Public Board of Directors

Thu 12 March 2026, 09:00 - 12:00

Lecture Hall, Sandford Education Centre, Cheltenham

Agenda

09:00 - 09:00 0 min

Agenda

00_Agenda March Board public.pdf (2 pages)

09:00 - 09:00 0 min

1. Chair's welcome and introduction

Deborah Evans

09:00 - 09:00 0 min

2. Apologies for absence

Deborah Evans

09:00 - 09:00 0 min

3. Declarations of interest (pertaining to agenda)

Deborah Evans

09:00 - 09:00 0 min

4. Minutes of previous meeting - 15 January 2026

Deborah Evans

04_ January public meeting minutes.pdf (16 pages)

09:00 - 09:00 0 min

5. Matters arising

Deborah Evans

09:00 - 09:00 0 min

6. Questions from the public

Deborah Evans

09:00 - 09:00 0 min

7. Patient Story

09:00 - 09:00 0 min

8. Chair's Report

Deborah Evans

08_Chair's Report to Board.pdf (3 pages)

09:00 - 09:00 0 min

9. Chief Executive's Report

Kevin McNamara

09_CEO Report - March Board Final.pdf (7 pages)

09:00 - 09:00 0 min

10. Maternity Services Regulatory Compliance Report

Matt Holdaway, Heather Gallagher

10_ CQC S31 Report to Board of Directors March 2026 copy.pdf (29 pages)

09:00 - 09:00
0 min

11. Perinatal Quality Oversight Report Q3 2025/26

Matt Holdaway

09:00 - 09:00
0 min

12. Audit and Assurance Committee Report

John Noble

12_ Audit Committee report.pdf (3 pages)

09:00 - 09:00
0 min

13. Modern Slavery Statement 2026/27

Kerry Rogers

13.00 Modern Slavery Statement report.pdf (4 pages)
13.01 Modern Slavery Statement 2025-26 tracked.pdf (4 pages)

09:00 - 09:00
0 min

14. Quality and Performance Committee Report

Sam Foster

14_QPC Alert Advise and Assure (AAA) report.pdf (4 pages)

09:00 - 09:00
0 min

15. Organ Donor Committee Annual Report

Mark Pietroni, Ian Mean

15.0_Report to Board of Directors March 2026 Committee Organ Donation Committee Annual Report with acronyms expanded in bold.pdf (3 pages)
15.1_Summary report NHST Gloucestershire Activity April to September 2025.pdf (3 pages)
15.2_Summary report financial year 2024 2025.pdf (3 pages)

09:00 - 09:00
0 min

16. Integrated Performance Report

Alan Sheward, Matt Holdaway, Mark Pietroni

16.00 IPR - Cover Sheet Board - March 2026.pdf (5 pages)
16.01 January 2026 IPR.pdf (48 pages)

09:00 - 09:00
0 min

17. Learning From Deaths Report

Mark Pietroni

17_LfD Report - board - V3.pdf (16 pages)

09:00 - 09:00
0 min

18. People and Organisational Development Committee Report

Marie-Annick Gournet

18_ PODC AAAA February 2026.pdf (3 pages)

09:00 - 09:00
0 min

19. Gender Pay Gap Report

Deborah Tunnell

19_Pay Gap Reports for Board FINAL.pdf (13 pages)

09:00 - 09:00
0 min

20. Staff Survey Update

Deborah Tunnell

EMBARGO 20_0 Report to Public Board_NSS25 Results v0.2.pdf (5 pages)
EMBARGO 20_1 NSS25 Results Summary - Public Board - March 2026 v0.2 (proposed version to go to board).pdf (18 pages)

09:00 - 09:00
0 min

21. Finance and Resources Committee Report

John Cappock

21.01 v2 FRC January 2026 - (AAA) Report.pdf (3 pages)
21.02 FRC February 2026 - Alert Advise and Assure (AAA) Report.pdf (3 pages)

09:00 - 09:00
0 min

22. Budgets 2026/27

Karen Johnson

22.0 Board budget setting update paper Feb 26 vSP2.pdf (7 pages)

09:00 - 09:00
0 min

23. Any other business

Deborah Evans

09:00 - 09:00
0 min

24. Governor observations

Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 12 March 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** • 15 January 2026	Assurance	Report	09.05
5.	**Matters arising**			
6.	**Questions from the public**			09.10
7.	**Patient Story**			09.20
8.	**Chair's report,** *Deborah Evans, Chair*	Assurance	Report	09.30
9.	**Chief Executive's Report** *Kevin McNamara, Chief Executive Officer*	Assurance	Report	09.40
	MATERNITY SERVICES			
10.	**Maternity Services Regulatory Compliance Report (s31 Notice)** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Report	09.50
11.	**Perinatal Quality Oversight Report** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Verbal	10.00
	GOVERNANCE			
12.	**Audit and Assurance Committee Report** *John Noble, Non-Executive Director*	Assurance	Report	10.10
13.	**Modern Slavery Statement 2026/2027** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.20
	BREAK			
	PERFORMANCE & QUALITY			
14	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Report	10.30
15.	**Organ Donor Committee Annual Report** *Mark Pietroni, Medical Director and Ian Mean, Chair, Organ Donor Committee (presentation)*	Assurance	Report	10.40
16.	**Integrated Performance Report** *Al Sheward- Chief Operating Officer* *Matthew Holdaway – Chief Nurse.* *Mark Pietroni – Medical Director.* *Deborah Tunnell –Deputy Director for People and Organisational Development.* *Karen Johnson – Director of Finance*	Assurance	Report	10.55

17.	**Learning from deaths report** *Mark Pietroni, Medical Director and Director of Safety*	Assurance	Report	11.25
PEOPLE				
18.	**People and Organisational Development Committee Report** *Marie-Annick Gournet, Non-Executive Director*	Assurance	Report	11.35
19.	***Gender Pay Gap Report*** *Deborah Tunnell, Deputy Director for People and Organisational Development*	Assurance	Report	11.45
20.	**Staff Survey Update** *Deborah Tunnell, Deputy Director for People and Organisational Development*			11.55
FINANCE				
21.	**Finance and Resources Committee Report** *John Cappock, Non-Executive Director*	Assurance	Report	12.05
22.	**Budgets 2026/27** *Karen Johnson, Director of Finance*	Assurance	Report	12.15
STANDING ITEMS				
23.	**Any other business**			12.25
24.	**Governor observations**			12.25
	Date and time of next meeting: Thursday 14th May 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 15 January 2026, 09:00-12.30, Sandford Education Centre, Cheltenham General Hospital		
Present	Deborah Evans	Chair, Non-Executive Director
	John Cappock	Non-Executive Director
	Sam Foster	Non-Executive Director
	Marie-Annick Gournet	Non-Executive Director
	John Noble	Non-Executive Director
	Sally Moyle	Non-Executive Director
	Shawn Smith	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
	Al Sheward	Chief Operating Officer and Deputy Chief Executive Officer
Attending	James Brown	Director of Engagement, Involvement and Communications
	Sarah Favell	Trust Secretary
	Heather Gallagher	Interim Director of Midwifery
	Emma Teare	Theatres Team, LGBTQ+ network lead
Apologies	Vareta Bryan, Non-Executive Director	
Observers		
Governors	Douglas Butler, Mike Ellis, Andrea Holder, Gwyn Morris, Ian Craw, Helen Bowen and Emma Mawby	
Other	Members of the Phlebotomy team, Francis Ryan (Unison)	
Public	Two	

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. In comments directed to phlebotomy colleagues she assured them that the Trust senior leadership was working to resolve the dispute. 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 Vareta Bryan, Non-Executive Director
3	**Declarations of interest**
	There were no declarations of interest in respect of agenda items.
4	**Minutes of previous meeting**

	The Board reviewed the minutes of the public board meeting held on 13th November 2025. There was an amendment to top of page 9 which would be resolved outside the meeting. **RESOLVED:** The Board APPROVED the minutes of the meeting held on 13th November 2025 (subject to the amendment above).
5	**Matters arising**
	Deborah Evans, Chair, confirmed there had been a very useful meeting of the Governor's Governance Working Group earlier in the week at which there had been a constructive conversation regarding the future role of the governor and the focus on patient experience & community engagement. This had resulted in a co-produced proposal for the Governor/Non-Executive Director workshop on 5th February.
6	**Questions from the public**
	There were no questions submitted.
7	**Staff Story**
	The Board was joined by Emma Teare, Theatre Practitioner and recent Chair of the Trust's LGBTQ+ network and a member of the Trust's Trans community. Emma spoke to the board about her enthusiasm for engaging with colleagues to educate and engage on issues affecting the Trust's LGBTQ community. She spoke positively about the support she had received from patients and colleagues but also highlighted some experiences of discrimination and hostility which had motivated her to use the network forum to try to inform colleagues. She spoke of her disappointment that there had been low levels of engagement from Trust colleagues and that it had been disheartening to invest her time, including personal time, for events to be poorly attended. She also spoke about the challenges which had prompted her to take a step back from chairing the network; the lack of visibility for Chairs working clinically and the need for dedicated time away from clinical duties to undertake the role. She remained positive about the role of staff networks but encouraged the board to look at practical ways in which to support networks. Claire Radley, Director for People and Organisational Development thanked Emma for taking the time to speak with the Board and acknowledged the challenges faced by staff network chairs across both the Trust and the wider NHS. She confirmed this was an area of focus for the Trust, referring to a report later in the meeting agenda. Deborah Evans, Chair also expressed the thanks of the Board for highlighting the issues from a personal perspective and confirmed the work being done to address the issues identified by Emma, including the need for dedicated time for Network chairs to progress their agendas. Several Non-Executive Directors echoed the comments of the Chair with John Cappock asking Emma about her experience as a trans employee within the Trust, whether she felt safe and supported. Emma was clear that she has not experienced discrimination from patients, and she feels supported by Trust management but there have been occasions when she has experienced passive transphobia from colleagues and that was why she was so keen to be involved in the education and engagement agenda. The Board expressed its thanks to Emma for taking the time to highlight her experiences, both positive and less so.

8	**Chair's Report** *Deborah Evans, Chair*
	Deborah Evans, Chair, presented her report (taking the report as read), highlighting the various visits she has been on across the Trust since the November board meeting. Those included visits to maternity services alongside Vareta Bryan, Non-Executive Champion for Maternity Services. Another visit was to shadow Mark Eveleigh, Speciality lead for Anaesthesia, which was particularly interesting and thought-provoking visit as he shared the Chair's interest in addressing the issue of same-day cancellations of surgery. This would be a focus as part of the Quality and Performance Committee workplan for 2026-27. She had visited the Patient Advice and Liaison Service to explore the various issues impacting on patient experiences, in particular cardiology waits, and teething problems experienced with the transition to an automated out-patient booking process. She spoke positively of her night duty visit to the wards in the Tower Block at Gloucester Royal Hospital. Accompanied by Noel Peters, Research and Development lead and Coral Boston, EDI Manager, she had visited during the nightshift to ensure that she met staff who, because of the working patterns, are not visible outside of their immediate clinical areas. Many of the staff are international nursing and health care assistant colleagues and it was an opportunity to better understand their experience of working within the Trust in terms of management responsiveness, career development opportunities and their experience of racism. She noted that her colleagues had made a visit approximately 2-3 years ago, and they reported that this recent visit had felt much more positive, colleagues described feeling listened to and supported, particularly about their concerns regarding corridor care on wards, which had been stopped. Other highlights had been the recent Quality Improvement graduation event, and particularly the presentation from Emergency Department colleagues on sepsis management. As a consequence, the Executive Tri had confirmed that sepsis management would be a quality improvement focus for the Emergency Department with a report to come to the Quality and Performance Committee during 2026/2027. Deborah Evans, Chair acknowledged the uncertainty caused by the NHS 10-year plan as to the future role of Governors within Foundation Trusts whilst national guidance is awaited. Whilst recognising it was unlikely there would be a formal governor role she was clear that the work of the Trust's governors was very much valued and the Board enjoyed a good relationship with the Council of Governors. During the recent Governor Governance Working Group meeting the focus had been on how to manage any transition period and how to capture the wealth of experience within the governor body, through a focus on both patient experience and community engagement. She was very much looking forward to the joint Governor/Non-Executive Director workshop in early February. John Noble, Non-Executive Director, commenting on the visit to the Patient Advice and Liaison Service, asked it the Board could receive a future update on the automation of the out-patient booking process. It was confirmed that this would be looked at by the Quality and Performance Committee. **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 impact of the resident doctors' industrial action over the weekend immediately prior to Christmas and also commenting on the ongoing phlebotomist's industrial action. He advised the board that since the board meeting in November there had been several productive conversations with phlebotomy representatives and one meeting to which all phlebotomists were invited. The two proposals were outlined: (i) that the current job description (Band 2) be submitted to the national Job Evaluation Group for an independent and objective evaluation. This was an option which had been proposed by the Trust earlier in the year but would require both the Trust and the Phlebotomists to agree to be bound by the independent determination. (ii) a proposed new Band 3 Phlebotomy and Out-patient Health Care Support Worker role. Phlebotomy colleagues would be voting on these two options, and it was hoped that the outcome would be confirmed imminently. Kevin McNamara commented that if the preferred option was the new Band 3 role, then this could be progressed quickly as it was within the Trust's control. If the decision was to agree to submitting the job description for evaluation by the national panel, then this would take longer to conclude with an indication of a 6-8 weeks' timescale. Other items highlighted included the recent Care Quality Commission National Maternity Survey, published in December 2025, which highlighted significantly improved results for the Trust. The team were to be commended but all recognised there was considerable ongoing work. This would include resolving the decision to temporarily suspend the home birth service because of safety concerns raised by community midwifery staff and in the context of a national focus on this issue. Whilst less than 2% of the population avail themselves of this service it was recognised that it was an important choice for those patients and consequently a lot of work was being undertaken to provide reassurance to affected families. The issue had attracted some media attention, with three other Trusts in the South-West in a similar position. Finally on maternity issues, it was confirmed that the Trust was still awaiting the report following the Care Quality Commission's inspection in September. Kevin McNamara also highlighted the recent unannounced Care Quality Commission's inspection visit to the Trust's Urgent and Emergency Care teams, which had taken place as part of their work on winter pressures. He confirmed that the Trust had received notification in December that there would be a further planned inspection in February commenting that these inspections involve a lot of work for teams during a very busy period both clinically with Winter pressures, and generally as the NHS completes it annual planning round. The focus for the Executive Team was on supporting teams and the continued delivery of good patient care. Commenting on the ongoing Winter pressures it was noted that whilst very busy (OPEL 4 level response) it had not been necessary to declare a critical incident. This was as a result of effective planning and hard work by teams who had been focused throughout the year, and in particular the Winter period, on improving clinical flow, ambulance handovers and reducing the need for intermittent corridor care in the Emergency Department. Kevin McNamara acknowledged the impact of corridor care in the Emergency Department at Gloucester Royal

