance Committee with an assessment of nursing staffing levels at Gloucestershire Hospitals NHS Foundation Trust and evaluate compliance with Developing Workforce Safeguards (NHSI, 2018). This framework builds on the National Quality Board (NQB) standards and the National Institute for Health and Care Excellence (NICE) guidance (DH, 2014).

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in the right place at the right time. Using this approach will ensure safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to staffing decisions is also supported by the CQC.

National Quality Board: Safe, Sustainable and Productive Staffing

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1 – National Quality board: Safe, Sustainable and productive Staffing

The report differs from previous reports as it is structured around three primary themes: Right Staff, Right Skills, and Right Place and Time, looking back over a 12-month period.

Expectation 1 Right Staff

2.1 Evidence Based Workforce.

The following section details the results of the September Safer Nursing Care Tool (SNCT) audit, the variance shows where this is above or below the SNCT suggested establishment.

This is followed by the nurse sensitive indicators (NSI's), drawing out the two most workforce sensitive indictors and comparing them to the last audit in March 2025. Evidence has shown a direct correlation between the incident of falls and pressure ulcer damage with the size of the workforce (Aiken et al, 2014 and Griffiths et al, 2018) All NSI data has been standardised into incident ratio per 1,000 beds days to enable comparisons across wards allowing for the differences between ward sizes.

2.1.1 Medical Division SNCT Results and Discussion

Hatherley has demonstrated considerable variability throughout the year, marking this as the first full year within the new department. The data further indicates an enhancement in patient flow and effective step-down of stroke patients to Woodmancote, thereby supporting increased capacity for future stroke surges.

The Acute Medical Unit (AMU) will remain under ongoing observation. It is anticipated from October onward, there will be a discernible rise in admissions via the Medical Assessment Zone (MAZ) pathway, creating a need for additional staffing resources. Additionally, a trend has been noted of more patients being transferred from Same Day Emergency Care (SDEC) later in the evening; continued surveillance is recommended, with an internal SNCT review advised prior to January. In anticipation of the forthcoming Urgent Treatment Centre proposal, it is expected there will be a decrease in patient entries through the MAZ and SDEC routes as the services evolve in response to changes in patient admissions.

Within Cardiology, efforts are focused on bed modelling and optimising the utilisation of Coronary Care Unit beds which will take into the account the appropriate care levels and staffing allocations.

According to SNCT findings, the elderly care departments may require a reassessment of nursing staff levels. Wards have been managing a significant proportion of patients requiring enhanced support, with enhanced care data showing these areas accounted for 51% of enhanced care team capacity over the past four months.

However, with multiple ward relocations and departmental reconfigurations anticipated in the coming 12 months, the plan is to closely monitor the impact of these changes on both patient care and workforce needs.

In Respiratory, further analysis is warranted as current metrics do not align with projected outcomes. Although funding allows for 13 Registered Nurses per shift to accommodate High Dependency Unit (HDU) patients, actual staffing typically stands at 11. This situation will be reassessed during the winter period, coinciding with peak activity.

Medical Division				
Ward	No: beds	*Funded Est: wte	Suggested Est:	Variance wte
Hatherley	21	53.34	34.04	19.30
AMU	40	86.8	73.02	13.78
Cardiology	41	79.03	82.66	-3.63
FAU	17	34.02	33.66	0.36
Gallery 1	24	36.64	39.84	-3.20
Gallery 2	24	36.64	39.68	-3.04
Guiting	30	44.5	48.53	-4.03
Knightsbridge	16	29.81	26.80	3.01
Ryeworth	32	48.94	56.19	-7.25
Ward 6a	23	45.52	36.29	9.23
Ward 6b	35	52.36	51.80	0.56
Ward 7a	30	44.61	38.45	6.16
Ward 7b	23	34.13	38.10	-3.97
8th Floor	56	111.8	78.01	33.79
Ward 9b	28	47.12	39.21	7.91
Woodmancote	32	54.18	56.38	-2.20
			Total variance	66.77

Table 2: Medical Division SNCT Results

Medical Division										
						Incidents per 1000 bed days				
Ward	Official Complaints	Drug Errors	MSSA	C-Diff	Nutrition	Falls Sep-25	Comparison Mar-25	Pressure Ulcers Sep-25	Comparison Mar-25
	Incidents per 1000 bed days								
Hatherley	0.00	0.00	**1.85**	0.00	**94%**	0.00		**5.55**	
AMU	**0.78**	**3.13**	0.00	0.00	**70%**	0.00		**1.56**	
Cardiology	0.00	0.00	0.00	0.00	**92%**	0.00		**0.74**	
FAU	0.00	**1.92**	0.00	0.00	**85%**	0.00		0.00	
Gallery 1	0.00	0.00	0.00	0.00	96%	0.00		0.00	
Gallery 2	0.00	0.00	0.00	0.00	**89%**	0.00		**1.40**	
Guiting	0.00	0.00	0.00	0.00	97%	0.00		**2.28**	
Knightsbridge	0.00	0.00	0.00	0.00	**84%**	**2.07**		0.00	
Ryeworth	0.00	**1.04**	0.00	**1.04**	**90%**	0.00		**1.04**	
Ward 6a	0.00	0.00	0.00	0.00	**91%**	0.00		0.00	
Ward 6b	**1.91**	0.00	0.00	0.00	**89%**	**0.96**		0.00	
Ward 7a	**1.12**	0.00	0.00	**2.24**	**94%**	0.00		**1.12**	
Ward 7b	**1.57**	0.00	0.00	0.00	**85%**	**1.57**		0.00	
8th Floor	**0.61**	**0.61**	**0.61**	0.00	**92%**	0.00		0.00	
Ward 9b	0.00	0.00	0.00	0.00	**92%**	0.00		**1.20**	
Woodmancote	**1.06**	**1.06**	0.00	0.00	98%	0.00		0.00	

Table 3: Medical Division Nurse Sensitive Indicators

2.1.1a Emergency Department

Following a collaboration between the Emergency Department and Emergency Care Improvement Support Team, changes have been made to the working pattern in the department. The changes came into effect from the 16th September and should result in a more effect staff deployment model to support the peaks and troughs in activity. The changes made to the working pattern are within the current financial envelope.

At the time of writing, the department was undertaking an SNCT audit at the Gloucester site, with a plan to replicate in the next month in Cheltenham. These results will be included in the next safer staffing report. Unfortunately, due to staff turnover within in the department, more staff have had to undergo training to ensure a robust audit process hence the delay.

Surgical Division SNCT Results and Discussion

It is noteworthy that improvements have been observed on the 3rd floor following the reallocation of nursing funds, which facilitated the addition of one full-time equivalent registered nurse (RN) per shift. This change has contributed to enhanced performance in key quality indicators, as evidenced by a reduction in both pressure ulcers and falls.

Nevertheless, ward 3a continues to flag a workforce concern albeit low and efforts will remain focused on analysis of SNCT data, staff experience, and relevant quality indicators, with plans to review the staffing template again next year.

Concurrently, ward 4b is scheduled for reconfiguration this year in conjunction with the endocrine service.

For Snowhill and Bibury, reconfiguration is planned by year-end to establish a dedicated day case area and an inpatient ward; after these changes, a reassessment of SNCT data will be necessary to reflect the new service structure.

Special attention is required for ward 5a, where emergency surgical capacity and patient acuity have increased significantly, as indicated by the rise in monthly Surgical Assessment Unit (SAU) numbers from 800 prior to the SAU changes two years ago, to between 1,200 and 1,600 currently. This growth is impacting both SAU and ward 5a.

And lastly within the department of Critical Care, work is underway to understand the workforce requirement to support the growing activity and acuity especially around the winter months. A proposal has been put forward which looks to increase the staffing from 20 RN's to 22 RNs which is currently being considered by the Integrated Care System (ICS).

Surgical Division				
Ward	No: beds	*Funded Est: wte	Suggested Est:	Variance wte
Bibury / Snowshill	38	38.53	38.78	-0.25
Tivoli	21	39.26	25.28	13.98
Ward 2a / Annexe	29	43.70	46.10	-2.40
Ward 2b	22	32.42	29.84	2.58
Ward 3a	30	48.31	49.24	-0.93
Ward 3b	29	52.36	49.14	3.22
Ward 4a	29	43.70	37.67	6.03
Ward 4b	29	44.02	41.91	2.11
Ward 5a	29	43.70	45.61	-1.91
5b/SAU	29	41.88	50.91	-9.03
			Total variance	13.39

Table 4: Surgical Division SNCT Results

Surgical Division	Incidents per 1000 bed days								
Ward	Official Complaints	Drug Errors	MSSA	C-Diff	Nutrition	Falls Sep-25	Comparison Mar-25	Pressure Ulcers Sep-25	Comparison Mar-25
	Incidents per 1000 bed days								
Bibury / Snowshill	0.00	0.00	0.00	0.00	**84%**	0.00	▶	0.00	▼
Tivoli	0.00	0.00	0.00	0.00	**75%**	0.00	▶	0.00	▶
Ward 2a / Annexe	**1.15**	0.00	**1.15**	0.00	**82%**	0.00	▶	0.00	▼
Ward 2b	0.00	0.00	0.00	**1.52**	**62%**	0.00	▶	0.00	▼
Ward 3a	0.00	0.00	0.00	0.00	**97%**	**1.11**	▲	0.00	▶
Ward 3b	**1.15**	0.00	0.00	0.00	**91%**	0.00	▼	**2.30**	▼
Ward 4a	0.00	0.00	0.00	0.00	**78%**	0.00	▼	**3.45**	▲
Ward 4b	0.00	**1.15**	0.00	0.00	**82%**	0.00	▶	0.00	▼
Ward 5a	**2.30**	0.00	0.00	0.00	**80%**	**1.15**	▲	**1.15**	▼
5b/SAU	**4.60**	0.00	0.00	**2.30**	**31%**	0.00	▶	**1.15**	▼

Table 5: Surgical Division Nurse Sensitive Indicators

2.2 Women's and Children's (W&C) SNCT Results and Discussion

Womens & Children's Division				
Ward	No: beds	*Funded Est: wte	Suggested Est:	Variance wte
9a	13	21.69	20.26	1.43
Paediatrics	38	78.36	75.58	2.78
			Total variance	4.22

Table 6: Women's and Children Division SNCT results

Womens & Children's Division	Incidents per 1000 bed days								
Ward	Official Complaints	Drug Errors	MSSA	C-Diff	Nutrition	Falls Sep-25	Comparison Mar-25	Pressure Ulcers Mar-25	Comparison Mar-25
	Incidents per 1000 bed days								
9a	0.00	0.00	0.00	0.00	61%	0.00		2.56	
Paediatrics	2.31	0.00	0.00	0.00	0%	0.00		0.00	

Table 7: Women's and Children Division Nurse sensitive indicators

2.3.1 Children and Young People Services

The children inpatient ward is funded for 10 Registered Nurses and 4 healthcare Support Worker on each shift. Within the templated staffing numbers, 2 Registered Nurses are allocated to Paediatric Assessment Unit (PAU) and 1 Registered Nurse to Oncology, making the templated as 7 Registered Nurses for inpatient beds including a high dependency unit (HDU). This is adjusted based on occupancy and acuity of the children and young people as per the Royal College of Nursing and Association of British Paediatric Nursing (ABPN) safer staffing guidance, following nurse-to-child ratios of HDU 1:2, under 2 1:2 and other age ranges 1:4. With a minimum of two Registered Nurse (child) on duty in all children ward and depts 24hours a day.

There has been significant improvement in the recruitment of Registered Nurses (child) over the past 12 month. With a 16.14WTE vacancy rate in January 2025 to being fully recruited by the end of October, with 14 new starters joining in September and October 2025. An additional fixed term clinical educator is in post to support their induction and preceptorship period.

Safer staffing and daily acuity are monitored through Safe Care Live and regularly reviewed by Senior Nursing team.

2.3.2 Neonatal Unit (NNU)

The Neonatal Unit is part of the Child Health Service Line and is funded for 10 Neonatal Registered Nurses and 1 Nursery Nurse on every shift. This is amended based on occupancy and dependency of the babies as per British Association of Perinatal Medicine (BAPM) guidelines. With one of the Registered Nurses being allocated to Transitional care (TC), making the template for the Neonatal Unit 10 plus 1 for TC.

Between April 2025 and June 2025, the average cot occupancy was 53%, with 59% at intensive/high dependency care. This makes the unit the second highest in acuity among the southwest network local neonatal units. Nursing staffing numbers are planned for 80% occupancy and is flexed as needed to maintain BAPM standards of nurse-to-baby ratios (1:1 Intensive Care, 1:2 HDU, 1:4 SC/TC), supported by redeployment strategies, we achieved a 95.5% compliance rate during this period.

Neonatal Qualification in Speciality (QIS) rates are at 70.1% which is above the national recommendation of 70%.

As of September 2025, nursing staffing shows a gap of 18.45 WTE due to maternity leave (6.6 WTE) and vacancies (10.12 WTE) following internal promotions; recruitment is ongoing and full staffing expected to be achieved by January 2026.

Nursing numbers and acuity data are recorded in Badgernet and Safe Care Live, which is reviewed daily by senior staff to ensure compliancy with recommended BAPM standards. This data is also mapped against the rest of the network and provide quarterly benchmarking reports.

2.3 Diagnostic and Specialist (D&S) Services

During this period, the Pharmacy manufacturing unit was closed, and all stem cell transplant patients, who are typically admitted to Rendcomb side rooms, have been receiving treatment in Bristol. This change reduces patient acuity on the day before and during transplants, when 1-to-1 care is required, as well as during the minimum two-week inpatient stay post-treatment, when nursing needs remain elevated.

Since Rendcomb is divided into two adjacent but separate areas, nursing coverage for both the main ward and the side rooms cannot safely be reduced below four registered staff, even during periods of lower acuity. The oncology and haematology nursing teams operate flexibly across all three ward/day case areas at Cheltenham and provide chemotherapy care support to patients in Critical Care when needed.

The Lilleybrook team has observed an increase in both the number and complexity of patients admitted through Acute Haematology Oncology Unit (not included in the ward establishment or this audit), which may affect their capacity to allocate staff from this area to the main ward during times of high acuity. Ongoing reviews will continue to support safe care delivery across both areas.

Incident and data reports indicate a low level of harm across these wards, with consistently favourable Friends and Family Test responses above 95%.

Avening has experienced an ongoing rise in demand for chemotherapy, making it increasingly challenging for the team to provide enough appointment slots for all required treatments. The current situation is manageable, but continued growth in demand may lead to insufficient capacity, both regarding nursing support and available physical space.

A time and motion study conducted last year indicated six additional nurses would be needed to meet this demand. The service line is reviewing this requirement further, which may result in a business case being presented. Any newly recruited nurses will require extensive training to achieve Systemic Anti-Cancer Therapies competencies, a process that typically takes up to one year.

There are also considerations in advanced practice across Haematology and Oncology, where several positions exist and teams are evaluating funding for additional specialties. These roles require substantial training pipelines, and coverage

issues can arise during periods of maternity leave, as there may not be individuals with the necessary competence to maintain service delivery at these levels.

Diagnostic & Specilialist Services				
Ward	No: beds	*Funded Est: wte	Suggested Est:	Variance wte
Lillybrook	21	21.95	27.37	-5.42
Rencomb	22	33.23	25.00	8.23
			Total variance	2.80

Table 8: Diagnostic and Specialist Services SNCT results

Diagnostic & Specilialist Services	Incidents per 1000 bed days								
Ward	Official Complaints	Drug Errors	MSSA	C-Diff	Nutrition	Falls Sep-25	Comparison Mar-25	Pressure Ulcers Sep-25	Comparison Mar-25
	Incidents per 1000 bed days								
Lillybrook	0.00	0.00	0.00	0.00	88%	0.00		0.00	
Rencomb	0.00	1.52	0.00	0.00	92%	0.00		0.00	

Table 9: Diagnostic and Specialist Services Nurse Sensitive Indicators

2.4 Benchmarking at National Level

Care Hours per Patient is a measure of Trust level productivity, the chart below shows the Trust as being in the part of quartile 3. The Trust CHpPD is 10.0 which is above the provider median of 9.0 and the regional peer median of 9.0. The CHpPD captures the actual worked position rather than planned.

Very low rates indicate the potential patient safety risk where has very high rates may suggest the Trust has opportunities to improve roster efficiencies.

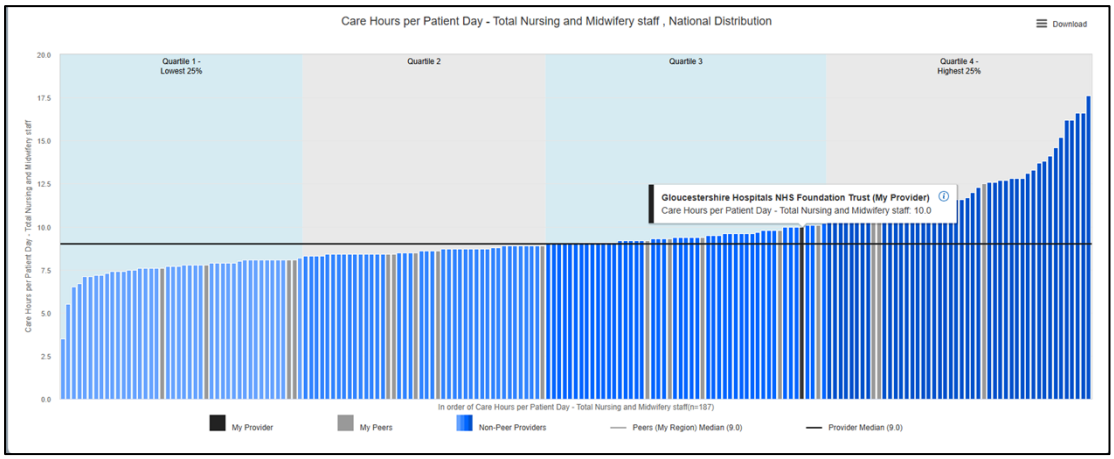


Chart 1: Care Hours Per Patient Day July 2025 Data

Recognising this is a point in time, the graph below shows the Trust position from April 2021 to July 2025, since November 2024 the trend is significantly above that of the provider and peer median suggesting a change in the reporting process. Between January and July 2025, Rendcomb ward underwent renovations and as result were caring for patients over two locations. The works completed in July 2025 and it is anticipated this will captured in the Model Hospital data going forward. In addition, Maternity data was added to the return, this also coincides with the January 2025 step change.

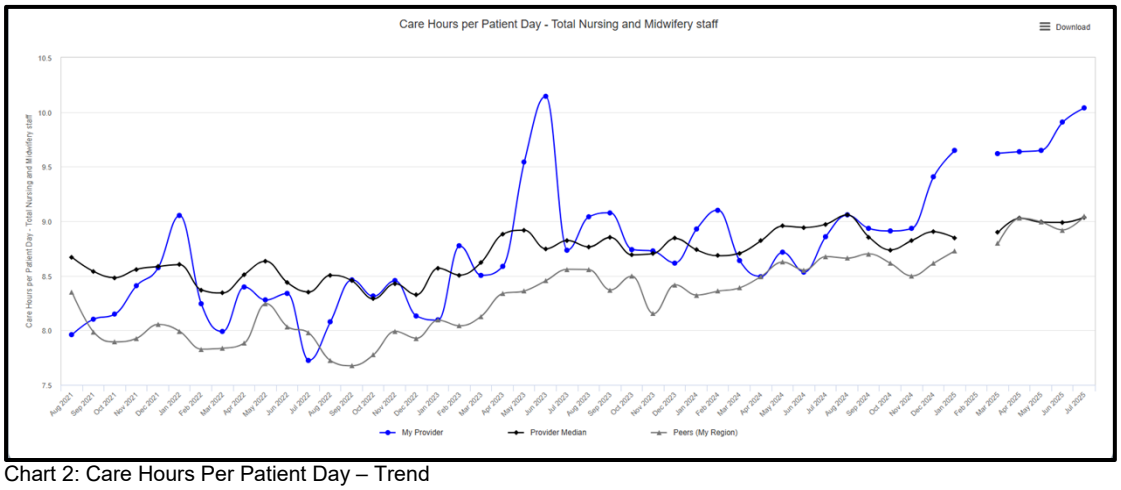


Chart 2: Care Hours Per Patient Day – Trend

In summary, although the SNCT tool has identified both staffing gaps and instances of overstaffing, overall staffing remains appropriate, and the tool has enabled valuable reviews of workforce practices, especially in preparation for the winter period. In addition, a comprehensive review of staffing changes implemented over the past two years has been undertaken.

As MAZ and AMU continue to evolve, we recommend conducting another SNCT assessment in December or January to inform decisions for anticipated winter surges.

Looking ahead, the planned introduction of a UTC is expected to relieve pressure on AMU by redirecting some patient cohorts currently attending MAZ.

Finalising the workforce configuration in line with the Tower works also provides an opportunity to address any short falls over the next 12 -18 months.

Expectation 2 Right Skills

3.1 Mandatory Training Development & Education

Over the past year, the organisation has introduced significant enhancements to its mandatory training programme, aligning with the national NHS Statutory and Mandatory Training programme. As part of this work a major development has been the transition to the national eLearning content for mandatory training, ensuring staff access standardised, high-quality material across all required subjects.

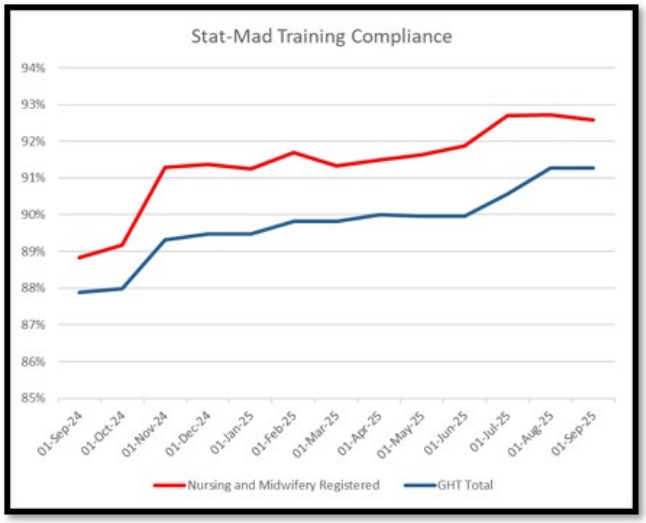
In addition to these national requirements, the organisation also undertook a comprehensive review of all local Training Need Analyses (TNAs). This process ensures training is assigned only when it is relevant to the role, minimising unnecessary training and focusing resources where they will have the greatest impact on workforce safety and effectiveness.