	Hospital on both patients and staff and emphasised the continued work to limit corridor care to the absolute minimum. Finally, he commented on the National Oversight Framework which ranks individual Trust performance in the form of league tables. Whilst the Trust remained 17th out of 134 acute trusts it had been moved into Segment 1 (high performing) which meant the Trust was the highest placed Trust in the South-West and the third ranked large acute Trust in the country. This was a result of significant hard work of teams across the Trust, focused on reducing waiting lists and improving patient services. **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. 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 main item of note was that the Trust has self-assessed all eight conditions as complete and compliance sustained. The Quality Governance and Maternity teams would be considering when to arrange a re-inspection by the Care Quality Commission with the aim of achieving removal of the conditions in place. This would not be done immediately and the thinking for that decision was two-fold. First, the Board would require its own assurance, via the Trust's governance routes, that the compliance was embedded. Second, Matt Holdaway and the wider senior team were very aware of the capacity pressures for the maternity clinical and management team. A Care Quality Commission inspection would add to those demands at a time when the team was very busy clinically and with responding to the Baroness Amos investigation team. A decision as to the timeline for the reinspection request would be made in the next month. Deborah Evans, Chair commented that this was a very positive development. Sam Foster, Non-Executive Director and Chair of the Quality and Performance Committee commented that this was good news and reflected the progress evident within the Committee's Alert Advise Assure (3As) report, with many maternity related items transitioning from red rated to amber. She passed on her thanks to the team for the hard work involved but also suggested that it was perhaps time to consider introducing stretch targets for some of the safety critical measures. She observed that whilst it was great to achieve an 85% target this still meant that 15% were not at the standard required. Matt Holdaway, Chief Nurse, commented that this would be something that should be explored. She also commented on the recent withdrawal of the proposed s29 Warning Notice by the Care Quality Commission following representations from the Trust. Finally, she requested more information on the improvement against the Venous Thromboembolism target. Matt Holdaway advised that this had been achieved through the upskilling of clinical leaders in quality improvement methodology, enabling them to make necessary changes locally. Sally Moyle, Non-Executive Director, asked about the monitoring of dips in performance against compliance targets. Matt Holdaway advised that it was a key part of Quality Improvement methodology to monitor and not to respond too quickly to anomalies but to

	ensure consistent monitoring and escalation of protracted dips in performance or safety critical events. John Cappock, Non-Executive Director commented on the high number of data requests across the various external regulators and how this was managed in the context of capacity demands for the team. Matt Holdaway, Chief Nurse, advised that the team worked closely with the Business Intelligence team to ensure the most appropriate monitoring data was available. This was being refreshed in light of the new national change to maternity reporting and the data requirements for both Trust boards and committees. These changes would be explored in a later session of the board meeting **RESOLVED:** The Board NOTED the content of this report for assurance
11	**General Perinatal and Maternity update** *Matt Holdaway, Chief Nurse & Director of Quality*
	Matt Holdaway, Chief Nurse, confirmed that this report had been superceded by a decision to explore in a separate board session the new maternity reporting requirements. An updated report would be brought to a future public board meeting.
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 November meeting of the Committee, with much of the report being taken as read. He confirmed that the Committee, with the support of both the Internal Auditors and relevant Trust teams, continued to focus on the achievement of the annual work plan and timely resolution of Audit recommendations, mindful of the need to continues the improvements achieved during the previous 18 months which had resulted in an improved Head of Internal Audit Opinion in April 2025. It had been noted that there had been some movement in the work schedule, but the Committee had received assurance from the Internal Audit team that there were no concerns that the full audit programme would not be achieved by financial year end. **RESOLVED:** The Board NOTED the report as a source of assurance.
13	**Strategic Risk Report** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance, presented this report which had a two-fold purpose; to provide an update on the re-alignment of the Board Assurance Framework against the Trust's updated Strategy and to provide assurance as to the scrutiny of relevant strategic risks since November 2025. The report, together with the summary Board Assurance Framework appended, were to be taken as read with the report outlining the new strategic risk descriptions and current risk scores against the Trust's refreshed risk appetite. Within the report it also set out the proposed review of the realigned Strategic Risks by board assurance committees during January and February. Committees would be seeking assurance from the executive directors that the controls were properly identified and were effective. Kerry Rogers, Director of Integrated Governance, confirmed that whilst the risk management tools had been significantly improved it remained an evolving journey of maturity. Both responsible executives and relevant committees would be expected to focus on the effectiveness of controls, any gaps in controls and assurance integrity over the next 12-month period. It was also confirmed that there would be changes in the processes that underpin the

	Board Assurance Framework with the Trust Secretary supporting responsible executives to bolster assurance through the triangulation of information from primary, internal and external sources (3 lines of defence methodology). In addition to the reports to Committees, a full Strategic Risk report to be brought to the Board three times a year. This frequency would allow themes/trends analysis as to the outputs of the relevant action plans. The Board were taken through the risk descriptors, noting that they were materially consistent with the areas of risk within the previous iteration of the Board Assurance Framework but now more closely aligned to the Trust's refreshed strategic aims, golden threads and core enablers. John Cappock, Non-Executive Director commented that he considered the refresh of the Board Assurance Framework a positive indicator of the strengthening of the Trust's governance processes. He welcomed the planned focus on risk controls and triangulation of assurance from various sources. Lee Pester, Chief Digital Information Officer summarised the work undertaken in respect of the two risks aligned to the Digital First agenda. He welcomed feedback from board colleagues on these risks as it was an evolving process. **RESOLVED:** 1. The Board reviewed and APPROVED the updated Board Assurance Framework, new strategic risk descriptions and initial risk scorings, considering the Trust's revised Risk Appetite Statement (Appendix 3) and the Updated Board Assurance Framework. 2.The Board NOTED 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. 3.The Board DISCUSSED the need to focus on the effectiveness of controls and sources of assurance. 4. The Board DELEGATED 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 5.The Board AGREED to timetable a review of the Board Assurance Framework, alongside the Risk Appetite Statement at the May Board of Directors meeting. 6.The Board NOTED for assurance the review of current strategic risks during November and December 2025.
14	**Integrated Governance Report – Legal, Regulatory and Policy Update** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance, presented the first iteration of the report. It was intended as a summary of recent regulatory and compliance guidance relevant to the Trust. It also included a section on other national/NHS events or incidents to stimulate a 'true for us' discussion and was intended to provide the board with additional resource for its learning/continuous improvement focus. Kerry Rogers asked board members to feedback to her what they felt worked well within the report and what areas they would welcome more focus on in future reports. She explained that the central message she wanted the Board to take from the report was the need to continue to question whether, in light of the regulatory framework and policy guidance, the Trust's internal controls remained effective. This would further reinforce the work on the Board Assurance Framework, providing opportunity to triangulate assurance or gaps in controls to

	facilitate focus on specific areas of risk such as the management of corridor care, medicines management, staff culture or financial planning. Deborah Evans, Chair, commented that the report was very helpful and next steps would be to ensure that relevant external information was provided to Board Committees to inform their review of assurance provided. It would also be useful in identifying and supporting the board's development agenda. John Cappock, Non-Executive Director, suggested the inclusion of 'thought leadership' pieces from Internal and External auditors. The 'true for us' section prompted the suggestion from Kevin McNamara, Chief Executive that the People and Organisational Development Committee focus on violence and aggression against staff, looking at the effectiveness of the Challenging Behaviour Panel and with a specific focus on issues relating to Equality, Diversity and Inclusion (hate crime incidents). **RESOLVED**: 1. The Board NOTED the content of the report and the proposal that members should, through additional enquiry, seek further assurances/reassurances that the Trust's internal controls' actions are sufficient to ensure regulatory compliance. 2. The Board SUPPORTED Committee chairs and the Corporate Governance Team to ensure relevant focus on key risk areas in the report through Committee and Board agendas and workplans.
15	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*
	Sam Foster, Committee Chair, presented the report detailing the assurance received by the Committee in November 2025. There was no meeting of the Committee during December 2025. Alert items included the ongoing management of fire safety risks and the connected issue, exacerbated by Winter pressures, of the use of corridor care in the Emergency Department at Gloucester Royal Hospital. Whilst Winter demand had contributed to the use of corridor care in the department, this had been compounded by the coincidence of the need to close wards as part of the Tower Building decant programme. This would remain under review, with the Chief Operating Officer acknowledging that Trust staff were keen to reduce/eliminate the need for corridor care in the Emergency Department. Clinical and Operational Executive leads would be providing updates as to mitigation to the Committee. The completion of the action plan relating to the Pseudomonas incident was noted and colleagues, in both the clinical areas and Infection Control Team alongside Gloucestershire Managed Services colleagues, were commended for the assurance provided. The oversight of the complaints process was highlighted with encouraging improvements in the numbers of long-standing complaints remaining unresolved. Kevin McNamara, Chief Executive, commented that he would be encouraging the Complaints team to set a further 'stretch' target for timely complaint resolution – that this was consistent with the Trust's strategic aim as to Patient's voice and experience. Sam Foster, confirmed the new meeting structure for the Committee, moving to a frequency of 6 essential business meetings and 4 'deep dive' focus sessions. The first of those 'deep dive' sessions to be on maternity triage.

	In response to a question from Shawn Smith, Non-Executive Director, regarding lithium batteries/fire safety Al Sheward confirmed that checks had been undertaken to ensure all batteries were still within their life cycle, with a process for monitoring the same, Lee Pester confirmed alternatives were being actively pursued. Additionally, a risk assessment had been undertaken in all areas, with remedial work to remove combustibles from storage areas undertaken. In response to a question regarding the Deteriorating Patient Audit (Advise section) Matt Holdaway provided the board with an update on the work to respond to the Internal Audit report. This included the reforming of the Deteriorating Patient Group, chaired by an experienced Emergency Department consultant, to provide focus to the action plan, including improved ways of recording observations. These actions would be monitored through the clinical governance process **RESOLVED:** The Board NOTED the report for assurance.
16	**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*
	Performance Al Sheward, Chief Operating Officer, presented the performance section of the Integrated Performance Report for November (with some commentary on the unvalidated data available for December). <u>Urgent and Emergency Care</u> Performance against the 4-hour wait target was at 64.2% against a target of 78% and whilst there was still work to be done it was noted that this was the highest compliance rate in two years. There had been improvement in performance at both Cheltenham Hospital Emergency Department and Paediatric Emergency Department, despite the marked increase in attendance levels. There was a continuing focus on the need to improve processes across Minors area if there was to be a material impact on performance across the non-admitted patient group. Al Sheward commented on the disappointing return of corridor care in the Emergency Department due to a combination of increased demand against reduced capacity. It was recognised this was not the standard of care the Trust wanted for its patients and staff. In late October/early November the average treatment time in a corridor was 4.5 hours. Mitigation plans were in place and would be monitored. Winter planning, including the system resource plan, had worked as anticipated with performance matching anticipated figures with no critical incident initiated. It was confirmed that the response to Winter pressures had felt improved compared to the previous year with increased numbers of patients choosing to utilise 111 and alternative care provision. It was acknowledged that this had been challenging for Gloucestershire Health Trust colleagues, managing the 111 and clinical advisory services.

Ambulance handover times had stabilised at 22 minutes average which was a credit to the Emergency Department teams but had come at a cost with the re-emergence of corridor care. Volume of ambulance conveyances remained high, particularly when compared to post attendance admission figures. During peak periods the Emergency Departments were receiving 145-160 ambulances a day. This remained a continued focus in discussion with ambulance trust colleagues.

Patients 'discharge ready' (formerly known as 'No criteria to reside) had remained steady at approximately 120 but this was being actively monitored as it was impacting on clinical flow and would impact future stages of the Tower Building improvement programme.

Raj Kakar-Clayton, Associate Non-Executive champion for welfare, asked about staff well-being over the Christmas period. Overall, it was considered improved compared to previous years, assisted by the increased visibility on site of senior clinical teams. Al Sheward advised that he was due to meet with the Freedom to Speak Up Guardian to triangulate data regarding issues concerning clinical staff but he did not believe the Trust had seen a risk in staff concerns or external complaints. It was noted that the visibility of Chantal Baker, Divisional Director of Quality and Nursing, in the emergency and urgent care departments, had been a positive for staff and patient care.

<u>Elective: 45 Week wait</u>

The number of 45-week waits had reduced significantly, from 822 to approximately 636 in November 2025, primarily because of moving a number of dermatology patients to alternative providers (Modality Health) to ensure additional capacity. The reduction was likely to be smaller for December 2025 due to the BMA industrial action.

There had been a slight improvement in RTT performance within 18 weeks. Total incompletes waiting list was at 63,893 with 10 specialities making up 43% of that figure. Those specialities were receiving targeted support.

<u>Cancer RTT (referral to treatment) (Standard 85%)</u>

Achievement of target 85% by testicular and breast services. Marked improvement in urology. Focus remains on dermatology and lower gastrointestinal services, which remained under pressure with 149 recorded on backlog. Remedial actions had been identified.

<u>Diagnostics</u>

Overall position was one of moderate improvement with a waiting list reduction of approximately 319 patients. Improvements evident in ECHO and Gastroscopy, but off-set by deterioration in Endoscopy. A business case would be submitted for additional funding for services during Q4.

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. Family and Friends Test responses remain above average at 92.4%, including an improvement in November for Emergency Department. Closure rate for Patient Liaison and Advisory Service has been maintained

above target. Resilience within the team had improved, compared to last year and the team is more able to manage periods of sickness absence.

It was noted that the Trust's rates for postpartum haemorrhage remained slightly above national average. Those figures continued to be monitored by the Perinatal Delivery Group.

The focus remained on improving the timeliness of responses for Patient Safety Incident Response Framework (PSIRF) learning responses, with planned increased numbers of clinical colleagues to receive investigation training and an increased focus on local divisional responses to patient concerns. Timeliness of complaints responses continued to improve with only 4 complaints outstanding at six months but with a noted dip in performance in November which was attributed to capacity issues. Kevin McNamara, Chief Executive, commented that the infographics did not appear to match the narrative and he would want greater assurance on the management of those complaints over six months.

Sam Foster, Non-Executive Director, challenged the performance for Duty of Candour and requested that a fuller report be brought to a meeting of Quality and Performance Committee. **ACTION**

Use of Resources/Finance metrics

Karen Johnson, Director of Finance, provided an update on financial performance as at Month 8, commenting that whilst the figures before the Board related to November there had been significant changes in the position by January 2026, which would be referenced in the board discussions regarding business planning. As at Month 8 revenue was £3.3 adverse to planned deficit of £0.5m. This was consequent to the industrial action and the continuing shortfall against the Financial Sustainability Programme target for recurrent savings. It was also noted that the Trust had not met NHSE target for agency and bank spending, again as a consequence of BMA industrial action. It had been confirmed by Region that there would be some support for industrial action costs. The Forecast Outturn was anticipating an improved deficit position to £6.6m deficit but the focus on financial prudence, particularly in respect of the Financial Sustainability Programme must continue. Capital remained underspent (£12.8m) against a planned spend of £26.6m. Those figures would improve once December data was verified. It was noted that Gloucestershire Managed Services had secured additional resource within the capital team which would enable the team to focus on capital projects, both infrastructure and digital.

People

Claire Radley, Director for People provided an update on the current workforce issues. She confirmed the focus remained on areas of under-performance; sickness, appraisals and use of bank and agency staff.

The target for sickness absence was set at 4% with Trust compliance throughout the year being between 4-5% with improvement in the latter months. It was noted that there had been a particular improvement within Women's & Children's Division. Primary cause of absence was anxiety/stress/depression and managers were encouraged to utilise the well-being offering for staff, signposting staff to various support programmes. An increase in sickness absence across the Health Care Assistant cohort had been noted and was being monitored. It was believed that this may relate to the recent removal of the sickness incentive scheme when this cohort returned to Agenda for Change standard terms. The incentive scheme had

	been offered eight years previously to address a high level of sickness absence and had been successful but there had been a noted increase in sickness levels since the change to Agenda for Change terms. The national target for appraisal compliance was 90% with the Trust currently at 82%, with variable compliance across teams. There had been some successes in teams which had been supported by the appraisal outreach team but managers were reporting an increased lack of awareness of the new paperwork and process. This was being addressed through focused interventions and the embedding of appraisal learning and development for managers. Internal Audit would be undertaking an audit of appraisal processes during Q4 The use of temporary staff continued to be a focus but the impact of recent industrial action was noted. Additional 'grip and control' meetings across medical & dental, nursing and non-clinical were in place and were proving effective. Matt Holdaway, Chief Nurse, supported the use of local controls, including the movement of temporary staff to address safer staffing at ward level. He acknowledged that it had caused stress in the system and additional work for matrons but overall the measures had a positive impact. Mark Pietroni, Medical Director, highlighted the positive performance in terms of job-planning compliance with the October 2025 target of over 60% met. This was largely attributed to the move to E-rostering and the improved data provided to the divisions on a regular basis and other support from the job-planning team. He confirmed the next focus would be on the quality of the job-plans. Sally Moyle, Non-Executive Director, asked if there was data available on the update of employee support programmes/psychological support by staff of sick for mental health reasons. The Director for People and Organisational Development would include a report in a future People and Organisational Development Committee (by June). **ACTION** **RESOLVED**; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
17	**Safer Staffing for Nursing Report (annual)** *Matt Holdaway, Chief Nurse and Director of Quality*
	Matt Holdaway, Chief Nurse, presented the report, noting that it had been previously considered and approved by the Quality and Performance Committee to provide assurance as to compliance with Developing Workforce Safeguards (NHSI, 2018) and other relevant standards. The focus within the report was based on three key themes: Right Staff, Right Sills and Right Place and Time. In presenting the report Matt Holdaway confirmed that the Trust had demonstrated significant improvements in nurse staffing over the past three years, with a significantly reduced vacancy list and reduced staff turnover. He confirmed the systems in place to support safer staffing, including regular gap analysis, risk assessments and timely approvals of recruitment. In summary he confirmed that the Trust was compliant with all regulatory requirements. He advised that next steps would be to focus on reviewing areas of over and under establishment. It was noted that business case development for additional staffing had been delayed in recognition of the impact of the Tower Building improvement programme, with a focus on supporting displaced staff to move to other areas. Areas of over establishment were subject

	to an audit programme with audits in September 2025 and planned for January 2026 with the output of those audits determining next steps. **RESOLVED:** 1. The Board NOTED the report for assurance that the Trust has effective systems and governance in place to ensure safe nurse staffing, in line with national guidance. 2. The Board NOTED 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.
18	**People and Organisational Development Committee Report** *Marie-Annick Gournet, Non-Executive Director*
	Marie-Annick Gournet, Non-Executive Director, presented this report, noting the use of the newly introduced AAA template. The three areas to alert were identified as (i) recent pulse survey results had noted a deterioration in staff experience, particularly relating to management capability and organisational learning. (ii) the absence of a Freedom to Speak Up Guardian within the wholly owned subsidiary, Gloucestershire Managed Services and (iii)the addition of a new workforce risk relating to the impact of industrial action on staff well-being and services. It was confirmed that a number of actions had been put in place to address these alert issues, and their impact would be monitored by the Committee. Within the 'Advise' section the need to focus on the transformation agenda alongside workforce reduction targets if the Financial Sustainability target was to be achieved was commented on. Within the Assure section the strengthened vacancy controls were noted. Kaye Law-Fox, Chair of Gloucestershire Managed Services (GMS), responded to the item relating to the Freedom to Speak Up role within the subsidiary. She confirmed the GMS board were fully sighted on the issue, having received a report in October and an action plan was in place. This included the recruitment of a Freedom to Speak Up Guardian and a range of other measures including the support of the Trust's Freedom to Speak Up Service and triangulation of data to ensure the risk was appropriately managed. Lee Pester noted the recorded n/a within the report template against implications for Digital First. He commented that there were digital implications for many of the matters within the report, including the provision of accurate data. This was noted by Marie-Annick for future reports. **RESOLVED:** The Board NOTED the report for assurance.
19	**Equality, Diversity and Inclusion overview: staff network development** *Claire Radley, Director for People & Organisational Development*
	Claire Radley, Director for People & Organisational Development presented the report exploring the Trust's Equality, Diversity and Inclusion landscape, exploring the work of the Inclusion Network which incorporated three principal staff networks; Ethnic Minority, LGBTQ+ and Disability. It was acknowledged that recent leadership changes and limited protected time/funding had affected the visibility and sustainability of the networks.

	In response to concerns articulated by the Networks and considering recent national guidance the Trust was proposing measures including dedicated funding for network Chair's (£3,000), protected time and enhanced support for inclusive events. An output of the recent engagement sessions led by Eden Charles had been the recognition that networks needed to be empowered to drive change for themselves. This initial inclusion network event had been very positive and provocative, with a follow-up session planned for February 2026. Each Network would be supported to develop an annual plan. Additional planned initiatives included a reciprocal mentoring programme, a review of progression for Black Band 7 staff and the establishment of a central fund to support managers with the provision of reasonable adjustments for disabled staff. It was hoped that this latter initiative would empower disabled colleagues and their managers to resolve issues without anxiety as to available local budget. The first provision was to support a dyslexic colleague with additional software and other support. The funding budget was relatively small but would be kept under review as the scheme was utilised. The roll-out of the Royal College of Nursing led cultural ambassador programme was discussed as a positive development with half supporting recruitment programmes (after attending relevant training) and the other supporting investigations and Human Resources processes impacting on ethnic minority staff. Kevin McNamara confirmed his support for this body of work and spoke of the value of involving networks in areas outside the traditional scope of Equality, Diversity and Inclusion programme. He also noted role of the central team to provide specific support to network chairs, noting the comments of Emma Teare who had spoken during the Staff Story agenda item about the challenges faced by clinical network leads who work remotely from the central EDI team. This would be a focus for the team, following the completion of the Eden Charles programme. He endorsed the need for additional funding which would be discussed further at the Executive Team meeting. Kaye Law-Fox, Non-Executive Director, commented that it would be important to consider how we monitor the effectiveness of these initiatives to properly capture their value. This would be something that the Director for People and Organisational Development would give thought to and include within a future report to the People and Organisational Development Committee but could include use of survey data, the cultural heatmap and the recently introduced 'Report, Support and Learn' programme. **ACTION** It was confirmed that there would be a future session with Eden Charles for the Trust Leadership Team and the final board session would focus on effective actions. **RESOLVED:** The Board: 1. NOTED dedicated funding to provide backfill and protected time for staff network Chairs, in line with NHS England guidance. 2. SUPPORTED the proposal for an inclusive Trust wide event, with funding to be explored in partnership with the Hospital Charity. 3. ENDORSED the importance of staff networks as partners in organisational change, ensuring conditions are in place for them to thrive.

	4. SUPPORTED the launch of the Reciprocal Mentoring Programme in May 2026, recognising its role in driving cultural change and leadership development. 5. ENDORSED the review of progression for Black Band 7 staff, including tailored development programmes to strengthen representation at senior levels. 6. NOTED the establishment of a central fund for reasonable adjustments, with responsibility embedded in the Health and Wellbeing Team. 7. NOTED the role of Cultural Ambassadors, noting that the Trust now has 10 trained Ambassadors to support fairness in workplace processes.
20	**Finance and Resource Committee Report** *John Cappock, Non-Executive Director*
	John Cappock, Non-Executive Director, presented this report relating to the November meeting of the Finance and Resource Committee, noting that this had been the last Committee meeting chaired by Jaki Meekings-Davis. The report was taken as read with the areas for Alert continuing to be achievement of the Financial Sustainability programme and Capital Programme, which was a particular imperative in light of the continued concerns regarding the estate infrastructure. The additional funds from region were noted. **RESOLVED:** The Board NOTED the report for assurance.
21	**Any other business**
	There was no other business before the Board.
22	**Governor observations**
	Andrea Holder, Lead Governor, provided observations on behalf of the attending governor observers commenting in particular on the current uncertainty as to the future role of the governors and the recent positive discussions with the Chair and Katherine Holland, Head of Patient Experience, regarding the planned joint Governor/Non-Executive Director workshop. .

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

ACTIONS/DECISIONS

Item	Action	Lead / Due Date	Update
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	Complete
26/Jan Item 16	A report to PODC on violence and aggression against staff, looking at the effectiveness of the Challenging Behaviour Panel generally and with a specific focus on issues relating to Equality, Diversity and Inclusion (hate crime incidents)	Director for People and OD/PODC	May 2026 board
26/Jan Item 16	A report providing assurance on the management of complaints (long-term delayed responses) to QPC	Medical Director	April 2026
26/Jan Item 16	A report on Duty of Candour compliance to be brought to QPC	Medical Director	April 2026

26/Jan Item 16	A report on the update of employee support programmes/psychological services by staff of sick for mental health reasons	Director for People & OD	April PODC meeting 2026
26/Jan Item 18	A report to PODC on how to capture the outputs and value from the additional investment in staff networks and additional EDI initiatives	Director for People & OD	April PODC 2026

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	12 March 2025
Report title	Chair's Report
Sponsoring Director/Author	Deborah Evans, Trust Chair

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

Executive Summary	
This report gives an update on the activities of the Trust Chair since the last Council of Governors meeting which took place on 4 December 2025.	
Previously considered by	N/A

Recommendations:
*The Board is asked to **NOTE** this report.*

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

Impact on any Strategic Risks?
N/A

Implications on:	
Equality, Diversity and Inclusion	
Health Inequalities	
Finance and Resource	
Regulation/Legal	
CQC-Key line of enquiry	
Green Plan	

Main Report

1. Purpose

This is a brief account of my activities since our last Board meeting in January 2026

2. Thanks

This will be the last Board meeting for John Cappock, one of our Non Executive Directors who is nearing the end of his first term with us. John has served as Audit Committee chair, chair of Finance and Resources Committee and Vice chair and has been instrumental in supporting our drive to improve governance across the organisation.

3. Working together on a future role for Governors

Since the NHS 10 Year Plan was published in July 2025 and announced that “Advanced Foundation Trusts” would not have governors we have been advancing a dialogue about a future role for our valued colleagues who have served as public, staff or stakeholder governors. These discussions have been taking place at the Council of Governors, at the Governor Working Group and at the joint development sessions between Governos and Non-Executive Directors. The consensus in these discussions is that the value of governor’s contribution lies in public and community engagement, in hearing and reflecting patient experience. This fits well with our revised strategy which puts patient experience at the centre of our focus for the future, and which recognises that health inequalities is a golden thread which must run through all our work. In that context we agreed at the last governor working group that with effect from the beginning of April 2026, Governors would not sit as observers on committees. It is also the case that we are moving to a different model, with Quality and Performance committee opting for six business meetings a year with four deep dives / visits. This will provide a new opportunity for governors to be involved in a deeper review and visits to selected services.

It is clear from conversations across the NHS Providers Chairs Group that many other Trusts are proposing to reshape the role of governors as we have described. Some Trusts are having difficulties with quoracy and in ratifying appointments.

4. Visits

My visits have included:

- The official opening of the refurbished Maggies Centre by The Queen, who is the royal patron of Maggies nationally. I had previously also visited the refurbished centre with its chief executive and joined the Maggies Christmas Concert at Christchurch.
- Phlebotomy – I have described in a previous report my visits to the GRH tower block to talk to night duty staff and to ask amongst other things how they reacted to taking patients' blood on night duty. Early in January I attended Edward Jenner clinic and walked around outpatients to see how the new arrangements for taking blood work. This includes that children and young people now have their blood taken in the children's centre which is more age appropriate.
- Interfaces with primary care. I joined colleagues at the integrated flow hub to talk about how effective our interface with primary care is using Cinapsis. I had taken it for granted that this sort of arrangement is functioning well across the country, but it seems that Gloucestershire is highly regarded for the work which primary and secondary care do together to improve how we work together for the benefit of patients. This was reinforced at a meeting I had with our primary care colleagues who run Gdoc and he Gloucestershire Health Access Clinic. They are creating a single voice for GPs across Gloucestershire and in a constructive discussion they were keen to say that they would like to see our Trust involved in an alliance model of creating any future Integrated Health Organisation as the vision for Neighbourhood Health in the NHS 10 Year Plan matures. Our Executive colleagues are keeping closely involved in these developments so that we can play the most constructive role.
- NED / Governor visit to Renal ward and dialysis unit. This was a very informative joint visit which also illustrated the possibilities for working well across the interface with primary care. It was also striking that most Gloucestershire patients who require renal transplant go to Oxford rather than Bristol. This may be about clinical relationships.
- Maternity and Neo Natal Voices Partnership – several of us were invited to the re launch of this local partnership whose role is to engage with women, birthing people and families on our services. It is a very welcome vehicle for co production.
- National Maternity and Neonatal Inquiry – Baroness Amos and her team have been using our Trust as one of 12 sites on which to base their investigation of maternity services. They interviewed mothers and families, colleagues and leaders. I put it to them that there's a risk inherent in ICB Gloucestershire Health Needs Assessment that we paint a polarised choice between choice of birth setting versus increased complexity of care. I believe this is a mistake as a tailored and co produced antenatal and targeted preconception care can support those communities and individuals who go on to experience the poorest outcomes.
- Thanks to our Library Service – who have produced three literature searches for me which I contributed to the ICB for their Health Needs Assessment, and the National Maternity and Neonatal Inquiry. I note that library colleagues, working with Sheema Rahman our Head of Health Inequalities are introducing a Health Literacy component into the PROMPT training which is multidisciplinary training on dealing with obstetric emergencies.
- Care Quality Commission Well Led Inspection. Thanks are due to the Executive, the Divisional leaders and all contributing colleagues, but especially to our corporate governance team. For me the most useful part was the day we all spent together with the Trust Leadership Team, and which is now going to be built into our annual planning round.

FOI: Public

Chief Executive Report to Board – March 2026

1 Patient Experience

1.1 Baroness Amos interim report

The interim report from the Independent Investigation into Maternity and Neonatal Services published at the end of February makes for very difficult reading and reflects many of the challenges in maternity services across the country. It also highlights the experience and lasting impact this has had on families, communities and staff.

The report concludes that maternity and neonatal services in England are not consistently delivering safe, equitable and compassionate care for women, babies, families or staff. The issues identified are systemic, long-standing and national, rather than isolated to individual organisations, and there is evidence of repeated failures to learn and improve when things go wrong.

The report highlights that capacity pressures affect all stages of the maternity and neonatal pathway nationally. This means families can experience long waits, limited time for appointments and poor flow through services, particularly in triage and assessment areas. Staffing shortages in some Trusts have also led to frequent redeployment, disrupting continuity of care, while increasing clinical complexity and fragmented IT systems further increase risk and workload.

The investigation also found that the culture and leadership within maternity services are inconsistent and, in some settings, undermine safety and experience. The report highlights examples of poor teamwork, cultures of blame and fear, variable leadership capability and a failure to address unacceptable behaviour. These issues contribute to low morale, burnout and reduced staff wellbeing.

There is significant concern about the high levels of racism and discrimination which are described as persistent and systemic, contributing directly to unequal outcomes. Black and Asian women and babies face significantly higher risks of harm, with deprivation compounding inequalities. Discrimination also affects disabled people, LGBTQ+ families, young parents and those needing interpretation, while staff report experiencing racism with limited organisational response.

Families' experiences when things go wrong were a major concern. The report identifies a lack of compassion, openness and involvement following harm or bereavement, variable quality investigations and limited evidence of learning or improvement. Many families are left without clear answers or a sense of accountability.

The quality of maternity and neonatal estates varies widely and can undermine safety, dignity and family-centred care. Outdated or poorly designed environments affect privacy, infection control, partner involvement and bereavement care, with a negative impact on both families and staff.
Workforce challenges underpin many of these issues. Despite meeting some staffing benchmarks, some services often feel unsafe in practice due to vacancies, turnover, skill-mix issues and inconsistent senior clinical cover, particularly out of hours.