Alongside this, the organisation has implemented the national Inter-Authority Transfer (IAT) process within the Electronic Staff Record (ESR) system, ensuring training records are securely and accurately transferred with staff as they move between NHS

organisations. This measure streamlines compliance and reduces unnecessary duplication of training.

There has also been close collaboration with individual divisions to improve the accuracy and usefulness of mandatory training reports. By working together, divisions and the central training team have enhanced reporting processes, enabling better tracking of compliance, identification of gaps, and targeted support where needed.

The graph below shows the Stat-Man Training compliance for nursing and midwifery which is above that of the rest of the Trust.



Graph 1: Stat-Man training compliance.

With regards to the National Continuous Practice Development (CPD) funding, the Trust continues to use this money to support individual staff development. Staff are encouraged to attend education events, webinars and conferences in addition to more formal forms of academic study. The funds have enabled the Trust to improve staff knowledge, skills and understanding in key areas should as health safety, end of life care and other clinical skills.

3.1.1 Preceptorship

The preceptorship programme is aligning with the National Preceptorship Framework (2022), adopting a multidisciplinary approach for consistency and fairness across professions. Enhanced support, supervision, and evaluation have improved early career experiences and retention.

Over the past 24 months, from November 2023 to September 2025, a total of 366 individuals have participated in the preceptorship programme. Of these, 288 successfully completed the programme during the first 12 months (November 2023 to October 2024), while 78 remain actively enrolled for the period November 2024 to September 2025. The programme has maintained a low attrition rate of 6% (21 leavers) over the entire 24-month period, with no recorded leavers in the most recent 12 months.

3.1.2 Pre-registration Nursing and Midwifery

The Higher Education Institutes (HEIs) we partner with for pre-registration nursing programmes are The University of Gloucestershire, The University of Worcester, and The University of the West of England. We also have placement agreements with Oxford Brookes University, The Open University, and the University of Plymouth to support out of area placements for students. Six of these placements have been facilitated Sept 2024 – Aug 2025.

The table below shows how many overall placements have been facilitated throughout the organisation within nursing and midwifery. This indicates the number of placements rather than number of individual students as some students will attend more than one placement within the organisation throughout the year.

Profession	**Total number of placements facilitated Sept 2024 – Aug 2025**
Adult Nursing	696
Child Nursing	54
Nursing Associates	173
Midwifery	85
Learning Disability	4
Mental Health	3
Paramedic	68
	Total 1083

Table 10: Leaner Placements within the Trust.

There are 53 identified placement areas within nursing and 9 identified placement areas within midwifery across the trust to facilitate these placements. All of which have had their placement audits completed.

As per the Nursing and Midwifery Council (NMC) Standards for student supervision and assessment (2023) all students on an NMC approved programme are assigned to a nominated practice assessor (PA) for a practice placement. Practice assessors conduct assessments to confirm student achievement of proficiencies and programme outcomes for practice learning.

The number of students a PA can work with is not strictly fixed and is guided by the Nursing and Midwifery Council (NMC) Standards for Student Supervision and Assessment (2018). There are currently 877 PAs within the trust, which represents a 7% reduction in PAs since the previous report. This may be attributed to improvements in the process of recording this competency on the Electronic Staff Record. However, based on the total number of placements facilitated, this equates to each PA supporting approximately 1.14 learners —indicating that current capacity is sufficient.

In 2025, in house training for Practice Assessor, Practice Assessor Update, and Practice Supervisor Refresher training has been launched to prepare PA to demonstrate achievement in:

- Interpersonal communication skills, relevant to student learning and assessment
- Conducting evidence-based assessments of students
- Providing constructive feedback and knowledge of the assessment process and their role within it. (NMC 2018)

Increasing the number of PAs should help alleviate the burden caused by high workload pressures, lack of protected time, and extensive documentation requirements, while also providing greater opportunities for early identification of underachievement as more assessors are prepared for the role.

3.2 Working as a multi-professional team

3.2.1 Registered Nursing Associates

Nursing Associates (NAs) contribute to the Registered Nurse staffing establishment. They are trained via a 2-year Apprenticeship route to meet the NA part of the NMC register. As an organisation our first cohort was in April 2017 and have continued to run 1-2 intakes a year since. 10 Student nursing associates (SNAs) have commenced programme between Sept 2024 – Aug 2025.

As of 15/09/2025:

- 32 SNAs currently on programme. This represents a 65% decrease in the number of SNAs on the programme since the last report, attributed to smaller cohort sizes driven by vacancy rates, associated salary costs, ongoing clarity of the role, and increasing academic failures at a partner Higher Education Institute.
- 7 SNAs on a break in learning
- Total of 115 SNAs completed programme since Apr 2017, which includes 15 who have qualified between September 2024 and August 2025.
- Total of four non completions. Of the four, three were due to personal reasons requesting withdrawal and one was due to academic failure.

A recent trial has been conducted to review whether IV drugs should be within the scope for administration by NAs within the Department of Critical Care. As of September 2025, the Medicines optimisation committee are supportive and is pending Nursing agreement.

3.2.2 Registered Nurse Degree Apprentices (RNDA)

The trust continues to support the Registered Nurse Degree Apprenticeship (RNDA) as a route for existing employees within the organisation to obtain a BSc (Hons) and register with the NMC as a registered nurse. Six colleagues have enrolled onto the RNDA (step on) programme between September 2024 and August 2025. This represents a one-third reduction in those receiving organisational support, primarily driven by vacancy rates and associated salary costs.

Future plans include launching a pilot cohort in September 2025 at the University of Worcester, with a completion in 18 months of commencing programme, and supporting our first Registered Nursing Associate (RNA) to progress onto a child-specific Registered Nurse Degree Apprenticeship (RNDA) programme, with the aim of strengthening the pipeline in this specialty.

3.2.3 Return to Practice

The trust continues to support Return to Practice colleagues within nursing and midwifery. Funding is available via NHSE for tuition fees associated with the programme and is paid directly from NHSE to our university provider. The programme usually takes between three and nine months to complete. This financial year we have supported one RtP midwife and one RtP nurse. Nurses are not paid while on programme and supported via placement agreements as other BSc nursing students.

3.2.4 Advanced Practice

As of March 2025, the Advanced Practice workforce at the Trust has grown to 81 practitioners (10 Consultant Practitioners, 31 Advanced Practitioners, 39 trainees), totalling 70 WTE with an average of 0.92 WTE each. The workforce increased by 32.8% from the previous year.

Attrition included four practitioners leaving—one retired, two left due to dissatisfaction, and one moved to a non-advanced role.

The introduction of a transition panel to oversee progression from trainee to qualified Advanced Practitioner has led to ten successful completions, improving governance and recognition of development.

Achievements:

- Implemented a comprehensive governance framework for Advanced Practice, including updated policies and audit templates.
- Established a transition panel to ensure validated clinical competence before qualification as an Advanced Practitioner.
- Maintained an accurate central register of APs, trainee APs, and Consultant Practitioners for workforce planning.
- Developed an Enhanced Practice policy (awaiting ratification) to clarify career progression pathways.
- Created standardised job descriptions and person specifications for AP roles, aligned with NHS England standards.
- Introduced a Team Lead framework for AP teams with more than six staff to support rotational leadership.

<u>Feedback from the Workforce</u>

A staff survey evaluating the Trust Lead for Advanced Practice role showed marked improvements across several areas:

- Clarity of vision: Ratings increased from 2.9 to 3.8, reflecting better organisational alignment and communication.

- Leadership support: Improved from 2.7 to 3.6, indicating greater support and recognition from senior leaders.
- Sense of belonging: Rose significantly from 2.7 to 4.2, demonstrating a stronger connection to the AP workforce through enhanced communication and forums.
- Overall experience: Increased from 4.0 to 4.4, suggesting greater career satisfaction for APs.
- Role value: All respondents considered the Trust Lead role important or extremely important.
- Direct support: Over 80% felt well supported by the Trust Lead, citing accessible leadership and clear guidance.
- Need for continuity: Most respondents emphasised the necessity of retaining the role to maintain progress and workforce cohesion.

3.3 Recruitment and retention

3.3.1 Recruitment

Due to minimal Nurse vacancies within the Trust in September 2024, the decision was made not to hold a career fair within the past 12 months. However, the Trust did promote a Women's & Children's recruitment event in October 2024 which at the time was a hard to fill area. This event attracted a diverse range of attendees who had the opportunity to speak with our inspiring clinical staff within this speciality who also offered tours within the clinical areas and provided a learning zone for discussion with staff

The Trust has been present regularly over the past 12 months at job fairs held by local Higher Education Institutes (HEI's)

We have also built excellent networks with our local providers, One Gloucestershire, where we have attended local Higher Education institutes with them to talk to T level students who had just completed their T level apprenticeships and were considering further higher education in Nursing.

We have also supported networking with Gloucester Employment and skills hub and attended a life skills forum event for Not in Education, Employment or Training (NEET) young people, between the ages of 16 – 24, who were not in education, employment or training where staff from the Trust shared their career stories.

3.3.2 Domestic Pipeline

Maintaining the domestic pipeline has been key to the Trusts recruitment success. The table below details the new starters as well as the internal movement of staff during the last 12 months.

Internal / External	Band 3	Band 5	Band 6	Band 7	Grand Total
External Recruitment	127	38	13	8	186
Internal movement of staff	40	44	103	24	211
Grand Total	**167**	**82**	**116**	**32**	**397**

Table 11: New Starters by Band by route of entry into the Organisation.

In May 2024 we interviewed and successfully recruited 27 Newly qualified staff and although it was challenging to place them in areas of their choice, following shadow shifts and regular contact with them, they were all placed by September 2025

Since September 2024 we have attended monthly student nurse forums to give an overview of present band 5 vacancies and offered application and interview support to those graduating who had had clinical placements within our Trust.

3.3.3 Internationally Educated Nurses

In January 2024 the Trust stopped offering the OSCE training internally due to the previous year's successful domestic and international recruitment campaign.

Since January 2024 there has been an increased awareness by the Trust of international educated nurses, who are presently in band 3 Health Care Support Workers roles (HCSW), passing their OSCE externally and now have an NMC PIN.

We value our HCSW within the Trust and have actively supported them with completion of band 5 application forms and interview preparation

The table below details the number of HCSW and their position in their NMC journey to become a registered nurse.