A number of the issues described in the report are recognised locally and continue to be a key focus of our improvement work, and although we continue to make progress there is further to go (progress is described in our maternity report).

The next phase of the investigation will produce a single set of national recommendations, followed by a National Maternity and Neonatal Taskforce to oversee delivery of a national action plan aimed at addressing the structural issues that are contributing to poor care. A localised report is also expected.

1.2 Phlebotomy Industrial Action

For almost a year the Trust has experienced a strike from phlebotomy staff over pay and in that period we have sought to work constructively with UNISON and our phlebotomy representatives to find a way to resolve the ongoing dispute.

A year is too long. This must not become about records but about resolution, and it must be about our patients. We want to welcome our phlebotomy colleagues back to work to support patients.

Over the 12 months the Trust has made numerous offers and concessions to try to break the deadlock. These have been fair, proportionate and appropriate, and deliberately designed so they do not create knock-on impacts for wider staff groups or services across the organisation.

Unfortunately, at every stage, these offers have been rejected.

Since July 2025, we have proposed that we jointly commission an independent national Job Evaluation Panel to determine the correct banding of the role, in line with the nationally agreed rules and processes between trade unions and NHS employers.

That independent route is designed specifically for disputes like this, and we have been clear we will be bound by the outcome. Alongside this, we have also put forward options to help bring the dispute to an end, including a new Band 3 role offer.

In January, the phlebotomists rejected the two options that they had help shape and agreed they wanted to ballot on, to help end the strike.

Instead, Unison and Phlebotomist asked the Trust re-band the roles to Band 3 without going through any job evaluation process, provide five years of back pay and make no changes to phlebotomy roles or services for a minimum of 24 months. This is outside of any normal process that governs and protects the pay or terms and conditions for all NHS staff.

As a direct consequence of the prolonged strike action, the Trust has had to adapt how blood tests are taken and processed across our hospitals.

These changes were made to maintain patient care, and they have also delivered real and measurable improvements for patients, including:

- Earlier and faster blood sampling
- Faster turnaround of results
- Earlier discharge from hospital
- Improved patient flow
- Improved waiting areas for patients
- Improved clinic space for Phlebotomy clinics

These improvements are now benefiting more patients every day. They are helping people receive care sooner and supporting safer, more efficient hospital stays. It is important that we do not lose the positive progress that has been made for patients, or compromise the quality of care people are now receiving.

The Trust has negotiated in good faith throughout the past year and continues to seek a way forward that is fair to all, including the rest of the workforce.

However, the union and phlebotomy representatives have been unwilling to compromise or to follow the nationally agreed processes that exist specifically to resolve disputes of this nature. Those processes are designed to provide objectivity, fairness and confidence for all parties.

It is not appropriate to step outside national job evaluation, pay and workforce frameworks, nor to agree conditions that would restrict the Trust's ability to improve services for patients.

1.3 Tackling abuse and harassment of staff

On 20 January 2026, a Gloucestershire resident was given an 18-month suspended prison sentence and an indefinite restraining order after pleading guilty to charges of stalking NHS and care staff.

This marks an important step forward after years of targeted and sustained stalking and online harassment through a number of social media accounts, directed at NHS staff across Gloucestershire.

Our colleagues come to work to care for others, and they have the right to feel safe and free from harassment. The prolonged online abuse they experienced has caused deep and lasting personal and professional harm.

We are grateful to Gloucestershire Police and the Crown Prosecution Service for their support in bringing this long-running targeted behaviour to an end. Their commitment has ensured that this abuse has been taken seriously and in keeping staff feeling safe.

We would also like to thank the colleagues who spoke up and provided information to support the investigation. We will always stand by and support our colleagues. Harassment, intimidation, stalking, and abuse, online or in person, will never be accepted.

As an action we are seeking to develop our own Trust wide anti-stalking policy to protect staff.

1.4 Chief Officer appointments to new ICB Cluster

At the end of January the new executive team for the NHS Gloucestershire and NHS Bristol, North Somerset and South Gloucestershire ICBs cluster was announced and includes:

- Chief Clinical Leadership and Delivery Officer (Nursing) – Rosi Shepherd
- Chief Clinical Leadership and Delivery Officer (Medical) – Dr Ananthakrishnan Raghuram MBE
- Chief Finance and Corporate Services Officer – Cath Leech
- Chief Population Health Improvement Officer – Dr Joanne Medhurst
- Chief Transformation, Organisational Development and People Officer – Jo Hicks
- Chief Strategic Commissioning Officer – David Jarrett

This is an important next step in the development of the new ICB as a strategic commissioner and over the coming months there will be further work on the transition including developing the structures and supporting partners on local service priorities and strategic plans to transform the NHS over the longer term in line with the 10-year health plan.

The new ICB remains fully committed to place-based working, which will be integral to supporting a greater shift to prevention and development of community services across Gloucestershire, Bristol, North Somerset and South Gloucestershire.

As further details and local plans emerge we will update the Board.

1.5 Organ Donation

In January 2026 the National Organ Donation Joint Working Group (ODJWG) published an extensive review of the current challenges and future opportunities for organ donation across the UK. Over 8,000 people are currently waiting for a transplant across the UK, and one person dies every day due to the shortage of available organs.

Nationally, consent and authorisation rates have fallen to 59%, down from 68% pre-pandemic, with an 18% reduction in the pool of potential donors. These trends have contributed to the highest ever number of people waiting for a transplant, highlighting the urgent need for renewed societal engagement, clearer communication, and a stronger clinical environment to support organ donation conversations.

The review concludes that although public support for organ donation remains consistently high, action does not yet match sentiment. A bold change is required, one that strengthens the national organ donation brand separate to NHS Blood and Transplant (learning from Spain and Australia), expand public education (including in schools), and simplifies the family approach during end-of-life care. The clinical recommendations focus on embedding Specialist Nurses for Organ Donation within NHS Trust, something Gloucestershire has been involved in for a number of years.

Locally, Gloucestershire is already responding to the national call for greater engagement and community awareness. In early January, the Trust launched a recruitment campaign inviting volunteers to support the work of the Gloucestershire Organ Donation Committee.

This generated an exceptional level of interest, with 17 people signing up to join the Committee, reflecting the strong local commitment to organ and tissue donation. Volunteers will support the Trust in raising awareness in schools, community groups and at public events, encouraging conversations about organ donation and promoting the gift of life.

Through our local community engagement there is a clear opportunity for the county to contribute to the wider national ambition, ensuring more people record their decision, supporting families during donation discussions, and ultimately helping to save more lives.

2. People, Culture and Leadership

2.1 Nursing pay and career progression

In February the Government announced a significant review and proposed reforms to address long-standing concerns around nursing pay, role recognition and career progression in England

Following lengthy engagement with the Royal College of Nursing (RCN), the reforms will prioritise graduate pay, establishes the first national framework for nursing preceptorship, and introduce a comprehensive review of all Band 5 roles to ensure that pay and job descriptions reflect the work nurses are actually undertaking.

Nationally and locally this will mean that all Band 5 nurses will undergo formal job evaluation, and reflect acknowledgement by the Department of Health and Social Care that many nurses have been working at higher levels over many years without appropriate compensation. Additional funding will be allocated to support the reforms and expected salary changes for those affected.

This will require careful planning locally as more guidance is issued.

2.2 Faith, Culture and Community: Ramadan, Lent and Chinese New Year

Tuesday 17 February marked the beginning of Ramadan, a sacred month observed by many of our Muslim colleagues and communities. This year is particularly notable as Ramadan aligns closely with the start of Lent, which began on Wednesday 18 February, a rare moment in which members of different faith traditions enter parallel periods of fasting, reflection and spiritual focus.

In addition, Chinese New Year also begins on 17 February, welcoming the Year of the Horse, offering another opportunity for cultural celebration and recognition across our hospitals.

To support colleagues and patients who may be fasting during this period, helpful guidance is available on our websites, included practical advice on flexibility, health considerations, and ways teams can ensure colleagues feel supported and included.

As in previous years, the Trust hosted its popular Iftar gatherings at both hospitals, bringing colleagues together to break the fast at sunset. New for 2026, we are introducing a ‘pay it forward’ initiative, enabling staff to donate the cost of an Iftar meal through the Hospitals Charity so that more colleagues can take part regardless of personal circumstances.

These overlapping cultural and spiritual occasions of Ramadan, Lent and Chinese New Year, provide a meaningful opportunity for us to reaffirm our commitment to being an inclusive, compassionate organisation. They also offer moments for shared understanding, celebration and togetherness across our diverse workforce.

3 Quality, Safety and Delivery

3.1 Home Birth

The Trust took the decision to temporarily suspend the home birth service in November 2025 following concerns raised by midwives about safety. Around the same time were a number of high-profile national cases, including a Coroner’s Prevention of Future Deaths Order, following the tragic death of a mother and baby during a home birth in Manchester. NHS England then wrote to all Trusts asking them to urgently review the safety and quality of home birth provision.

Home births account for less than 2% of births (around 4-6 home births per month) in Gloucestershire and are intended for low-risk deliveries, but when complications arise, it can become unsafe for both mother and baby.

Following the decision to temporarily suspend home birth, judicial review proceedings were initiated by a number of claimants, who raised concerns about the process followed by the Trust in implementing the change. In particular, the application sought to test whether the Trust had complied with its public involvement and consultation duties when taking the decision, and whether sufficient assurance had been provided regarding plans for the safe reinstatement of the service.

There is a provision in legislation that allows NHS organisations to change or suspend a service, without allowing time for consultation with the relevant local authority, where they are genuinely satisfied there is an imminent risk to the safety or welfare of patients or staff. This is outlined in Section 23(2) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The judicial review applications against the Trust has now been withdrawn for the time being pending further information and engagement requested by the claimants. We continue to explore all avenues for how to reinstate the service in a way that is safe for women, babies and our staff.

3.2 Bone cement supply disruption

In mid-February there was significant national and global supply disruption of specific bone cement products manufactured by Heraeus Medical. Initially, the disruption was expected to cause delays to elective joint replacement procedures for some weeks and some elective procedures have

already been postponed as a result. However, alternative supply arrangements are now emerging and appear promising, meaning that the overall level of disruption may be more limited than first anticipated.

Bone cement is a critical component in both trauma and elective orthopaedic procedures, particularly hip and knee replacements and complex revision surgery. National clinical guidance has required remaining stock to be prioritised for patients with the most urgent clinical need, including hip fracture trauma, urgent cancer-related orthopaedic surgery, infected joints and complex revision procedures that cannot safely be delayed. Urgent and emergency procedures continue to be prioritised.

As a result, a total of 78 planned operations were postponed and are now being rescheduled. Our surgical teams continue to review cases and have been contacting patients, to keep them informed and plan next steps. Urgent and emergency care continued as normal, and other planned operations and outpatient activity outside orthopaedics were not been affected.

3.3 New service development - Robotic Waterjet Ablation, Urology Care

The Trust has continued to advance its urology services, based at Cheltenham General Hospital, through the use of robotically-assisted Aquablation therapy, a heat-free, high-precision surgical technique for treating benign prostatic hyperplasia (BPH).

The AquaBeam Robotic System employs a high-pressure waterjet guided by real-time imaging and planning software, enabling targeted removal of prostate tissue while preserving continence and sexual function. This minimally invasive approach offers predictable procedure timings, shorter recovery periods and a safer alternative to traditional methods, which can involve greater variability and higher risk of complications.

In December 2025, the Trust achieved a UK first by successfully treating seven patients in a single operating session, all as day cases. This demonstrates both the efficiency and scalability of the technology, supporting the Trust's ongoing efforts to manage waiting lists and improve elective throughput.

The expansion of Aquablation capability reflects the Trust's ambition in innovative urological care. The ability to deliver multiple high-quality procedures in a single session, combined with opportunities for surgical training, strengthens the Trust's work in minimally invasive treatment pathways and contributes to improved outcomes and patient experience

4 Regulatory

4.1 CQC Well-led inspection

Between 10 and 12 February, the Care Quality Commission (CQC) undertook a Trust-wide Well-Led inspection, as part of the new Single Assessment Framework. This formed the first full assessment of our Well-Led domain since 2022 and the updated national approach came into effect.

The inspection focused on leadership, governance, culture, risk management and the extent to which the organisation demonstrates safe, inclusive and compassionate leadership from *ward to Board*. Preparation for this visit was coordinated through the Integrated Governance Team, with Divisions completing detailed self-assessments, evidence collation and interview preparation.

The feedback from CQC provided early insights, reflecting strong engagement from colleagues and examples of improvement work, including stabilising leadership, resetting culture, strengthening governance and improving operational resilience.

They also highlighted areas where the Trust needs to better articulate impact, strengthen cross-divisional working, and demonstrate how risks and learning are systematically acted upon and "closed-off." These discussions reinforced the importance of evidencing our improvement journey, particularly in relation to winter planning, operational resilience and staff experience.

The Trust is also awaiting a number of other reports, following separate CQC Inspections of maternity services at Gloucestershire Royal Hospital and Stroud Maternity Hospital in September 2025. The CQC also undertook unannounced inspections of Urgent and Emergency Care and Medical Care on 8 and 9 December 2025.

4.2 Proposals for local government reorganisation in Gloucestershire

The Government has launched a public consultation on the reorganisation of local government in Gloucestershire, following submissions made by the county's councils.

The consultation, published on 5 February 2026 and open until 26 March 2026, seeks views on proposals that aim to simplify governance arrangements and improve the efficiency, accountability and coherence of local services across the county.

Three structural options have been developed by Gloucestershire's seven councils for consideration:

- A single county-wide unitary authority, replacing the existing county and six district councils;
- An East/West two-unitary model, splitting the county into East Gloucestershire (Cheltenham, Tewkesbury, Cotswolds) and West Gloucestershire (Gloucester, Forest of Dean, Stroud);
- A Greater Gloucester model, creating an expanded Gloucester City unitary with a second authority covering the rest of the county.

The reforms sit within the Government's broader devolution plans, which aim to streamline two-tier areas of England and ultimately create a more standardised landscape of principal unitary authorities working alongside regional mayoral structures.

More information and how to respond to the proposals can be found on the County Council website: Proposals for local government reorganisation in Gloucestershire

As a consultee we have formally been asked to respond to the consultation which is in process, and aligns with the previous submission for health indicating a preference for a single unitary model.

Kevin McNamara
Chief Executive

Report to Board of Directors

Date of Meeting	12 March 2026
Report title	*CQC Section 31 Report*
Sponsoring Director/Author	*Matt Holdaway - Chief Nurse and Director of Quality* *Suzie Cro – Director of Quality Governance*

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

Executive Summary

Executive summary

1.1. The Trust has **self-assessed all eight CQC conditions as *fully met and sustainably embedded***, with strong evidence to support this assertion:

ASSURE – What the data shows and why confidence is warranted

- **All conditions show sustained compliance trends**, some for more than 12 months.
- **Risk assessment processes** (PPH, VTE and Fetal monitoring) are consistently performing at or above required thresholds.
- **Escalation processes** for CTG and early warning scores show high reliability.
- **Structured QI methodologies** (SMART aims, QI plans-on-a-page, SPC monitoring) are consistently applied across work streams.
- **Governance maturity has strengthened** significantly, with clear lines of accountability from point of care to Board.
- **External assurance structures** (ICB Extended Oversight Group, LMNS, maternity safety champions) have received reports with **no escalations raised** in the most recent cycles.
- Collectively, the data and governance evidence provide **a high level of assurance** that risks have been addressed, controls are effective, and improvements are sustainable.

APPLAUD – What Is Working Exceptionally Well
The Trust Board and regulator should note the following **exemplary areas of performance**:

- **Sustained achievement of all eight CQC conditions**, demonstrating embedded cultural and operational change.
- **Executive and Board oversight is strong**, consistent, and proactive, with clear evidence of grip.
- **High compliance (near 100%)** in key safety-critical standards:
    - VTE risk assessment
    - CTG escalation
    - PPH risk assessment
    - Intrapartum PPH risk assessment
- **Reduction in agency midwifery usage**, paired with a safe and structured induction system that improves continuity and quality.
- **Rapid adoption of national policy changes**—the Trust is ahead of schedule in preparing for national Maternal Early Warning Score (MEWS) and the NHSE Maternal Care Bundle elements.
- **Robust multidisciplinary collaboration**, particularly in PPH MDT reviews, VTE, fetal monitoring improvement, and governance teams.

In conclusion
These achievements demonstrate a **well-led, learning perinatal service, and organisation,** that is prioritising quality, safety, and continuous improvement.

Previously considered by	*Previous Reports reviewed by Quality and Performance Committee*

Recommendations:
The board are asked to: Note the report

Strategic Aims (tick as appropriate)	
Patient experience and voice	

People, culture and leadership	
Quality, safety and delivery	x
Digital first	

Impact on any Strategic Risks?

Inability to deliver safe and effective services against regulatory and statutory requirements

Implications on:	
Equality, Diversity and Inclusion	*No EQIA completed*
Health Inequalities	
Finance and Resource	*Brief narrative – impact on financial performance/sustainability and how report impacts*
Regulation/Legal	*Brief narrative e.g. The report ensures compliance with XX, demonstrating Trust adherence to regulatory expectations etc..*
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…*
Green Plan	*Brief narrative – direct or indirect impact, if any*

Main Report

2. Purpose of the report

2.1. The purpose of this report is to summarise the steps taken to eliminate immediate risk with respect to each point in the CQC Section 31 letter dated 9 May 2024. It also provides an update on the detailed plans we have put in place to ensure sustained improvement and to provide detail on how we have worked towards compliance in the all the areas highlighted within the enforcement notice.

2.2. In summary, the CQC have imposed the following conditions in Maternity.

The service must:

- 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**).
- Ensure maternity staff at Gloucestershire Royal Hospital complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in line with national guidance.
- 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.
- 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 and postnatal care.
- Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.
- 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**.

2.3. The CQC has requested sight of reports written to provide assurance to the senior leadership and/or Board of Directors. This report has been written to provide both CQC and the Trust Board of assurance on progress. After this report has been submitted to CQC each month this report will be received by Trust Board and the Quality and Performance Committee (Q&PC) (sub board) and the Perinatal (Maternity) Delivery Group (executive led).

2.4. This is an outline of the reporting schedule to CQC:

Dates due	Update
29 May 2024	– complete
28 June 2024	– complete
31 July 2024	– complete
30 August 2024	– complete
27 September 2024	– complete
30 October 2024	– complete
29 November 2024	– complete
~~31 December 2024~~ 8 January 2025	– complete
31 January 2025	– complete
28 February 2025	– complete
31 March 2025	– complete
30 April 2025	– complete
30 May 2025	– complete
30 June 2025	– complete
31 July 2025	– complete
29 August 2025	– complete
30 September 2025	– complete
31 October 2025	– complete
28 November 2025	– complete
~~31 December 2025~~ 9 January 2026	– complete
30 January 2026	– complete
27 February 2026	This report

3. Executive Summary

Continuing our improvement response actions

3.1. The Trust has continued to **respond to the issues/conditions** outlined within the CQC Section 31 enforcement letter and is actively taking actions to improve Maternity Services in order to ensure care is of an appropriate standard and people are not at risk.

3.2. Impact Assessment

3.3. Our improvement work continues to deliver measurable progress across key maternity safety areas.

3.4. Postpartum Haemorrhage (PPH)
We have embedded continuous PPH risk assessment throughout antenatal and intrapartum care, enabling earlier identification, better preparation, and timely intervention to reduce maternal harm. Use of the REDUCE checklist supports consistent practice during “high-pressure” situations. We will align this work with Element 5 of the newly published NHSE Maternal Care Bundle (national date set for implementation is by March 2027).

3.5. Venous Thromboembolism (VTE)
Risk assessment compliance remains above target (>95%), ensuring high-risk women receive timely thromboprophylaxis and reducing the likelihood of pulmonary embolism and maternal death. This programme will be further strengthened through implementation of Element 1 of the NHSE Maternal Care Bundle (national date set for implementation is by March 2027).

3.6. Electronic Fetal Monitoring (EFM)
Peer review compliance averages 90% (target 85%), supporting accurate and consistent interpretation of fetal heart rate monitoring. CTG interpretation accuracy is 90%, with escalation compliance at 95%, ensuring timely senior input and reducing the risk of adverse outcomes.

3.7. Agency Midwives
Use of agency staff has reduced, and those working with us now receive structured support to ensure safe and effective practice.

3.8. Maternal Early Warning Scores (MOEWS)
MOEWS continues to support early recognition of clinical deterioration. Monitoring of vital signs and physiological parameters enables timely escalation and improved safety for women requiring urgent care.

3.9. Our **5-key quality improvement work streams** continue to enact changes and improvements that will keep mothers, babies and birthing people safe. The next table summarises the compliance with the condition with key data, any actions taken and next steps.

3.10. Please note:

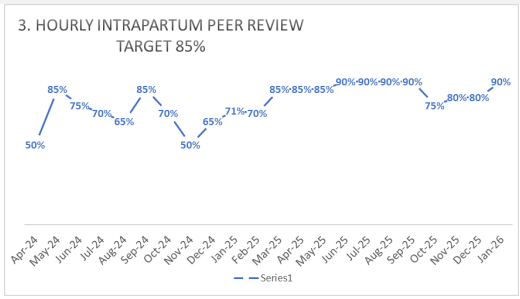
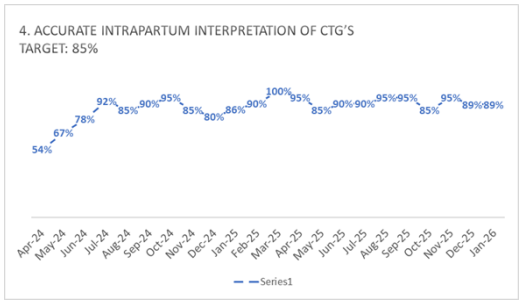
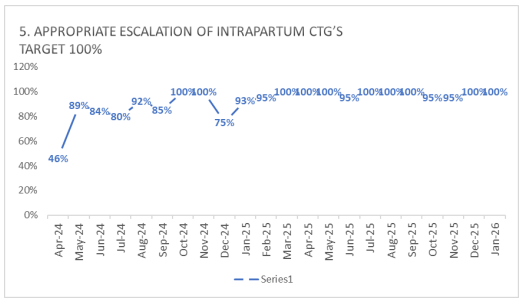
- We have rated all 8 conditions (self-assessed) as blue (complete and compliance sustained).

Table: Trust summary of position against CQC conditions

Position	Self-assessment	Total 8
Conditions met	Fully met and sustained	8

Table: Brief summary of metrics and targets

Condition	Condition description	Met/ not met	Focus
1.	**Implement** an effective system for ensuring staff at Gloucestershire Royal Hospital **continually risk assess and manage the risk of post-partum haemorrhage (PPH) and potential major obstetric haemorrhage (MOH**).	Met	**Risk assessment** – The general risk assessment at booking covers all the risk factors for PPH and completion rates are 100%. – 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 the obstetric theatres. - Continue work to implement the newly published NHSE **Maternal Care Bundle** (by March 2027) – element 5. - Closely monitor PPH rates for 1.5L and continue with case reviews.
2.	Ensure maternity staff at Gloucestershire Royal Hospital complete **hourly peer reviews (also known as 'fresh eyes')** during intrapartum care in	Met	Hourly peer reviews continued at 80% (target 85%). Actions are being taken to improve performance. Graph: Peer reviews

Condition	Condition description	Met/ not met	Focus
	line with national guidance.		
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	Graph: Accurate interpretation (target 90%)  Graph: Escalation 100% (target 100%) 
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	Met	We have paused auditing from next month so that teams can focus on new Maternal Early Warning Scores (MEWS) implementation. **Next steps** New national maternal early warning score system being implemented in March 2026.

Condition	Condition description	Met/ not met	Focus
	national guidance during intrapartum and postnatal care.		**Alert** – when testing it has been recognised by the Matron/Leads and digital teams that within the new MEWS the high dependency charts and postnatal charts have errors and this has been flagged to the regional team and System C (Badgernet).
5.	Implement an effective system for ensuring staff **complete venous thromboembolism (VTE) risk assessments**.	Met	Audit deferred until February 2026 due to National Maternity Investigation data collection. Guideline awaiting approval (Policy VTE M2014). 100% VTE risk assessment being completed in Jan 2026 and so plan is to review 6 monthly when this is approved at the Antenatal Forum. <u>Next steps</u> Implement the newly published Maternal Care Bundle (by March 2027) – element 1. Our first audits are being collated for this bundle.
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 was received by the Quality and Performance Committee in November 2025 and is next due in May 2026.
7 & 8	Monthly reports (to include PPH and	Met	Monthly reports have been submitted to CQC, Trust Board, PDG and Q&P

Condition	Condition description	Met/ not met	Focus
	Fetal Monitoring QI plan) Dashboard		with the Perinatal dashboard demonstrating compliance. Progress is reported within the Division in the Perinatal Quality Surveillance Report.

4. Quality Improvement Updates

Safety and effectiveness of Postpartum haemorrhage (PPH) and Massive Obstetric Haemorrhage (MOH) risk assessments and management

Issues in summary

Postpartum haemorrhage and Massive Obstetric Haemorrhage	Risk assessment and management of PPH/MOH

Continuing our improvement response

4.1. The PPH Team Leads are a Consultant Obstetrician (Labour Ward Lead), Labour Ward Matron, an Obstetric Anaesthetic Lead and the Education and Training Lead.

Where do we want to be?

4.2. The Team PPH identified 2 Specific, Measurable, Achievable, Relevant, time based (SMART) aims with a number of process metrics (risk assessment and management using the reduce checklist).

QI SMART Aim

1. To maintain the rate of PPH >1500ml to below the national average of 32 per 1000 deliveries
2. To maintain the PPH rate of 500-999ml to below 250 per 1000 deliveries

Prevention and management of PPH

4.3. Providing safe, quality, compassionate care is important to the Maternity Service. The Trust have in place the **Management of PPH Guidelines** (M1042 review date March 2026) to provide guidance to staff to risk assess and manage PPH. The guideline is currently being reviewed and updated. This work will be completed before the end of March 2026 and was presented to the Intrapartum Forum for comments.

4.4. On 6 January 2026, a new Maternal Care Bundle was released by NHS England and element 5 is the management of obstetric haemorrhage. The PPH Team are carrying out a gap analysis against the recommendations and are developing an action plan to ensure that all elements are introduced (with a target date of March 2027).

4.5. **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. The Reduce Checklist (stepwise management) continues to be

used in practice and completion rates average 85% in the last 3 months (target 85-90%).

Graph: Step wise management compliance
(Orange = stepwise and grey=risk assessment)

Risk assessment compliance – process metrics

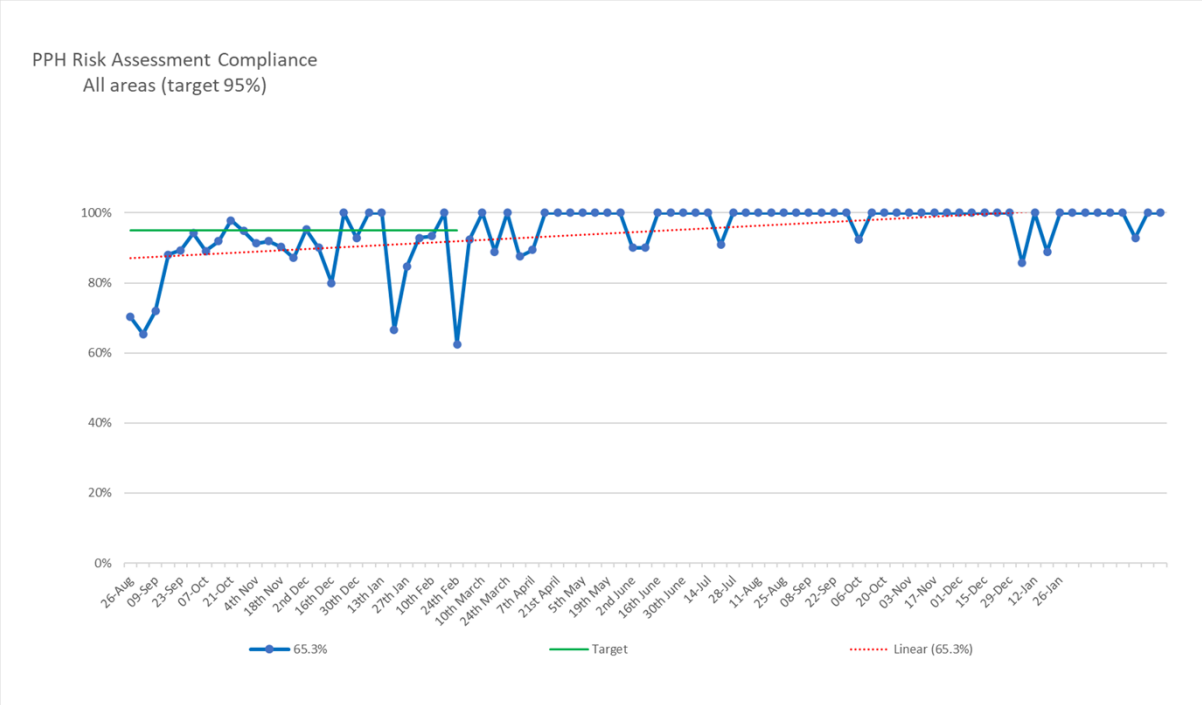
4.6. Risk assessments

4.7. Team PPH have oversight of compliance with systems for risk assessment and report to the Intrapartum Forum.

4.8. The completion of the general risk assessment at booking continues to have high compliance (100%).

4.9. The on-admission risk assessment average is 97% (target 95%).

Graph: on admission risk assessment



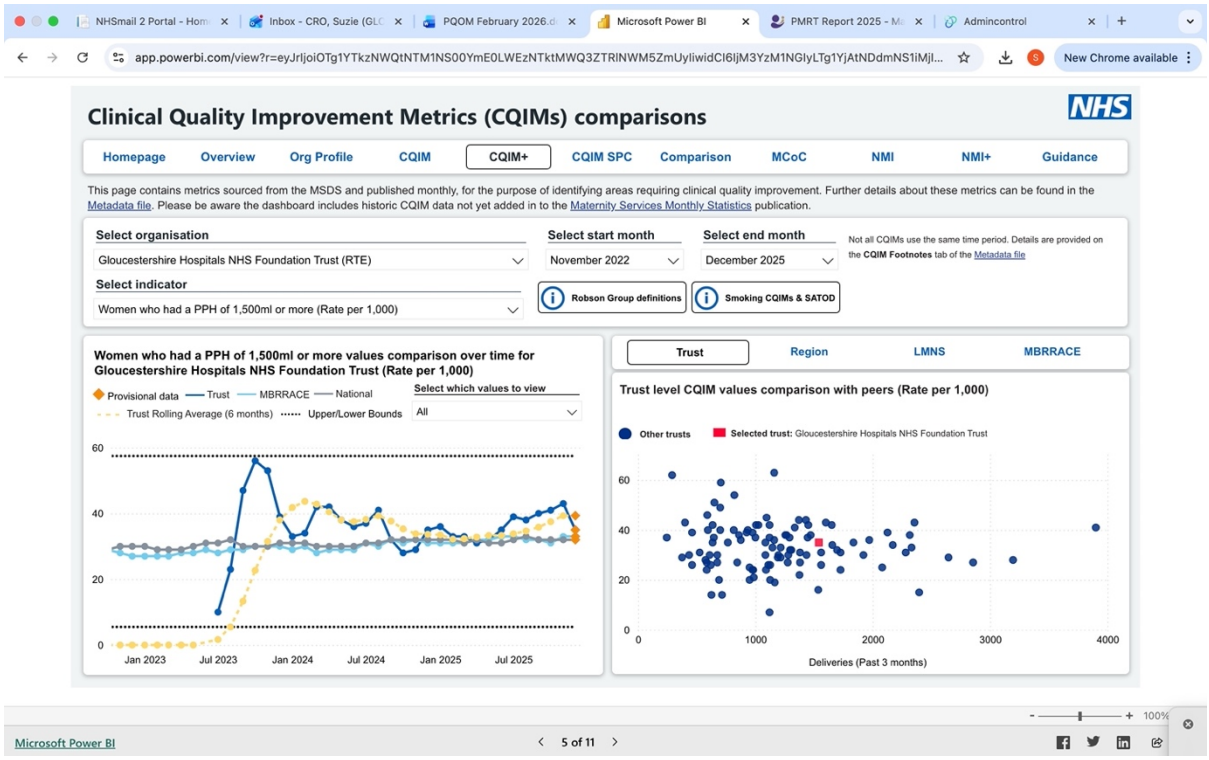
4.10. Outcome metrics

4.11. **CQUIMs – The latest** National Data was published and this demonstrates that our PPH rate for the CQIM metric is just above national average.