HCSW staff With NMC PIN	HCSW staff Awaiting NMC PIN	HCSW staff now in Band 5 Positions within Trust
9	7	11

Table 12: HCSW with Nursing Registration in their home country

3.4 Retention

3.4.1 Professional Nurse Advocacy

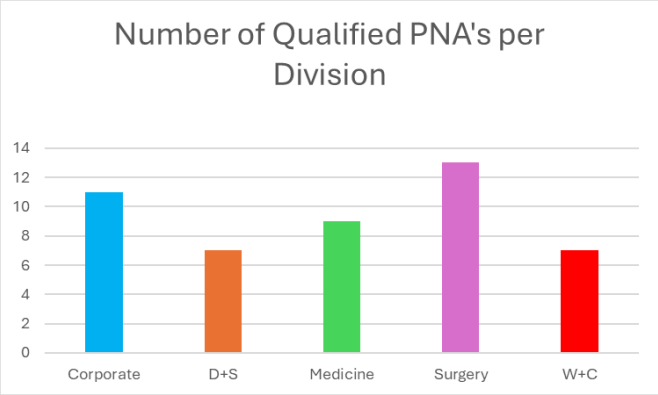
The Professional Nurse Advocate (PNA) role launched in March 2021, towards the end of the third wave of Covid. It was felt to be a critical recovery point for individuals, teams, and the NHS. For Nurses and Midwives, the Covid-19 pandemic had however exacerbated the issue of excessive demands on a workforce already at risk of stress and burnout, so is needed more than ever.

There is an expectation all organisations will support and develop this role and is part of both the NHS Contract and the Care Quality Commission (CQC) criteria when inspecting a service, ensuring the organisation has an Advocating and Educating for Quality Improvement (A-EQUIP) (NHS E 2017) model in some form.

NHSEI (29017) PNA guidance describes the PNA role and the A-EQUIP model of professional nursing leadership and clinical supervision and provides guidance on its implementation.

Since March 2021, PNA training places have been allocated and funded by NHSE Regional PNA Teams. Expressions of interest have been sought from individuals wishing to undertake the programme, or who have been nominated by their manager.

The graph below details the number of qualified PNAs per Division.



Graph 2: Professional Nurse Advocates by Division

A Provider Workforce Return is completed each month recording both the sessional and individual numbers of people receiving Restorative Clinical Supervision, Career Conversations and improvement projects/programmes supported.

The table below shows these individual numbers totalled between September 2024 and August 2025:

Restorative supervision sessions	Career conversation	Improvement projects supported by PNAs (rolling total)
236	72	12

Table 13: Restorative Clinical Supervision sessions.

A 0.8 WTE secondment PNA Project Lead (Band 7) was appointed in June 2022 to expand and embed PNA within the Trust and whilst the Clinical Lead post was substantiated in April 2024, the post has been vacant since November 2024 with no plans to actively recruit into it. The annual activity has seen a 35% decrease from the previous annual report, some of which could be attributed to this factor.

Women and Children's Division have appointed a Lead PNA for their Division temporarily for 1-year, further data will be required to see if this appointment increases activity across this specific Division.

3.4.2 Legacy Mentor

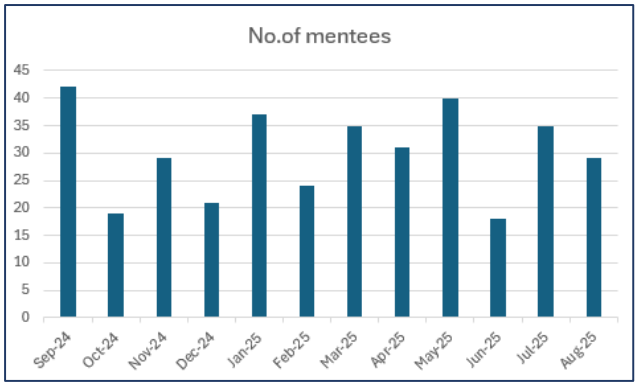
The Legacy Mentor role is an experienced health and social care professional in the later stages of their career. They provide support to early career nurses and midwives, international colleagues, Allied Health Professionals and those in other clinical roles, by imparting knowledge, skills and experience through coaching and supporting them in the early stages of their career.

In November 2022, One Gloucestershire were successful in a Southwest Health Education England bid and received one year startup funding to implement Legacy Mentors across the system within Nursing, AHP and Midwifery. A steering group was established and monies divided within primary and secondary care. In addition, a

system Lead Legacy Mentor was recruited to ensure reporting, evaluation, and the writing of a business case.

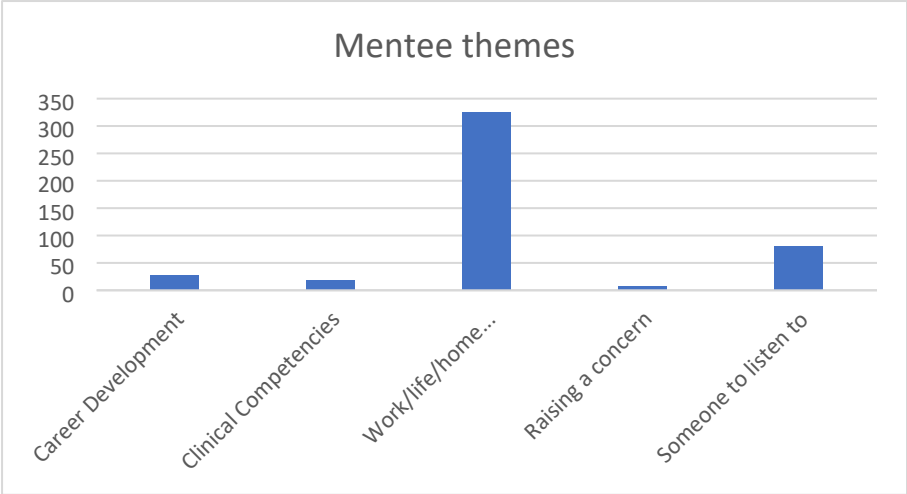
In August 2023, the Trust appointed the first Legacy Mentor in Nursing in Gloucestershire as part of this system project (Band 6, 0.8WTE). The Legacy Mentor has two functions a) to re-energise, empower, and value people in late career b) achieve an improvement in the experience for newly appointed nurses and increase retention in the critical first two years of their professional career.

The number of mentees supported between September 2024 to August 2025 were:



Graph 3: Total number of Mentees Supported

A third of people were seen more than once in the month. The below table highlights the number and types of conversation individuals wanted to see the Legacy Mentor about:



Graph 4: Mentee Themes

The annual activity of individuals requesting support with home/work/life balance has significantly increased from the previous annual report, from 26 interactions to over 300 interactions.

Qualitative feedback includes:
'Thank you for all your support throughout a difficult time, in my first year. Your support is greatly appreciated.'

“I was fortunate to have a legacy mentor who greatly impacted my career. She provided invaluable support during challenging work situations. Her guidance also helped me navigate interactions with management effectively. I am incredibly grateful for her wisdom and advice. It made a significant difference in my professional development. “

‘I appreciate Helen coming to speak to me. It gave me a chance to try and voice my concerns to someone who doesn't know me or my situation which was welcoming. Thank you :)’

3.4.3 Menopause

In collaboration with the 2020 Wellbeing Hub and colleagues from the Women’s and Children’s division, there continues to be a focus on supporting staff with peri menopause and menopause. In addition to the established Menopause Support Group that takes place each month, we have also held several Women’s Health Events throughout 2025 (below). Although a Trust initiative, these events were opened to the whole system with colleagues from Gloucestershire Health Care and the ICS also invited. Recordings and power point presentations from these popular sessions have been downloaded and can be found on our dedicated Menopause intranet page along with other useful resources for all staff.

Women’s Health Events.

Date	Event	Attendance	Key Topics
March 4th	Menopause Café	70	Anxiety and the menopause Pelvic health through peri menopause and menopause Q&A with consultant gynaecologist
May 14th	Women’s Health Seminar	50	Stress incontinence and prolapse, Smears, colposcopy and HPV, Menstruation/period problems
June 4th	Menopause Café	20	Exercise for pelvic health, Diet and the menopause, Sleep in the menopause
August 27th		50	Let’s talk about breast cancer with Miss Sarah Vesty, Consultant Breast Surgeon

Table 14: Women’s Health Events

We are looking forward to celebrating World Menopause Day again this year within the Trust on Friday October 17th with a stand in the atrium and an awareness session for male line managers, husbands and partners entitled ‘Beyond the hot flushes – what

men need to know!' being delivered by recently retired Dr Madhavi Vellayan, Consultant Gynaecologist.

3.4.4 Flexible working

Flexible Working was identified as one of three projects under the People Promise Programme here at the Trust, with the key deliverables being:

- Revision and launch of flexible working policy (from guidelines) – policy due to Human Resources Policy Group October or November
- Line managers capturing requests on ESR. User guide and drop-in sessions to be offered by ESR team with launch of policy
- Development of dedicated flexible working intranet page with associated resources, toolkits and videos
- Chief Nurse Matt Holdaway identified as Executive lead for Flexible working
- 'Let's talk flex in February' campaign and additional flex working promotional comms in National Work life week Oct'24 &'25
- Flexible working to be incorporated into new line managers development programme (now sitting with the People Development team)
- Trac adverts highlighting flexible working opportunities on standard template
- Team based rostering pilot in Neonates (March '25) awaiting 6mth report

Although slow to embed, flexible working should continue to remain an area of focus for Trust as not only is it an area in the annual staff survey , it features in the Government's new 10 year Health plan for England ''*to make the NHS the very best place to work – setting new standards for flexible, modern NHS employment, expanding training opportunities and reducing the burden of admin* ''

3.4.5 Widening Participation

Over the past year, the Trust has demonstrated a robust commitment to Widening Participation through strategic ICS collaboration, targeted programmes, and inclusive policy development. The Trust played a pivotal role in the ICS Widening Access Demonstrator (WAD) project, aiming to support 100 individuals from deprived Gloucestershire communities into employment, education, or volunteering. The Trust also facilitated levy transfers to expand apprenticeship access across the ICS, including Level 3 AI and Level 7 leadership pathways. Network meetings fostered cross-sector engagement, addressing barriers for care leavers, neurodivergent individuals, and young carers. The Trust's work experience policy was revised to reduce age restrictions and improve data capture. These efforts reflect the Trusts strategic alignment with national priorities and its dedication to creating equitable pathways into health and care, hopefully serving workforce planners for the future.

Expectation 3 Right Time and Place

4.1Productive working and eliminating waste.

The Trust continues to work with local and reginal colleagues to maximise the benefits of productive working and eliminating waste.

4.2 Trust Risk Register

The Trust Risk Register for the Nursing and Midwifery workforce is included in Appendix 1, at the time of the report there were only 2 risks which scored 12 or more. Both risks are longstanding and relate to the whole workforce rather than nursing and midwifery specifically. This reflects the current workforce position where the Trust has limited RN vacancies and continues to attract high number of applicants when advertising opportunities.