NB: The national data and the Trust data are aggregated slightly differently.

CQIMs Data	March 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2026
National	31	32	31	32	32	32	32	32	32	32
Trust data	33	31	32	35	39	38	40	41 37.5 = 6 month rolling average	43 39.33 = 6 monthly rolling average	35 39.33

Graph: Maternity National Database CQUIM data December 2025

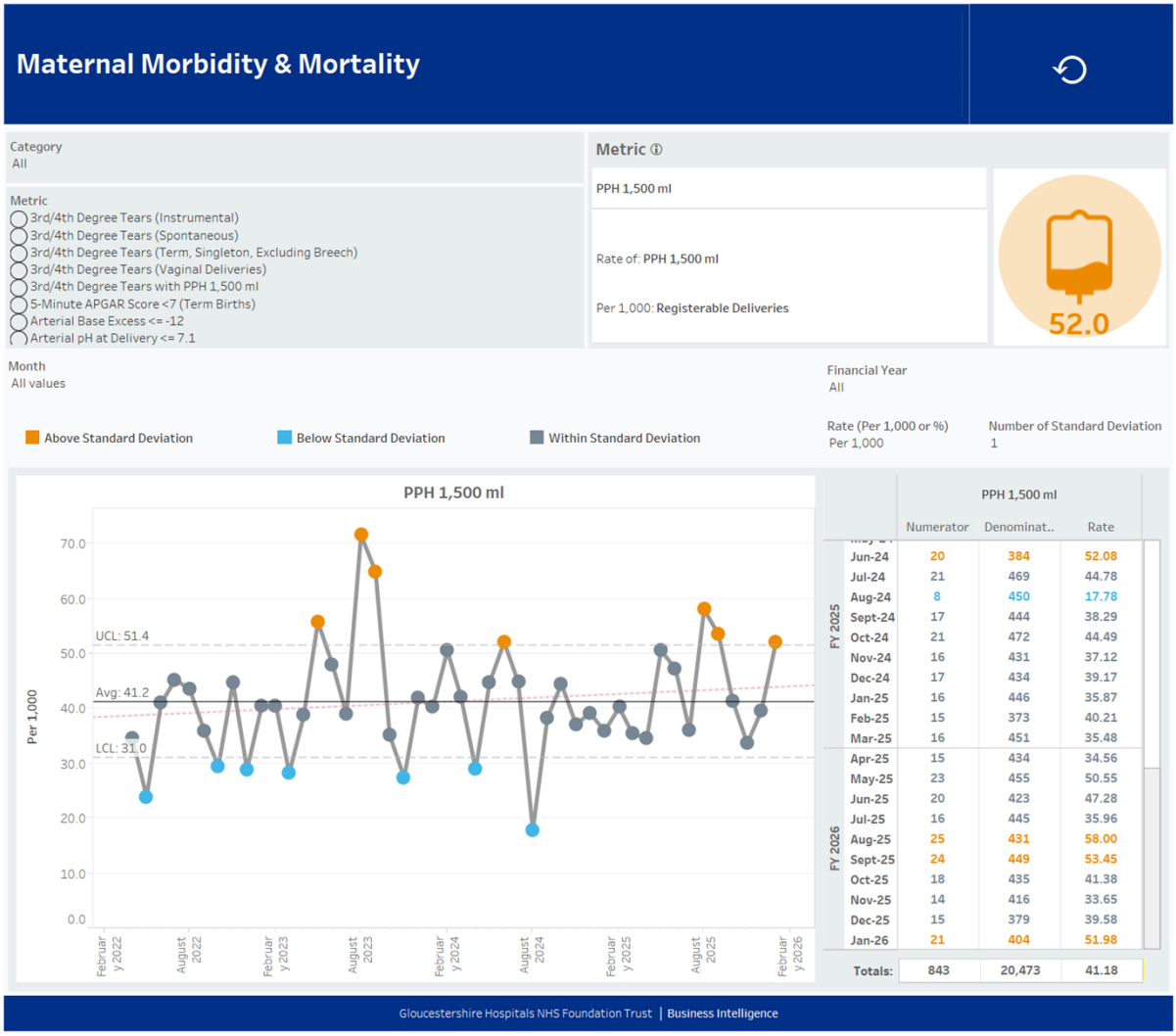


Trust data

4.12. The Team are continuing to review themes to see if any additional actions need to be taken.

Trust data	March 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Trust data	35.5	39.2	50.5	47.0	36.0	57.9	53.5	41.4	33.7	39.6	52.0

Graph: PPH 1.5L per 1000 deliveries



4.13. All the latest Trust data is within the dashboard that has been provided at appendix 1 (separate document).

Plan for audit

4.14. Cases where there is a concern voiced by the reporter are reported onto Datix as a safety incident.

4.15. Blood loss over 2.5L are to be scoped by Patient Safety Midwife using PPH Form, and then to flag for multidisciplinary (MDT) scoping if necessary.

4.16. Team PPH will review a sample of each 'band' each month to look at themes:

10 cases PPH 500-999ml
10 PPH 1-1.49L
5 cases of MOH over 1.5L

<u>Maternal Care Bundle (MCB) - Element 5: Obstetric haemorrhage</u>

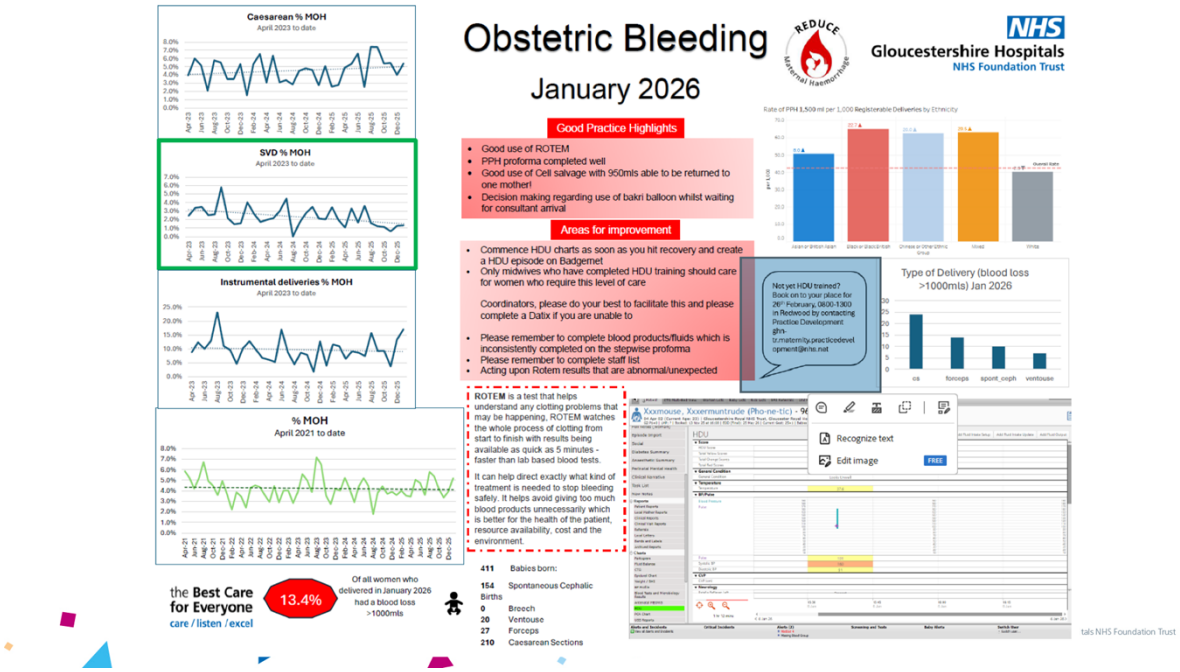
4.17. **"**5.3 Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month"

4.18. We have started this and have a separate meeting with the Reduce Team and Perinatal Governance Team to carry out PSIRF Multiprofessional Reviews.

Patient experience

4.19. The Team are working with the Maternity and Neonatal Voices Partnership with the aim to send out a survey to women. This has been paused until the new MNVP are ready and fully established.

Progress report and next steps as reported to the Intrapartum Forum



Fetal monitoring peer reviews, accurate assessment and timely escalation of concerns

Issues

Fetal monitoring	– Peer reviews – Accurate interpretation of electronic fetal monitoring, – Escalation of concerns

4.20. Continuing our improvement response

4.21. The Team Leads are a Consultant Obstetrician (Fetal Monitoring Lead), Labour Ward Matron and the Fetal Monitoring Midwife.

4.22. The QI Team have completed a QI plan on a page.

4.23. The Fetal Monitoring team identified SMART aims:

SMART AIM

To audit whether staff are identifying and escalating fetal compromise effectively and addressing any issues found, sharing learning and providing assurance.

Targets –

- To maintain our hourly peer review rate at 85% during intrapartum care
- To maintain initial intrapartum risk assessment at 90-95%
- To maintain hourly risk assessment at 85%
- To maintain the accurate interpretation of CTGs at 85% (escalated appropriately for their interpretation)

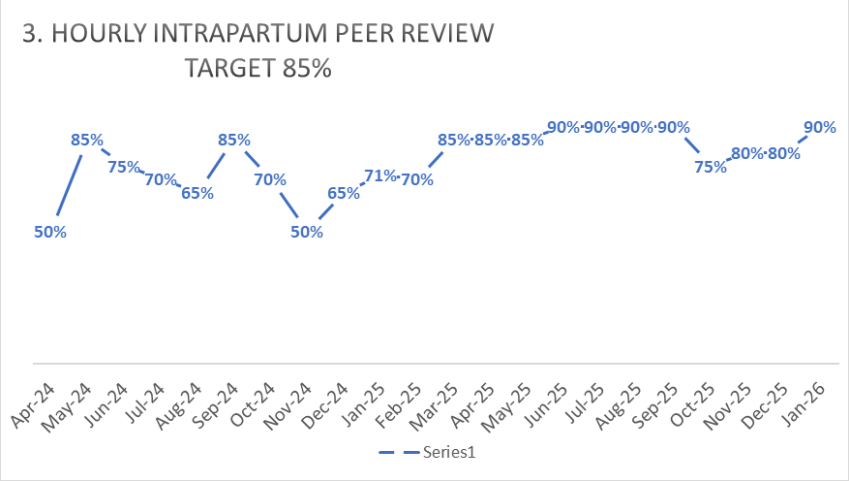
4.24. Audit and measurement plan

4.25. This month saw an improvement in 2 metrics back to target. There is continued improvement work ongoing as reported to the Intrapartum Forum.

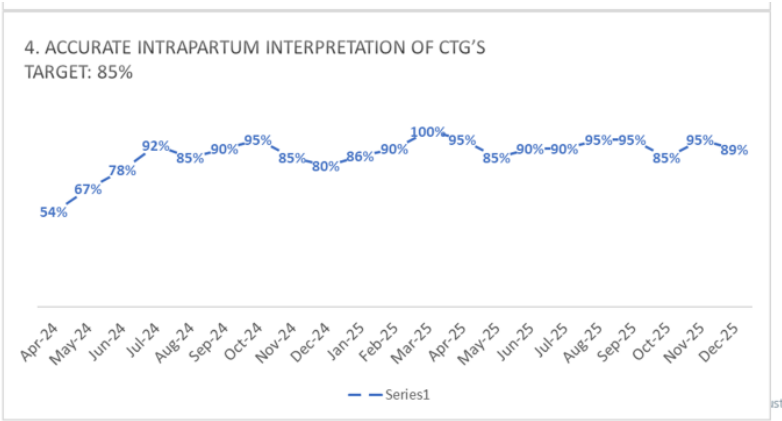
Issue	May 2025	June 2025	July 2025	August 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Target
Intrapartum risk assessment on admission	100%	90%	100%	100%	100%	90%	95%	95%	100%	Target 90-95%

Issue	May 2025	June 2025	July 2025	August 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Target
Hourly risk assessment	90%	85%	80%	90%	85%	65%	80%	90%	85%	Target 85%
Hourly peer review	85%	90%	90%	90%	90%	75%	80%	80%	90%	Target 85%
Accurate assessment	85%	85%	90%	95%	95%	85%	95%	89%	89%	Target 90%
Escalation	95%	90%	100%	100%	100%	95%	95%	100%	100%	Target 100%
Total mean of hourly intrapartum peer reviews	96%	94%	96%	98%	94%	95%	95%	99%	97%	Target 85%

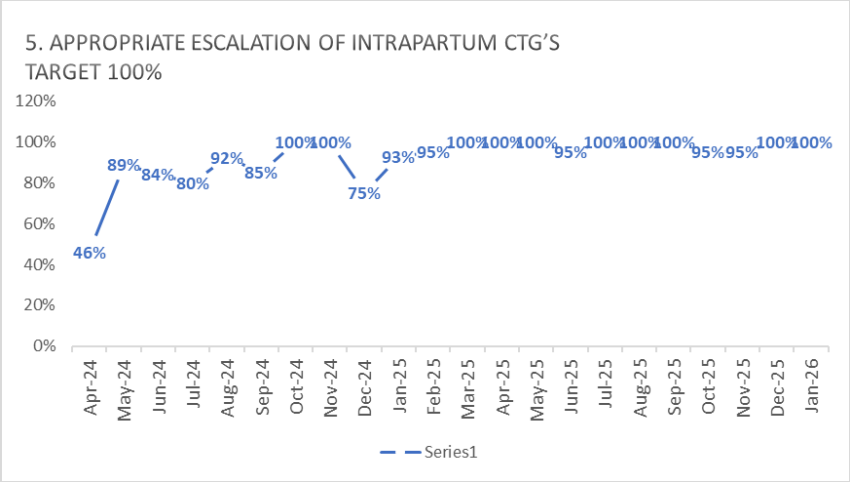
Graph: Hourly peer reviews (target 85%)



Graph: Accurate interpretation (target 90%)



Graph: Escalation 100% (target 100%)



Progress Report to the Intrapartum Forum for progress on the fetal monitoring guideline update

Action plan for NG229 to update Trust Guideline

(Following conversation with Rebecca Evans-Jones and K Harrison)

- N22: 2nd stage of labour – how to carry out IA
- N33: Information sharing with women re Fetal Monitoring in the AN period – Leaflet and video
- N40: GDM diet control monitoring in labour IA vs CEFM – REJ taking it to consultant meeting today
- N47: Increased surveillance in 2nd stage of labour → Introducing 30minly FMLRV in 2nd stage of labour
- N50: Guidance on CEFM around ARM for IOL
- N52: Meconium-stained liquor – "Mec is mec principle"
- N86: Add details of concerning characteristics of decels to GL
- N88: The main change in CTG classification – update trust GL word by word

Excel with detailed information being circulated

Temporary workforce (agency midwives) experience

Issues

Temporary workforce (agency)	– Induction – Support – Access to the unit – Access to Trust Policies – Access to BadgerNet – Access blood test results system

4.26. Continuing our improvement response

4.27. The Team Leads are the Head of Midwifery and the Maternity Recruitment and Retention Project Lead.

4.28. The Team completed a QI plan on a page. The Temporary Workforce Improvement Team identified a SMART aim and that aim has been met as all staff must complete an induction prior to booking a shift.