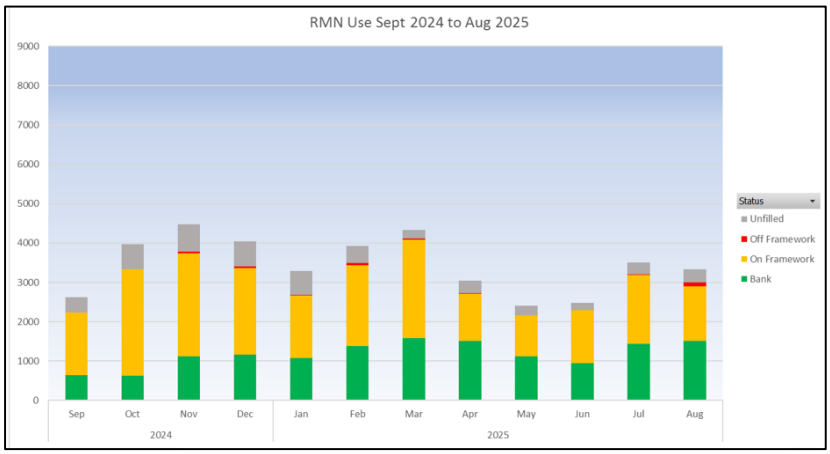
4.3 Efficient Deployment & Flexibility

Health Roster is used to schedule staff daily, and all inpatient units adhere to the Carter good rostering principles. The Trust's e-roster policy outlines rostering standards and key performance indicators (KPIs) established by the Trust. A KPI report is distributed monthly, highlighting areas of effective practice as well as areas for improvement. Efforts are underway to establish a Safe Staffing and Rostering Group, led by the Deputy Chief Nurse, which will provide a forum for analysing these reports and taking steps to improve practices.

The Trust utilises the SafeCare platform to support daily staffing decisions in all inpatient areas. Senior nurses conduct twice-daily staffing calls to address workforce concerns, with mitigation strategies including redeployment from other areas, reassignment from administrative duties, and requesting temporary staff when immediate coverage is required.

There is a Standard Operating Procedure is in place to outline the escalation process for requesting additional staff.

In the past year, the Trust reduced its average monthly use of Registered Mental Health Nurses from 3,769 to 3,452 hours.



Graph 5: Registered Mental Health Nurse Usage by Month

The graph above shows the month-on-month demand in hours by bank, framework agency and off framework. In the last 12 months the total demand has reduced by 3810 hours and a movement in provision from framework agency and off framework agency to bank. Bank RMNs now cover most of this demand, increasing from 4,412 to 14,115 hours over the last 12 months. With 43 RMNs on the bank, the bank team and Mental Health Liaison team are working together for a more sustainable, cost-effective workforce.

Most of the demand for RMN's is a direct consequence of activity related to eating disorder patients requiring refeeding and the mandate within the medical emergencies eating disorders guidance (MEED), which states feeding must be over seen by RMNs.

A further complication in year has been the lack of beds in the mental health estate which has resulted in patients being detained in an acute bed. The psychiatry team are working hard to minimise the impact of this where the risk profile permits.

4.4 Efficient employment, minimising agency use.

The following charts detail information on bank and agency cost, the data source was model hospital and relates to July 2025. At the time of writing the Trust was at the lower end of Quartile 3 with an average cost per shift of £561, which aligns with the provider and peer median, £563 and £561 respectively. These costs are for all disciplines, with the high costs being driven mainly by medical locums. The Trust continues to work collaboratively with regional colleagues to redress the reliance on agency and ensure the Trust continues to be price cap compliant.

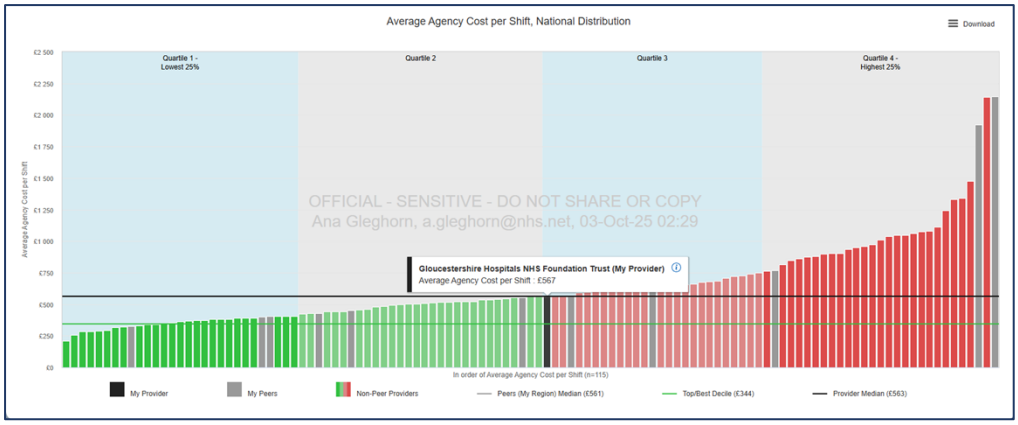


Chart 3: Average agency Cost per Shift

The trend data stems from August 2021 to July 2025. There are two clear step changes, the first in November 2022 and the second in December 2023. A data clarification request has been made to the model hospital team, the outcome of which is outstanding.

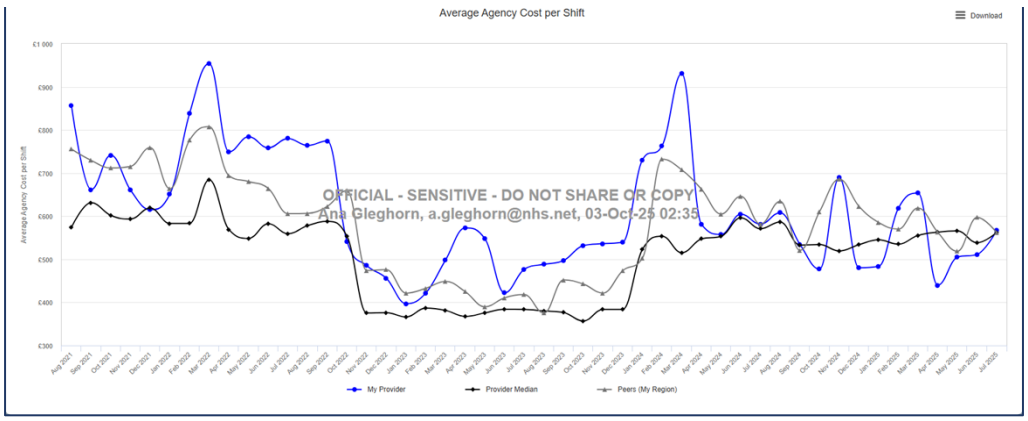


Chart 4: Average Agency Cost per shift – Trend Data

Whereas the following two charts relate to the average bank costs per shift, the Trust was in the lower end of quartile 4 in July 2025 with an average cost per shift of £378, compared with the provider and peer median of £320 and £284 respectively. This chart also shows the Trust to be the highest in region for average shift costs, a reflection of the current local pay rates awarded to bank staff. Work is underway to address this which will impact positively on future reports.

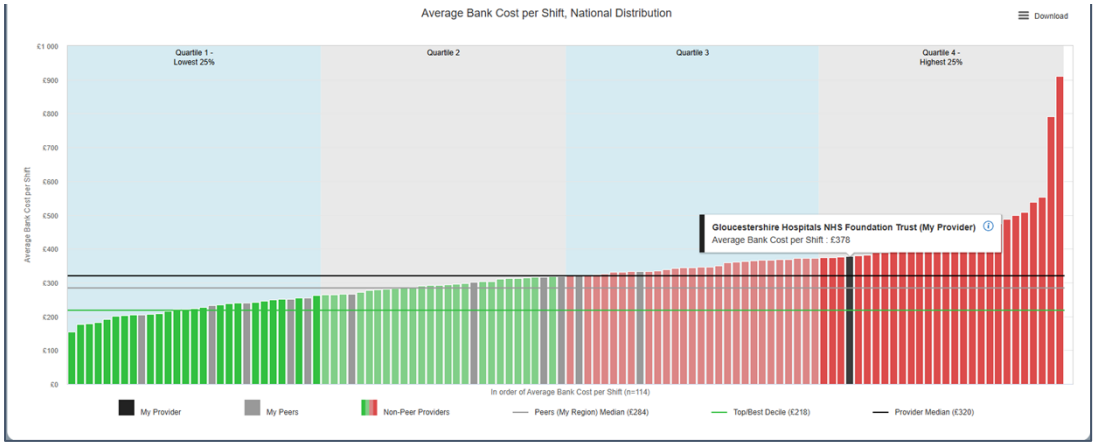


Chart 5: Average bank Costs per shift

The fluctuation seen in the trend below reflect the occasions where the average is driven by higher costs shifts.

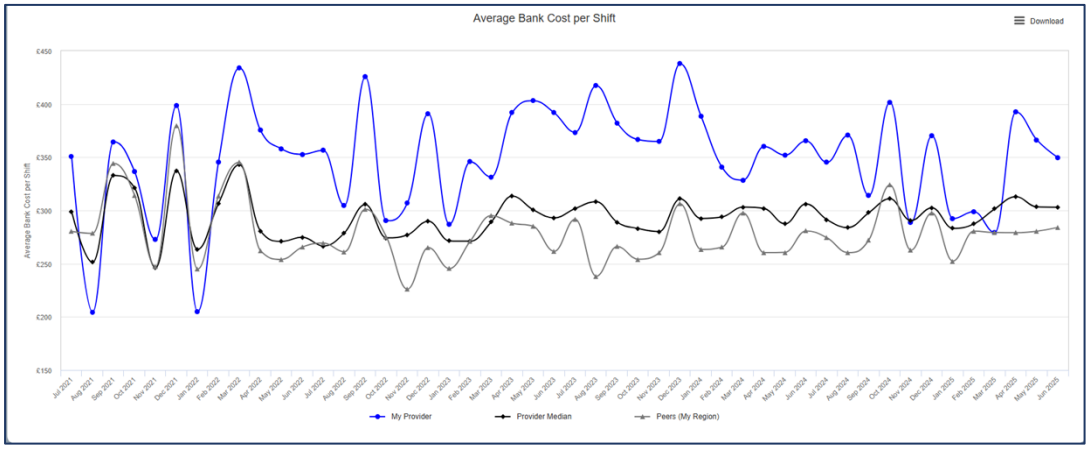
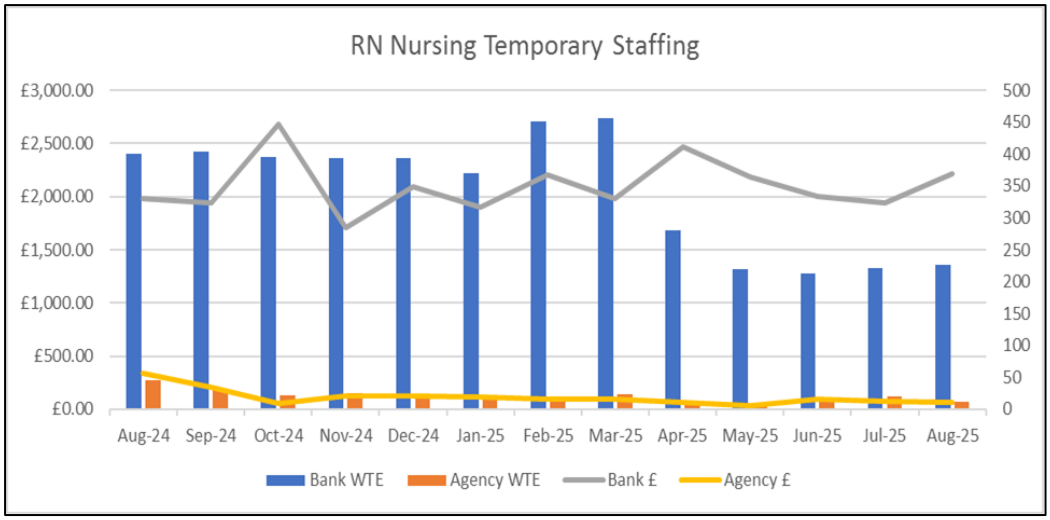


Chart 6: Average bank Costs per shift – Trend Data

The graph below indicates that while bank usage has declined since April 2025, spending remains largely unaffected due to local rates and incentives. If approved, aligning bank pay rates with the Southwest will reduce average shift costs but poses a minor risk of lower staff satisfaction and fill rates.



Graph 6: Registered Nurse Temporary staffing by WTE and Spend

5.0 Plans and Ambitions

The Trust remains committed to enhancing pre-registration education by continuing to embed the Safe Learning Environment Charter and collaborating with HEI partners and NHSE Southwest to trial both the new student app and the practice learner app.

In recognition of exemplary practice, internal awards will be developed for positive placement areas, and efforts to strengthen career opportunities for staff are underway. This includes piloting a cohort of HCSW apprenticeships and introducing a cohort for Higher Development Awards for HCSWs, alongside refreshed career conversations and participation in the NAHMP Summer Conference.

Advanced practice will be strengthened through succession planning in high-risk areas, such as Women and Children and MSK services, and by establishing an Advanced Practice Directorate with divisional leads. A Career Framework from Enhanced to Consultant Practice is also in development to provide clear career pathways.

To support workforce health and wellbeing, the Trust will continue to offer Legacy Mentoring within nursing, increasing touchpoints for newly qualified nurses (NQNs), and provide Restorative Clinical Supervision to nursing colleagues during preceptorship.

Efforts will focus on aligning bank pay rates with those of regional colleagues to ensure competitiveness and cost-effectiveness. Continued reduction in the reliance on agency workers remains a priority, while further strengthening the appropriate utilisation of RMNs will help to eliminate inefficiencies and unnecessary expenditure.

Collectively, these measures aim to reduce the reliance on temporary staffing and support a more sustainable, efficient workforce model.

A key ambition is to achieve a Band 6 nurse on every shift, an important safety measure to provide senior supervision 24/7. Significant progress has been made some

areas of Surgery Division are not yet able to adopt this model. This is always under review and is an area for future development.

Finally, we are very proud to be in a healthy position with regard to vacancies across nursing, our focus now turns to retention. This will be a key focus of the Lead Nurse for Workforce who returns to post from secondment. We look to report success in future reports by demonstrating a reducing turnover rate.

6.0 Recommendations

The QPC is requested to note the findings, which identify areas potentially requiring investment due to nursing time shortages, along with work undertaken throughout the Trust during the past year to right size the workforce.

Over the last twelve months, the Trust has significantly reduced its average monthly use of RMNs and shifted provision from external agencies to bank staff, with the bank team and Mental Health Liaison team collaborating to create a more sustainable and cost-effective workforce. However, ongoing challenges such as increased demand related to eating disorder patients particularly those requiring refeeding under the medical emergencies eating disorders guidance (MEED) and a lack of available mental health beds have placed additional pressures on RMN resources.

Despite these challenges, the Trust has maintained its average cost per shift below the provider and peer medians for agency staff, though bank shift costs remain high due to local pay rates. Efforts are underway to address these cost pressures to ensure both financial efficiency and staff satisfaction.

The Trust continues to review and adapt workforce models in response to the evolving clinical landscape, workforce shortages, and national guidance, with the aim of delivering safe, high-quality care while managing costs and supporting staff wellbeing.

6.0 References

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., & Sermeus, W. (2014). *Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study.* **The Lancet, 383**(9931), 1824–1830

Griffiths, P., Ball, J., Bloor, K., Böhning, D., Briggs, J., Dall'Ora, C., & Simon, M. (2018). *Nurse staffing levels, missed vital signs and mortality in hospitals: Retrospective longitudinal observational study.* **BMJ Open, 8(8),** e019575

Appendix 1 Nursing and Midwifery Staffing Risks on the Trust Staff Risk Register

Risk ID	Risk Description	Division	Service	Type	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Trend	Next Review Date
154	4009 The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher levels of discrimination, leading to low morale, poor health and wellbeing	Corporate	People & OD (Human Resources)	Workforce	20/02/2023	16	4	3	12	8			31/10/2025
722	4006 The risk that the Trust is unable to retain members of the substantive workforce.	Corporate	People & OD (Human Resources)	Workforce	20/02/2023	16	4	4	16	8			31/12/2025

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 15 January 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the People and Organisational Committee held on 25 November 2025
Board member lead(s)		NED Chair: Marie-Annick Gournet and Exec lead, Director for People and Organisational Development
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	✓
	Discussion	✓
	Note	

Purpose of report

To present an update to the Board of Directors from the meeting of the People and Organisational Development Committee held on 25 November 2025 (quorate).

This committee meets bimonthly and is attended by members of the Board and senior managers.

Key points

ALERT: matters that require the boards attention or action, e.g. non-compliance, safety concern or a threat to the Trust's strategy.

- **Deterioration in Staff Experience and cultural indicators.**
  Recent staff pulse survey results indicate a deterioration in staff experience, particularly relating to management capability and organisational learning. This presents a well-led risk associated with leadership capacity, staff engagement, and the Trust's ability to sustain a positive, learning culture.

- **Incomplete Freedom to Speak Up arrangements within GMS.**
  The continued absence of a Freedom to Speak Up Guardian within Managed Services, alongside policy misalignment with the Trust, represents a governance and cultural risk. This may undermine staff confidence in speaking up and the consistency of learning and response across the organisation

- **Industrial action risk impacting services and staff wellbeing**
  A new workforce risk has been added relating to disruption to services, patient care, and staff experience arising from ongoing industrial action (including the phlebotomy dispute). This requires continued Board oversight to ensure effective risk management, mitigation, and assurance of safe services.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance.

- **Delivery of workforce reductions and financial sustainability**
  Progress has been made against the WTE reduction target (119 WTE reduced against a target of 151), but delivery of the full £5m savings and remaining reductions will require service transformation rather than incremental change.

- **Controls and compliance: overpayments and secondary employment**
  Counter fraud audits into overpayments and undeclared secondary employment remain open. Further reporting has been requested to strengthen financial governance, management accountability, and assurance.

- **Sickness absence linked to stress and anxiety**
  While long-term sickness absence has reduced, short-term absence driven by anxiety, stress and depression remains a concern. Benchmarking and deeper analysis are underway to support preventative leadership and staff wellbeing interventions.

- **Capacity to scale medical e-rostering (Health Rota)**
  Early benefits have been demonstrated, including improved grip on medical staffing. However, rollout pace is constrained by administrative and implementation capacity, presenting a delivery risk to full system-wide benefit realisation.

ASSURE: inform the board where positive assurance has been received

- **Strengthened workforce governance and temporary staffing controls**
  The Committee received assurance that governance arrangements for workforce sustainability have matured, including strengthened grip-and-control processes, improved recruitment systems, and enhanced controls over nursing, midwifery and non-clinical temporary staffing.

- **Improved oversight of medical temporary staffing**
  Assurance was provided regarding improved recruitment into hard-to-fill specialties, reinstated weekly reviews of agency and locum usage, and early evidence that medical e-rostering is supporting safer, more efficient staffing decisions.

- **Sexual Safety Charter implementation and organisational response**
  The Trust has established appropriate leadership, governance, policy and reporting infrastructure to support the Sexual Safety Charter, demonstrating progress towards a safe, inclusive and learning-focused culture.

APPROVALS: decisions made by the Committee

- Endorsed the continued delivery and strengthening of the workforce sustainability and change programmes to support financial recovery and safe staffing.
- Endorsed the next phase of Sexual Safety Charter implementation, with a focus on communications, learning and staff confidence in reporting.
- Supported the triangulation of staff experience, Freedom to Speak Up, HR and workforce data to strengthen organisational insight and learning, in line with well-led expectation

Implications

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	Yes
People, culture and leadership	Yes
Quality, safety and delivery	Yes
Digital first	n/a

Board assurance framework

BAF reference	**SR 16 and SR 17**

Risks discussed

The Committee discussed the following risks of workforce-related strategic and operational risks:

- Ability to maintain a sustainable, engaged and resilient workforce with sufficient leadership capability and capacity to deliver operational performance and financial recovery.
- A workforce wellbeing and capacity risk was highlighted due to ongoing high levels of short-term sickness absence linked to stress, anxiety and depression.
- Operational resilience risk was discussed in relation to ongoing industrial action, including the phlebotomy dispute
- Benefit realisation risk was identified in relation to the pace of medical e-rostering rollout.
- Assurance gaps linked to financial and workforce controls, arising from open counter fraud audits relating to overpayments and undeclared secondary employment.

Recommendations

The Board of Directors is asked to **note** the report

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	15 January 2026
Report title	Equality, Diversity and Inclusion Overview: staff network development
Sponsoring Director/Author	*Coral Boston EDI Manager* *Claire Radley, Director for People and Organisational Development*

Purpose (confirm the appropriate box)		
For approval	**For discussion**	**For information**
		✓

Executive Summary

The report provides an overview of the Trust's current Equality, Diversity and Inclusion (EDI) landscape, highlighting both achievements and ongoing challenges. The Trust operates an overarching Inclusion Network, supported by three principal staff networks—Ethnic Minority, LGBTQ+, and Disability—as well as two sub-networks for Women and Armed Forces network. Recent leadership changes and limited protected time and funding have affected the sustainability and visibility of these networks.

NHS England has underscored the importance of staff networks in shaping inclusive organisational cultures and has issued guidance to support their effectiveness. In response, the Trust is proposing measures such as dedicated funding for network Chairs, protected time, and enhanced support for inclusive events. Recent engagement activities, including sessions led by Eden Charles, have reinforced the need for change driven from within the networks themselves.

Key forthcoming initiatives include the launch of a Reciprocal Mentoring Programme, a review of progression for Black Band 7 staff, and the establishment of a central fund for reasonable adjustments. The EDI Team continues to play a pivotal role in embedding inclusive practices, supporting staff networks, and aligning local initiatives with national NHS priorities. The report also highlights the importance of local ownership of EDI performance metrics and the integration of EDI work across organisational development portfolios.

Overall, the Trust is committed to strengthening its EDI agenda by supporting staff networks, driving cultural change, and ensuring equity and inclusion are embedded throughout the organisation.

Previously considered by	Public Board (13th November 2025) received an update on the WRES and WDES data and action plan.