SMART AIM:

To improve the orientation, induction and access experience of Agency Midwives with the Flow Midwife holding a meet and greet, to organise access and talk through induction pack.

Governance

4.29. The service continues to monitor bank and agency usage on a monthly basis.

4.30. The Trust Temporary Workforce Policy requires all new staff to have an Induction prior to commencing a shift. We have an action card describing maternity processes and this has now been published (B0720).

4.31. In the maternity governance structure the Workforce Meeting has oversight of temporary workforce. Escalation of issues is to the Maternity Oversight and Assurance Committee.

Venous thromboembolism (VTE) risk assessments

Issues

Maternal Venous Thromboembolism (VTE)	–	Risk assessments

4.32. Continuing our improvement response

4.33. The 2 clinical leads (matron and Consultant Obstetrician) commenced a quality improvement project to improve compliance of completing risk assessments.

4.34. The VTE Improvement Team identified a SMART aim:

SMART AIM (amended to 14 hours)

For >95% admission VTE risk assessment to be completed within 14 hours of admission – this target has been **sustained**

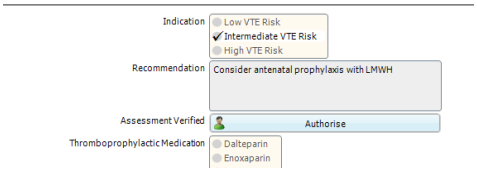
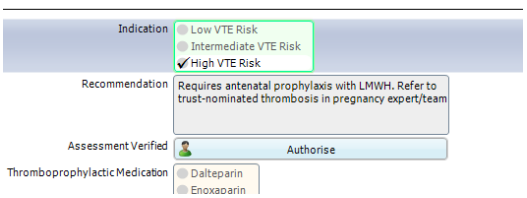
4.35. Data

4.36. The QI Leads have been re-established and are reviewing audit focus.

4.37. A new Obstetrician has been identified to lead this work due to retirement of the previous lead.

4.38. There are key prompts within the electronic patient record to provide guidance to staff on management.

Table: Badgernet prompts for intermediate and high risk VTE risk assessment

AN Intermediate VTE risk assessment	AN High risk
	

4.39. The new VTE Policy is going through approval groups and is now with Corporate Team.

4.40. Audits are now to be completed 6 monthly as the last audit demonstrated 100% compliance (February 2026). This plan will be agreed at the Antenatal Forum and the next audit is due July 2026.

4.41. Table: VTE Risk assessment compliance Production Board data

Issue	Feb 2025	Mar 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Feb 2026	Due July 2026	Target
Manual audits	100 %	90%	92%	100 %	96%	97%	100%	100%		95%

Thromboprophylaxis audits

4.42. Spot check audits, for both antenatal and postnatal women, demonstrated 90-100% compliance when last completed and will be checked in July 2026.

Update

- Audits for compliance with risk assessment completion will now be completed 6 monthly next due July/August 2026.
- New Midwifery Lead Antenatal Ward Manager CP-W
- On 6 January 2026, a new Maternal Care Bundle was released by NHS England and element 1 is the VTE. The Perinatal Governance Team have started the gap analysis against the recommendations and will develop an action plan to ensure that all elements are introduced with a target date of March 2027. The first audit has been completed which is to review high risk women at booking to make sure at booking they have already been commenced on treatment.

Maternal Obstetric Early Warning Scores (MOEWS) escalation

1.1. Continuing our improvement response

1.2. We identified 2 clinical leads (matron and Consultant Obstetrician) and they completed a QI plan on a page.

1.3. The MOEWS Improvement Team identified a SMART aim:

> **SMART AIM**
>
> To maintain compliance with acting on amber observations at 90%- 95%

1.4. What that data is demonstrating

1.5. We have a system implemented and described in MOEWS clinical guidelines (Severely Ill Obstetric Patient M2010).

1.6. The focus for the Team has been the “Act on Amber” metrics and Labour Ward and Maternity Ward are compliant with their rolling averages at 90-95%.

1.7. The Birth Unit saw a slight decrease in performance which will be monitored with the manager discussing the changed position with staff. This month there was 1 case that amber had not been acted upon but this woman was about to give birth and so repeated post-delivery and within normal limits.

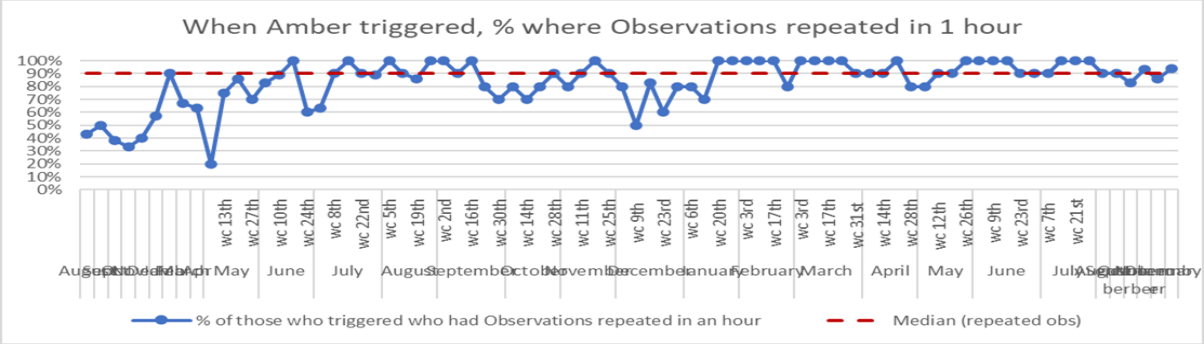
1.8. Compliance is monitored at the Postnatal Forum and any issues are escalated to the Perinatal Oversight and Assurance Meeting.

1.9. There were only 4 cases that had Amber scores in the Birth Unit and 1 case was not escalated (25%). The observations were repeated but this was not within 1 hour.

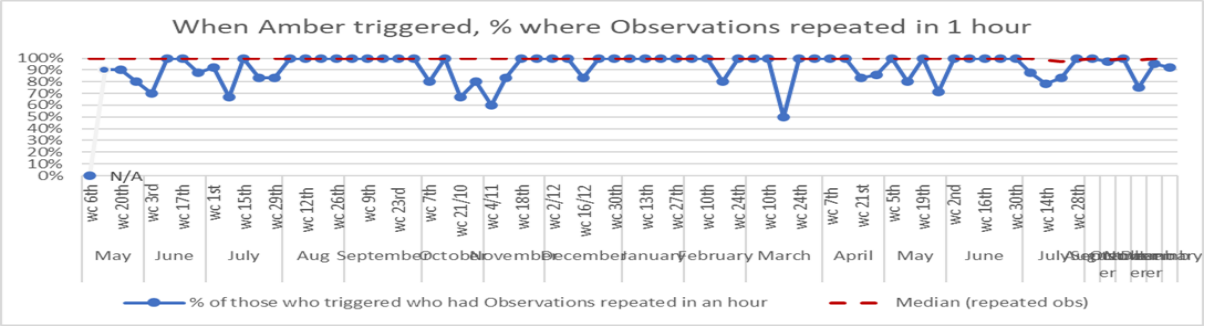
Table: “Act on Amber” compliance

Area	March 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Maternity Ward	90%	90%	93%	>95%	97%	90%	90%	80%	90%	87%	100%
Delivery Suite	90%	90%	91%	100%	>90%	100%	98%	100%	80%	95%	100%
Birth Unit GRH	70%	100%	100%	93%	90%	90%	78%	80%	75%	70%	75%

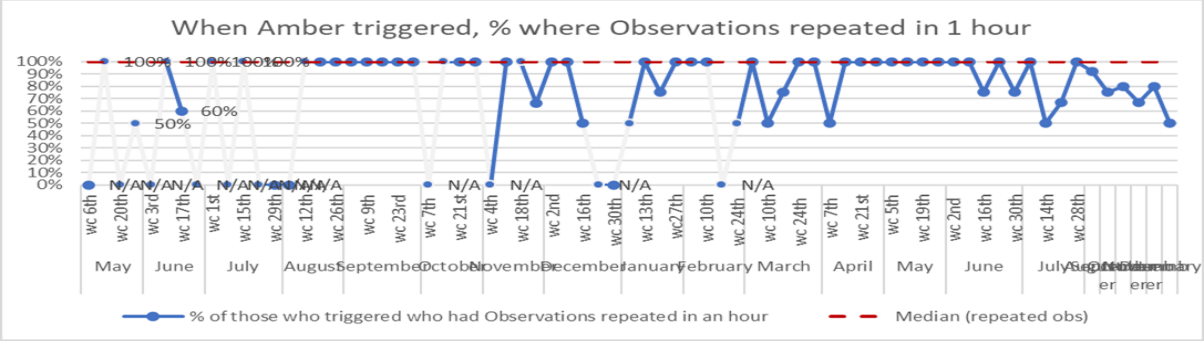
Graph: Maternity Ward



Graph: Delivery Suite



Graph: Birth Unit



Narrative - Jan 26 – 1 set of observations repeated and normal but not within 1 hour timeframe.

Plan

The plan is to implement new national MEWs at the end of March and so the current audits in this format will stop and a new audit tool developed. This is to enable the national MEWS implementation team time to focus on delivering on the new system.

Triage MEOWs completion

1.10. The new Triage dashboard has had MEOWs completion added and the average of all parameters physiological assessments completed is 89.3% (target 90%).

1.11. Action continues to be taken to improve our completion rates.

1.12. Next steps

1.13. The new national maternal early warning score (MEWS) system is being implemented now next month (March 2026) and there is an implementation plan for this. The focus has been preparing for the smooth transition to the new system.

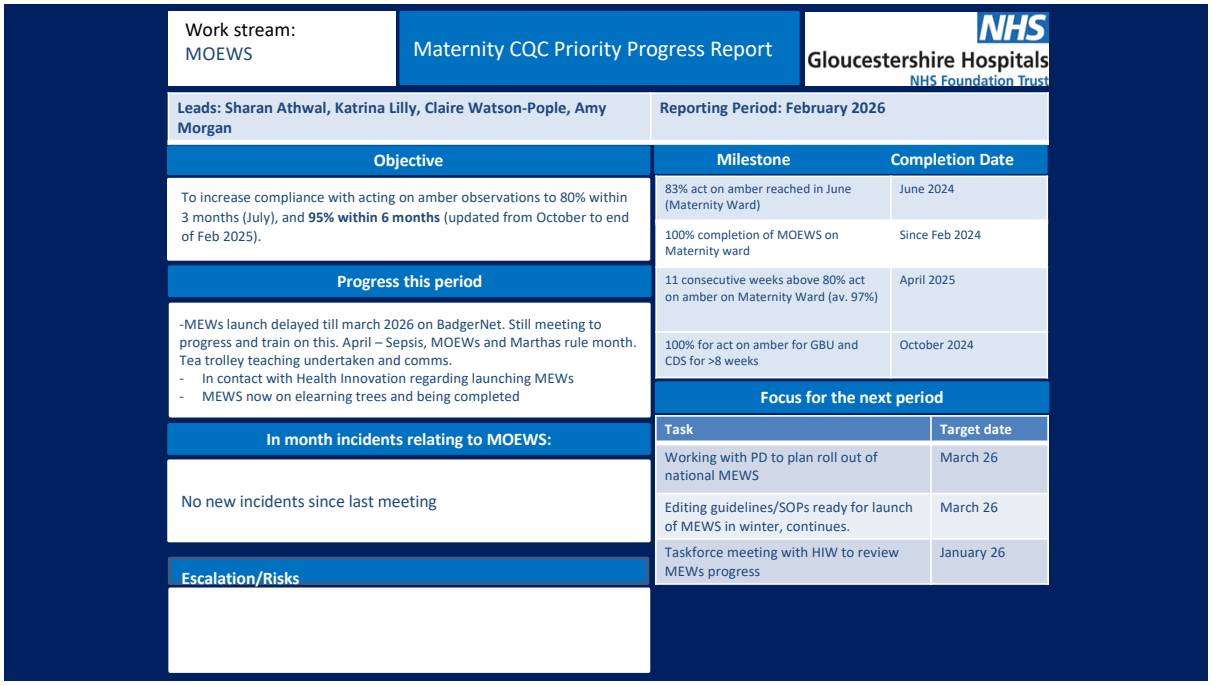
1.14. The new MEWS policy document is awaiting publication when new the MEWS system implemented.

1.15. The Postnatal Forum have requested to pause audits until new MEWs have been implemented.

1.16. The Maternity Service is a NHSE pilot site for Maternity Martha's Rule implementation.

1.17. The service will continue to monitor MOEWs completion via the Triage dashboard until the new dashboard is launch.

Progress report to Postnatal Forum



Work stream: MOEWS

Maternity CQC Priority Progress Report

NHS Gloucestershire Hospitals NHS Foundation Trust

Leads: Sharan Athwal, Katrina Lilly, Claire Watson-Pople, Amy Morgan

Reporting Period: February 2026

Objective

To increase compliance with acting on amber observations to 80% within 3 months (July), and **95% within 6 months** (updated from October to end of Feb 2025).

Progress this period

-MEWs launch delayed till march 2026 on BadgerNet. Still meeting to progress and train on this. April – Sepsis, MOEWs and Marthas rule month. Tea trolley teaching undertaken and comms.
- In contact with Health Innovation regarding launching MEWs
- MEWS now on elearning trees and being completed

In month incidents relating to MOEWS:

No new incidents since last meeting

Escalation/Risks

Milestone	Completion Date
83% act on amber reached in June (Maternity Ward)	June 2024
100% completion of MOEWS on Maternity ward	Since Feb 2024
11 consecutive weeks above 80% act on amber on Maternity Ward (av. 97%)	April 2025
100% for act on amber for GBU and CDS for >8 weeks	October 2024

Focus for the next period

Task	Target date
Working with PD to plan roll out of national MEWS	March 26
Editing guidelines/SOPs ready for launch of MEWS in winter, continues.	March 26
Taskforce meeting with HIW to review MEWs progress	January 26

2. Governance

Quality governance, reporting and executive oversight

Quality Governance Framework

2.1. The **Perinatal Governance Framework** has been published and there is a plan for an update as new regional/national processes have been published.