Recommendations:
• Note dedicated funding to provide backfill and protected time for staff network Chairs, in line with NHS England guidance. • Support the proposal for an inclusive Trust wide event, with funding to be explored in partnership with the Hospital Charity. • Endorse the importance of staff networks as partners in organisational change, ensuring conditions are in place for them to thrive. • Support the launch of the Reciprocal Mentoring Programme in May 2026, recognising its role in driving cultural change and leadership development. • Endorse the review of progression for Black Band 7 staff, including tailored development programmes to strengthen representation at senior levels. • Note the establishment of a central fund for reasonable adjustments, with responsibility embedded in the Health and Wellbeing Team. • Note the role of Cultural Ambassadors, noting that the Trust now has 10 trained Ambassadors to support fairness in workplace processes.

Strategic Aims (tick as appropriate)	
Patient experience and voice	
People, culture and leadership	✓
Quality, safety and delivery	
Digital first	

Impact on any Strategic Risks?
Board Assurance Framework – SR16: Culture, Experience and Retention.

Implications on:	
Equality, Diversity and Inclusion	The paper sets out how the EDI agenda for staff is being progressed.

Health Inequalities	There are clear relationships and inter-dependencies across the EDI and health inequalities agenda. This includes reference in the NHS 10-year plan to reducing health inequalities through inclusive recruitment and widening participation.
Finance and Resource	Budgetary commitments are required to ensure protected time for the chairs and development of the networks. There is currently a budget allocated for reasonable adjustments. A review of this budget will take place during 2026/27 to ensure that the allocation is appropriate.
Regulation/Legal	Equality Act 2010
CQC-Key line of enquiry	Well-Led: equality, diversity and inclusion; leadership; talent management and succession planning.
Green Plan	-

Main Report

1. EDI Update

1.1. This paper provides an overview of the Trust's current Equality, Diversity and Inclusion (EDI), landscape, highlighting both achievements and ongoing challenges.

1.2. The Trust maintains an overarching Inclusion Network supported by three principal staff networks. Ethnic Minority, LGBTQ+, and Disability, alongside two sub networks, the Women's and Veterans' Networks. Recent changes in leadership, coupled with limited protected time and funding, have impacted the sustainability and visibility of these networks.

1.3. NHS England has emphasised the critical role staff networks play in shaping organisational culture and has issued guidance to support their effectiveness. The paper outlines proposals to strengthen the Trust's approach, including dedicated funding for Chairs, protected time, and enhanced support for inclusive events. It also details recent engagement activities, such as sessions facilitated by Eden Charles, and sets out forthcoming initiatives including the Reciprocal Mentoring Programme, a review of progression for Black Band 7 staff, and the establishment of a central fund for reasonable adjustments.

2. Staff Network Overview - Background, Ambitions and Next Steps

2.1. The Trust maintains an overarching Inclusion Network, supported by three principal staff networks:
- 2.1.1. Ethnic Minority (EM) Network
- 2.1.2. Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) Network
- 2.1.3. Disability Network

2.2. In addition, two sub-networks, the Women's Network and the Armed Forces' Network contribute to advancing the wider inclusion agenda. These were established in 2025 and 2024 respectively.

2.3. Each of the above networks is supported by Executive and Non-Executives sponsors who provide senior level visibility ensuring that colleagues across the Trust have meaningful routes to shape organisational culture and decision making.

2.4. Although several network meetings were cancelled in recent months due to gaps in chairing and reduced member capacity, Execs sponsors have continued to stay closely informed about network activity. Their ongoing engagement has ensured continuity, with concerns from network members being escalated, addressed, and resolved despite challenges.

2.5. In recent months, there have been significant changes in network leadership. The Chairs of the EM, LGBTQ+, and Disability Network have resigned. At present, only the Disability Network has a newly appointed Chair in post.

2.6. Feedback from the previous Chairs consistently highlighted the lack of protected time to fulfil their responsibilities, which has been a major barrier to progress and the sustainability of these networks.

2.7. Over the past 12 months, the networks have experienced significant challenges in maintaining proactive engagement. Contributing factors include:

- 2.7.1. Limited protected time for network leads.
- 2.7.2. Competing operational priorities.
- 2.7.3. Reduced visibility and communication across the organisation.
- 2.7.4. Limited funding has impacted the ability to host key events such as Black History Month, Pride, and Disability Awareness activities. This has reduced opportunities for engagement and visibility across the organisation.

2.8. While the Trust's Inclusion Network and its associated staff networks have faced recent challenges with leadership capacity and sustainability, NHS England (NHSE) has emphasised the critical role such networks play in driving meaningful change. NHSE views staff networks as a cornerstone for shaping organisational cultures where colleagues feel a genuine sense of belonging. To support this ambition, NHSE has developed a toolkit, aligned to the NHS EDI Improvement Plan, to guide organisations in establishing and sustaining effective networks. These networks are important as they bring staff together around a shared purpose, creating collaborative platforms that improve staff experience both within individual organisations and across the wider NHS.

2.9. To strengthen our approach, the EDI team are undertaking a full assessment against the NHSE Staff Network Toolkit. This review will examine our current structures, resources, and ways of working to identify gaps, highlight areas of good practice, and determine where improvements are needed. The findings will inform a clear action plan to improve the effectiveness, sustainability, and impact of our staff networks and will form a basis for some of the development work currently underway with Eden Charles.

2.10. To ensure the effectiveness and sustainability of staff networks, it is important that individuals holding key roles are allocated protected time within their working hours to fulfil their responsibilities. Across the NHSE, the recommended benchmark is a minimum of two days per month, enabling network leads to successfully deliver on their roles and commitments. This arrangement will need to be agreed with both the individual's line manager and their Executive Sponsor, in line with guidance set out in NHS England » Developing your NHS staff network. Further discussions are currently underway with the Strategic Pay and Reward Lead to explore how the principle of staff taking on additional responsibilities can be supported within the pay arrangements within the Trust.

3. Dedicated Funding

3.1. To ensure the effectiveness of our staff networks, we are looking to secure dedicated funding for staff network chairs, to include backfill for key positions. This is particularly important for Chairs in clinical roles, where release from frontline duties can be challenging. Applying this approach across the three principal networks, Ethnic Minority, Disability and LGBTQ+, will help maintain continuity, strengthen engagement, and support delivery of the Trust's wider EDI objectives. Protected time, underpinned by appropriate funding, will enable Chairs to lead initiatives, organise events, engage members, and contribute to organisational priorities without compromising their substantive roles. Aligning this investment with NHS England's guidance will ensure the Trust is adopting nationally recognised best practice in strengthening and sustaining staff networks.

3.2. Beyond the support for protected time and backfill for staff network Chairs, discussions are also underway to explore opportunities for dedicated event funding. A meeting has been planned with the Hospital Charity team and the Strategic Pay and Reward Lead to seek support for a proposed inclusive event that would bring together all staff networks to celebrate and showcase the diversity within our workforce.

3.3. In October 2025, Eden Charles facilitated a session with the Inclusion Network, attended by 42 members. A key message emerging from the discussion was that, for staff networks to be successful, change must be driven from within rather than relying solely on senior leaders to "fix" issues. Networks were encouraged to remain anchored in their purpose and values, taking ownership of shaping the future as partners in organisational development rather than as dependents. Real transformation, it was emphasised, comes through honest conversations, embracing authenticity, and embedding equity and inclusion into the organisation's fabric so that progress endured beyond current leadership. In summary, next steps are as follows: -

- 3.3.1. A follow-up session with Eden Charles is scheduled for February 2026. In the interim, a facilitated Organisational Development session will take place in January 2026 to maintain momentum and further strengthen engagement.
- 3.3.2. Develop networks that are independent yet well supported, aligned with national standards, intersectional in approach, and fully embedded within organisational development. This reflects a long-term goal for networks to evolve into active drivers of equitable and sustainable cultural change.
- 3.3.3. Use the NHS England Toolkit along with to review governance and resourcing, develop a pathway for each network, strengthen leadership capability through OD facilitated development, formalise protected time and funding, enhance data driven planning, support intersectional collaboration, and embed networks more firmly into Trust governance and assurance processes.
- 3.3.4. Strengthen how our staff networks operate by using the NHS England Staff Network Toolkit to improve governance, sponsorship, and resourcing. Working closely with the networks we will work to develop a clear pathway for our network so they can grow in confidence and independence, supported by capability building through OD led development and support from Eden Charles.
- 3.3.5. Formalise protected time and funding for network chairs, enhance data driven planning using WRES, WDES, staff survey results and local insight, and encourage stronger collaboration across networks.

3.4. With the focused work planned over the coming year, the aim is that by the end of 2026 our staff networks will have established chairs, be productive, confident and well-established operating with greater independence and impact.

3.5. The Board is asked to note the importance of supporting staff networks as partners in organisational change, ensuring that the conditions are in place for them to thrive and contribute meaningfully to the Trust's EDI priorities.

4. Reciprocal Mentoring Programme

4.1. The Trust is preparing to launch a Reciprocal Mentoring Programme in May 2026. The initiative will be open to all members of the Inclusion Network, including allies, who will act as mentors to Executive leaders and colleagues and Band 8D staff. We are working towards approximately 30 mentoring partnerships being established.

4.2. The programme will run over a nine-month period and will be jointly facilitated by the EDI and Organisational Development teams. Mentors will gain valuable leadership development experience, increased confidence, and the opportunity to influence organisational priorities by sharing lived experiences and perspectives. Mentees will benefit from increased awareness and understanding of inclusion challenges.

4.3. The programme represents a significant opportunity to drive cultural change by nurturing honest dialogue and building mutual understanding between staff and senior leaders.

5. Progression Pipeline for Black Band 7s

5.1. During Black History Month 2024, a series of discussions were held to explore how the Trust could improve the experiences of ethnic minority staff. One of the key issues raised was the lack of Black matrons within the organisation. While representation of ethnic minority staff at Band 8A and above has increased, the number of Black leads and matrons has remained unchanged.

5.2. In response to concerns regarding under-representation at senior levels, the Trust has committed to reviewing the progression pipeline for Black staff at Band 7. Current data identifies 29 colleagues at this level who have remained in post for period of up to 16 years. Work is now underway to survey these staff members and engage with Divisions to identify individuals who are ready to progress to the next band.

5.3. The EDI Manager will be working closely with the Chief Nurse, the Lead for People Development, and Workforce and Education, alongside the Leadership and Development Team, to jointly support this cohort.

5.4. There are several programmes available now and upcoming.

1. In house Extended Leaders Network for all Band 7 staff. Is currently available and started in November 2025.
2. Nightingale Frontline Facilitation Online Masterclass Programme - A practical coaching-based programme that helps leaders support emotional wellbeing and psychological safety within their teams. Participants develop the skills and confidence to facilitate supportive, problem-solving sessions in their own workplace.
3. Florence Nightingale Leadership Development Programme - An online leadership course designed to strengthen personal leadership identity, influence, and confidence. It supports participants to lead with compassion, navigate complex challenges, and apply inclusive leadership principles in practice.

4. International Nurse/Midwife Online Leadership Programme, a commissioned development offer designed to strengthen the leadership potential of Internationally Educated Nurses and Midwives. It supports their own authentic leadership style, build confidence, and enhance the skills needed to improve services and progress in their careers.

5.5. We will begin by focusing on Black nurses, in response to concerns about the absence of Black matrons within the organisation. This initial work will aim to support career progression for this group, with plans to expand the approach more broadly to all Band 7 colleagues who have experienced challenges in progressing up the career ladder.

5.6. Our long-term ambition is to use divisional data to target interventions where they are most needed. The EDI team will provide divisions with regular workforce data to support proactive monitoring. Our ambition is to see measurable improvements in both divisional and Trust-wide performance against WRES and WDES, reflecting progress in representation and inclusion. Divisions have already received their 2025 WRES/WDES data, and the EDI Coordinator will continue to share updated recruitment data throughout the year. For governance, divisional leads will be required to present their data to the EDI Steering Group to ensure accountability and transparency.

6. Reasonable Adjustments

6.1. Research undertaken by the previous Chair of the Disability Network has highlighted the need for a more consistent and sustainable approach to reasonable adjustments. While a recurring central fund has now been established to support reasonable adjustments, alongside any contributions from Access to Work (AtW), there remains limited awareness among managers and colleagues about its existence or how to access it. This lack of clarity has meant that staff are not always receiving the support they require in a timely manner. Strengthening communication and guidance around the fund will be essential to ensure colleagues can benefit fully from the resources available.

6.2. Responsibility for reasonable adjustments is transitioning to the Staff Health and Wellbeing Team, recognising that this is fundamentally an issue of supporting staff wellbeing at work. Staff will soon be able to contact the team directly for advice, guidance, and signposting to Access to Work (AtW).

6.3. The Health and Wellbeing Lead, the wider team, and the EDI Manager will be meeting later this month to review a proposal for AtW training and related support. Our ambition is to create a streamlined, consistent, and sustainable process for managing reasonable adjustments and Access to Work (AtW) requests, ensuring colleagues receive timely and effective support. We aim for managers to be supported and have a clear understanding of the process and confidence in supporting their staff, and for the Health and Wellbeing (HWB) Team to be fully equipped to assist colleagues who may be struggling with reasonable adjustments**.**

6.4. Actions will include: -

- Creating and publishing a clear, step-by-step guide for reasonable adjustments and AtW requests on the intranet.

- Manager Training and Support - Roll out training for all managers on reasonable adjustments and AtW processes.

- Equip Health and Wellbeing Team - Deliver specialist training for the HWB Lead and wider team to provide advice, guidance, and signposting for AtW and reasonable adjustments. Establish the HWB Team as the central point of contact for staff requiring support.

- Communication and Awareness - Promote the existence of the £17k reasonable adjustments fund and AtW support through targeted communications.

- Monitoring and Continuous Improvement

- HWB Lead and wider team to track usage of the fund, AtW applications, and staff feedback to identify gaps and improve processes.

- Review and refine the approach annually to ensure sustainability and responsiveness to staff needs.

7. Cultural Ambassadors

7.1. The Cultural Ambassador (CA) programme plays a key role in strengthening inclusive recruitment, ensuring that selection processes are fair, culturally informed, and reflective of the diverse communities we serve. In addition, the programme supports organisations to improve equality, diversity and inclusion by improving the experience of staff involved in formal processes, reducing disparities in disciplinary outcomes for minoritised colleagues, as well as improving inclusive recruitment of diverse staff into senior roles.

7.2. To ensure clarity of role and effective implementation, a meeting has been arranged this month between the RCN course facilitator, the Investigation and Support Officer and the HR Business Partners so they can develop a shared understanding of how Cultural Ambassadors will support our processes. All current Cultural Ambassadors have also been added as Inclusion Champions for recruitment panels, strengthening our commitment to embedding inclusive recruitment practice.

7.3. Beyond these responsibilities, Cultural Ambassadors will help identify themes from cases, contribute to preventative learning, and support cultural improvement across the organisation.

7.4. Our ambition is to increase the number of Cultural Ambassadors over time, enabling broader coverage and further enhancing the work we are doing to build a fair, inclusive, and equitable recruitment and employee experience. And to increase the number of CA by the end of 2026

8. EDI Team

8.1. The EDI Team provides dedicated support to embed inclusive practice across the Trust. Through policy development, training, and targeted projects, the team ensures staff feel safe, valued, and able to thrive. They also play a central role in supporting staff networks, advising on reasonable adjustments, and aligning local initiatives with national NHS EDI priorities. Over the last year there has been an increasing focus on integration of the work across the wider organisational, cultural and people development portfolio, recognising that team and individual development is a key enabler of improvement and response to themes related to EDI, FTSU and health and wellbeing.

8.2. Working in partnership with divisions and teams to deliver programmes such as reciprocal mentoring, inclusive events, and tailored development opportunities, the EDI resource underpins the Trust's ability to drive cultural change, strengthen representation, and ensure equity and inclusion are embedded into the organisation's fabric. It has also driven a focus on local ownership and responsibility for monitoring and improving key EDI performance metrics, with reporting now included in executive performance reviews.

8.3. Our ambition over the next 12 months is to embed Equality, Diversity, and Inclusion (EDI) into the core of organisational culture and improvement strategies. This means ensuring divisions and teams take ownership for driving inclusion locally, supported by strong governance and accountability.

8.4. We aim to achieve fair representation and equitable access to opportunities across all levels, fostering a workforce that reflects the communities we serve. By moving beyond compliance to proactive cultural transformation, we will create an environment where inclusive behaviours are the norm and diversity is celebrated. Progress will be measured through EDI performance metrics embedded in executive reviews, driving continuous improvement and sustainable change.

9. Recommendation

9.1. The Board is asked to:

9.1.1. Endorse dedicated funding to provide backfill and protected time for staff network Chairs, in line with NHS England guidance.

9.1.2. Support the proposal for an inclusive Trust-wide event, with funding to be explored in partnership with the Hospital Charity.

9.1.3. Note the importance of staff networks as partners in organisational change, ensuring conditions are in place for them to thrive.

9.1.4. Support the launch of the Reciprocal Mentoring Programme in May 2026, recognising its role in driving cultural change and leadership development.

9.1.5. Endorse the review of progression for Black Band 7 staff, including tailored development programmes to strengthen representation at senior levels.

9.1.6. Acknowledge the role of Cultural Ambassadors, noting that the Trust now has 10 trained Ambassadors to support Case reviews and Inclusive recruitment.

9.1.7. Support the ongoing ATW process and Training.

9.1.8. Recognise the capacity of the EDI Team and consider future resourcing needs to sustain delivery of national priorities and local initiatives.

Enclosures - None

FOI: Public

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on Thursday 15 January 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Finance and Resources Committee held on 25 November 2025
Board member lead(s)		Committee Chair: Jaki Meekings Davis Executive Directors: Karen Johnson, Director of Finance Al Sheward, Chief Operating Officer Lee Pester, Chief Digital Information Officer
Written by		Corporate Governance (in the absence of the Committee Chair)
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	✓
	Discussion	✓
	Note	

Purpose of report

To present an update to the Board of Directors from the meeting of the Finance and Resources Committee held on 25 November 2025. The meeting was quorate.

This committee meets monthly and is attended by members of the Board and senior managers.

Key points

ALERT: matters that require the boards attention or action, e.g. non-compliance, safety concern or a threat to the Trust's strategy.

- **SR09: Financial Sustainability** - At Month 7, the Financial Sustainability programme continued to show signs of stress evidenced by £5.1M year to date deviation – a full year underdelivery risk of c£5.6m was highlighted. Within the overall £41.8m plan £25.2m of schemes were planned to be recurrent – the current forecast projected an underdelivery of this target by £3.5m. Given the level of red schemes it is anticipated the gap could continue to increase, although recovery plans are in place and as a consequence mitigations may materialise.

- There is a significant level of risk in the plan, with high-risk totalling £13.7M (including the gap). The £2.2m subsidiary programme would not deliver in-year and would add to the gap in Month 8.
  Reporting to NHSE includes a risk adjustment to the programme which highlights a potential underdelivery of c£11.5m – this is due to the NHSE treatment of red schemes and the inclusion of the temporary staffing reduction value of £4.3M as non-cash-releasing.
- **Capital and Estates Programme Delivery** -Challenges remained in achieving delivery of the capital programme, due to a number of high-value schemes' timescale slipping. Additional resources had been agreed to support Gloucestershire Managed Service and the Procurement team in accelerating the programme, as well as further schemes being added.
- **SR10: Condition of the Estate -** Scale of backlog maintenance stands at £86m, of which £57m is Critical Infrastructure Risk with a risk of clinical and operational downtime, resulting in increased costs and productivity/service issues impacting patient care.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance.

- **Contract Management Group Exception Report** - Asbestos remediation continued. The need to ensure current accommodation was fit for purpose was noted. Incidents and issues due to the deteriorating and aged estate impacted on operational/clinical delivery.
- **GMS Key Issues and Assurance Report** - A final decision was awaited from the Integrated Care Board and Trust around funding for security as the Integrated Care Board had approved the business plan subject to a caveat as to funding of any additional costs. Mitigations are in place and GMS continues to manage the service.
- **Financial Performance** - The Committee was advised that without action the Trust faced a significant deficit position by the end of the year, with further erosion to the underlying financial position. This high-level position had been shared with system partners. Actions were in progress and areas for improvement were noted.
- **Financial Well Led Checklist** – The committee received the report showing the actions that were in place against the NHSE checklist. Some areas remain in progress, and some have actions to be developed and will continue to be reported back to the committee.

ASSURE: inform the board where positive assurance has been received

- **Procurement Bi-Annual Performance & Assurance Report** - The Committee was assured that procurement processes remained robust, compliant, and aligned to national policy requirements.
- **Peer Review Report** - A review had looked at the robustness of savings plans, impact of cost pressures, capacity to deliver and controls over costs. Good practice stewardship and controls and improvement opportunities were highlighted. Recommendations were noted and an implementation plan was being developed.
- **Medium Term Planning** - The Trust's approach to medium term planning, and the national planning requirements was set out. The Trust's annual planning process had put the Trust in good position for submission of a joined-up plan for 2026/27, and the medium-term plan required by DHSC/NHSE.

APPROVALS: decisions made by the Committee

- **GMS Capital Margin:** The Committee APPROVED the increased capital margin for GMS to 8% for 2025/26 and recurrently.
- **Primary Percutaneous Coronary Intervention (PPCI) - Peninsula Purchasing and Supply Alliance (PPSA) contract -** The Committee APPROVED that a Call-Off Contract be awarded to each of the fifteen suppliers (Abbott Medical; Medtronic; Boston Scientific; Philips Electronics; Vascular Perspectives; Shockwave Medical; Cordis Medical; Terumo; Sahajanand Medical Technologies; Teleflex Medical; Merit Medical; APR Medtech; Biotronik; Cardiologic; Getinge) for the provision of Percutaneous Coronary Intervention (PCI) consumables.
  The contracts would run for an initial term of two years, with the option to extend for a further two years, giving a maximum contract duration of four years.
- **Infoflex Software Contract Extension** - The Committee APPROVED the renewal of the Civica Infoflex contract via direct award, with procurement made via the KCS Framework.

Implications

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	
People, culture and leadership	
Quality, safety and delivery	✓
Digital first	✓

Board assurance framework

BAF reference	SR09, SR10

Risks discussed

The Committee discussed the following risks: financial sustainability, delivery of the capital programme, condition of the estate

Recommendations

The Board of Directors is asked to take **assurance** from the report and note its contents.