Roles and responsibilities

2.2. From point of care to Board we have clearly defined roles and responsibilities for maternity quality governance.

Risk management strategy

2.3. We have clear risk management strategy, risk registers and risk reporting procedures (risk identification, risk assessment, risk mitigation and monitoring of maternity service risks).

Monitoring and reporting

2.4. **We have** established key performance indicators (KPIs) to track progress towards goals for clinical governance.

Maternity services dashboard

2.5. **We have** defined how information will be reported to the board, management, and other stakeholders.

2.6. We conduct regular reviews of governance practices to ensure effectiveness and compliance as we know that a clinical governance framework should be iteratively changed and improved. It's not a static document but a dynamic process that requires regular review and adaptation to ensure it remains effective in promoting quality and safety within our maternity service.

Table: Quality governance transformation tasks and next steps

Task	Date completed or to be completed by	Open/closed
Launch new Perinatal Quality Oversight Model within new PQS Report	Jan 2026	Closed
Launch of new Maternity Outcomes Signal System (MOSS)	December 2025	Closed

Task	Date completed or to be completed by	Open/closed
Direct coaching with Perinatal Governance Team	March 2026	Open
Trust Executive Led Weekly Mandated Support Meetings	Weekly until exit criteria met	Open

Quality Governance Reporting CQC S31 Report

ICB Extended Oversight Meeting (EOG)

2.7. The last Extended Oversight Meeting (EOG) was 12 January 2026 and the next 9 March 2026.

Trust Board

2.8. The last Board meeting was 15 January 2026 (reviewed November 2025 report) and the next meeting is 12 March 2026.

Quality and Performance Committee (sub board)

2.9. The Quality and Performance Committee reviewed the last S31 Report on 26 February 2026 and next meeting 26 March 2026.

Perinatal (Maternity) Delivery Group (Executive led)

2.10. On 11 March 2026, the Perinatal (Maternity) Delivery Group met and received the latest CQC S31 Report and noted the progress being made. There were no escalations to the Group members (attended by LMNS and ICB).

Maternity and Neonatal Board Safety Champions

2.11. The Director of Quality and Chief Nurse and the NED Maternity and Neonatal Safety Champion continue to conduct Patient Safety Champion Walkabouts and attend the Champions meetings.

3. Recommendation

3.1. The CQC are asked to note the contents of the report and be assured that the Trust are committed to delivery of this improvement plan.

Authors:

Women's and Children's Division

Supported by Director of Quality Governance - Suzie Cro

Sponsors:

Women and Children's Division Chief of Service - Simon Pirie

Director of Quality and Chief Nurse – Matt Holdaway

Deputy CEO, Director of Safety and Medical Director – Mark Pietroni

CEO – Kevin McNamara

Enclosures

None

FOI: *Public*

Alert, Advise and Assure Report to the Board of Directors Meeting held on Thursday 12 March 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Audit and Assurance Committee held on 9th February 2026
Board member lead(s)		NED Chair (deputising for Shawn Smith): John Noble & Executive leads Director of Finance and Director of Integrated Governance
Written by		Committee Chair and Trust Secretary
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 9 February 2026. 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.
Key business transacted related to Internal and External Audit activity as well as Counter-Fraud activity. Internal Audit reports were received in respect of mortuary controls (post Fuller 2 report) and Cyber Security.

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.

- Risk –The Trust risk appetite and profile alignment has concluded with the process of finalising the realigned strategic risks (against Trust Strategy) nearing conclusion; all risks will be before the relevant responsible

committee for review and approval during February and March. Remains an 'advise' whilst the process is concluding.

- Whistle-blowing and Speaking Up assurance – It has been recognised that there is a need for assurance as to the internal process surrounding the management of protected disclosures. A 6-montly report will be brought to Audit Committee and, where relevant, a report focusing on the culture and employee relations aspects will be brought to the People and Organisational Development Committee.
- There is a backlog of Trust policies and procedures outside relevant review periods. Risk Management Group and relevant Executive Leads are exploring remediation programmes including an electronic solution and a risk stratification approach to policy review

ASSURE: inform the board where positive assurance has been received

- High quality and well-prepared papers
- Satisfactory progress against annual internal audit plan, some reprofiling but at this stage all considered deliverable.
- Mortuary Controls Audit– In summary, satisfactory processes being effectively deployed. Recommendations agreed and action plans in place
- Cyber Security Internal Audit report and update report from service – satisfactory assurance with clear actions in place.
- Strong plans in place for the completion of the Annual Report and Accounts audit

APPROVALS: decisions made by the Committee

None

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	**All**

RECOMMENDATIONS

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

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	12th March 2026
Report title	Modern Slavery Statement
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

Executive Summary

This report presents the annual Modern Slavery Statement for approval by the Board in accordance with the requirements of the Modern Slavery Act 2015.

The Trust is committed to preventing modern slavery, human trafficking, forced labour and exploitation within its operations and supply chains. This is evidenced in its management of procurement, recruitment and staff policies and its safeguarding processes.

Board approval is sought for the publication of the attached Modern Slavery Statement on the Trust's website. For ease of reference the changes have been tracked on the enclosed Statement.

Previously considered by	n/a

Recommendations:

The Board is asked to

(1) Review and approve the Modern Slavery Statement
(2) Confirm commitment to ongoing monitoring and improvement
(3) Approve and authorise publication of the statement on the Trust website, signed by the Chief Executive Officer

Strategic Aims (tick as appropriate)

Patient experience and voice	x
People, culture and leadership	x
Quality, safety and delivery	x
Digital first	

Impact on any Strategic Risks?
Relevant to all Strategic Risks

Implications on:	
Equality, Diversity and Inclusion	The Trust's focus on the Equality, Diversity and Inclusion agenda is essential to achieve the safeguards embedded and intended by the statutory requirements set out in the Modern Slavery Act.
Health Inequalities	The safeguarding policy and training provided will empower our staff to identify and support those patients most at risk of exploitation. These patients often come from our most social/economically disadvantaged communities.
Finance and Resource	A core requirement of our procurement processes
Regulation/Legal	A legal requirement – Modern Slavery Act 2015
CQC-Key line of enquiry	Well-led
Green Plan	*n/a*

Main Report

1. Under Section 54 of the Modern Slavery Act 2015, organisations with a turnover exceeding £36 million must publish an annual statement outlining the steps taken to prevent modern slavery within their operations and supply chains. As an NHS organisation, the Trust has a responsibility not only to comply with legislation but also to uphold the NHS core values of dignity, respect and safeguarding. This is relevant to both our treatment of patients and staff but also our procurement decisions.

2. The attached Statement has been reviewed and updated (tracked) having been last published by the Trust in 2025 and largely remains unchanged other than to reflect the requirements of the NHS (Procurement, Slavery and Human Trafficking) Regulations 2025

3. Key areas of elevated risk identified within the NHS include the overseas manufacture of medical goods, agency and temporary workforce recruitment and estates services.

4. To mitigate those risks the Trust takes various actions during the course of a financial year including:
    - Use of approved NHS procurement frameworks;
    - Mandatory compliance with relevant employment laws;
    - Safeguarding reporting processes; and
    - Review of procurement controls
    - Staff training – procurement and safeguarding
    - Relevant policies and procedures – safeguarding, recruitment and procurement.

5. The Trust monitors effectiveness through:
    - Completion rates of safeguarding and procurement training (January 2026 – Level 1 95%);
    - Number of safeguarding referrals linked to exploitation concerns
    - Internal audit findings
    - Workforce recruitment audits

6. The proposed statement affirms the following:

- The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. We expect our suppliers and business partners to adhere to the same high standards and to take all reasonable steps to combat slavery and human trafficking.
- The Trust has in place due diligence procurement and tendering processes to ensure all its selected suppliers and any third parties are compliant with the Model Slavery Act (2015) and will be compliant with the 2025 Regulations referred to above.
- The Trust has in place measures to ensure appropriate and robust recruitment processes which recognise the risk of modern slavery in the employment sphere.
- The Trust's focus on its culture; particularly Equality, Diversity and Inclusion programmes and Raising Concerns policies provide a forum to enable staff to raise concerns regarding modern slavery and human trafficking of individuals or colleagues.
- The Trust provides safeguarding training to staff to enable the identification and escalation of concerns regarding modern slavery and human trafficking in the context of patients and service users.

7. The Board is asked to:

    (4) Review and approve the Modern Slavery Statement
    (5) Confirm commitment to ongoing monitoring and improvement
    (6) Authorise publication of the statement on the Trust website, signed by the Chief Executive Officer.

Enclosures

Draft Modern Slavery and Human Trafficking Statement for financial year 2025/26

FOI: Public

Gloucestershire Hospitals NHS Foundation Trust

Modern Slavery Statement 2025/2026

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Trust's Slavery and Human Trafficking statement for the financial year ending 31 March 2026

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting. Modern slavery is a crime resulting in an abhorrent abuse of human rights. It is constituted in the Modern Slavery Act 2015 by the offences of 'slavery, servitude and forced or compulsory labour and 'human trafficking'.

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

The Trust's Commitments

The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. We believe in treating individuals with respect and dignity, and do not condone the use of our products or services which infringe the basic human rights of others. The Trust has a zero tolerance for slavery and human trafficking and these concerns will be acted upon in accordance with related Trust policies and procedures.

We expect our suppliers and business partners to adhere to the same high standards and to take all reasonable steps to combat slavery and human trafficking. The Trust has in place due diligence procurement and tendering processes to ensure all its selected suppliers and any third parties are compliant with the Modern Slavery Act (2015)

The procurement of goods and services

- Procurement ensures all procurement activates are undertaken in line with UK legislation, industry best practice and national policy on tackling modern slavery in government supply chains.
- The Trust will adopt the national toolkit built into the procurement system to ensure an appropriate risk assessment at all relevant stages of a procurement

process. This is in accordance with the National Health Service (Procurement, Slavery and Human Trafficking Regulations 2025

- Procurement staff have completed eLearning on the Government Commercial College (GCC) with the Chartered Institute of Procurement and Supply (CIPS) qualified members also completing the annual CIPS Ethical Procurement and Supply e-learning.

- A large proportion of the goods and services are procured through national Government supply frameworks which appoint, with proper due diligence, reputable and reliable firms, ensuring pricing reflects appropriate employment conditions. ~~and c~~Contracts also require suppliers to comply with relevant legislation. We continue to work with our suppliers directly and via partners, such as NHS Supply Chain and Crown Commercial Services, to support initiatives related to modern slavery.

The recruitment of staff

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

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

The working conditions and practices for our employees

The Trust is committed to ensure that:

- Employment with the Trust and our suppliers is voluntary;

- Our workplace and those of our suppliers are free from discrimination or harassment based on race, colour, religion, gender (including pregnancy), sexual orientation, marital status, gender identity, national origin, age, disability, or any other characteristic protected by applicable law;

- Our workplaces are safe and healthy;

- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation.
- Our Equality, Diversity and Inclusion policies, together with our Grievance, Dignity at Work and Raising Concerns policies additionally give a platform for our employees to raise concerns about poor working practices.
- Our policies and practices promote and support equality, diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities.
- Our Freedom to Speak: Raising Concerns (whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and safeguarding teams actively ensure they are accessible to staff.
- We provide advice, training and support about modern slavery and human trafficking to all staff through our safeguarding children and adults mandatory training, our safeguarding policies and procedures and our safeguarding teams.
- Our Trust “Safeguarding Adults at Risk Policy”, and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites.

Patient Safeguard

As an NHS organisation, we recognise that healthcare services may be one of the few public services that victims of modern slavery come into contact with. We therefore acknowledge our critical role in identifying potential victims, responding appropriately to concerns, and ensuring individuals are safeguarded and supported in line with statutory safeguarding duties. Modern slavery is treated within our organisation as a serious safeguarding concern, encompassing human trafficking, forced labour, servitude, domestic servitude, criminal exploitation (including county lines), and child exploitation.

We ensure that all staff, both clinical and non-clinical, are aware that victims of modern slavery may not self-identify and may present with complex physical, psychological and social needs. Staff are supported to recognise potential indicators, including:

- Signs of control, coercion or intimidation by accompanying individuals
- Inconsistent or vague personal, medical or social histories
- Evidence of untreated injuries, neglect, exhaustion or malnutrition

- Barriers to communication, including lack of English or reliance on others to speak on their behalf
- Fearfulness, reluctance to engage, or avoidance of eye contact
- Children or young people with unclear relationships to accompanying adults or concerns about age.

Review of effectiveness

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

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

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

Signed

Kevin McNamara, Chief Executive April 2026

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on January 29th and February 26th 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the QPC Committee held on XX
Board member lead(s)		NED Chair – Sam Foster and Exec leads CNO/COO/CMO
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	x
	Discussion	x
	Note	

Purpose of report

To present an update to the Board of Directors from the meetings held 29 January 2026 (Extraordinary) and 26 February 2026 of the QPC Committee.

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.

- **Maternity Incentive Scheme – Year 7 (6/10 compliance):** The Trust is unable to declare full compliance. Areas of non-compliance relate to PMRT, perinatal workforce planning, training compliance and the perinatal oversight model. An action plan has been approved for submission to NHS Resolution.
- **Maternity service risks and leadership gaps:** Significant senior midwifery leadership vacancies (Director of Midwifery, Head of Midwifery and Consultant Midwife) impacting resilience and governance capacity. Interim oversight and regional NHS England support remain in place.
- **Temporary suspension of the Home Birth Service:** Continued suspension (minimum six months) due to safety concerns, practice outside guidance and training gaps. Notice of intent for judicial review received (process-based challenge; primary risk reputational). Restoration plan under development with regional input.
- **Three Never Events reported:** Wrong site surgery, incorrect implant and wrong patient nerve block. Thematic review underway to strengthen system reliability.

- **CSSD sterile set non-conformances:** Ongoing issues impacting trauma and orthopaedic activity and causing theatre cancellations. External oversight and contingency measures in place; risk remains live.
- **ED four-hour performance deterioration and corridor care:** Winter pressures have resulted in increased congestion. Corridor care continues to be rated as a red strategic risk and is not normalised within Trust culture.

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

- **Strategic Risk SR1 refresh:** Reframed to focus on the inability to deliver safe and effective care against regulatory/statutory requirements. To be mapped against thematic findings from the Amos review to ensure full coverage of drivers of unsafe care.
- **Maternity Health Needs Assessment:** First comprehensive assessment in 15 years. Highlights rising complexity, increasing intervention rates, workforce fragility and persistent inequalities. Moving to case for change and public consultation.
- **Health inequalities:** New maternity dashboard enables analysis across ethnicity, deprivation, BMI and age. Further thematic work required to understand disproportionate adverse outcomes.
- **Neonatal life support training compliance:** Identified gap addressed through rapid improvement plan; recovery trajectory being monitored.
- **RTT decline (68.4%) following winter pressures:** Long waits (>45 weeks) continue to reduce. Diagnostic capacity and screening programme visibility require strengthened oversight.
- **Cancer 28-day deterioration:** Seasonal demand and breast diagnostic capacity issues contributed; recovery actions implemented. Screening performance (breast and bowel) to receive greater routine oversight.
- **Complaints handling capacity:** Ongoing pressures, particularly within maternity services, with risk of backlog development.
- **Readmissions and discharge safety:** Further analysis commissioned to assure safe discharge and understand return outcomes

ASSURE: inform the board where positive assurance has been received

- **All Section 31 conditions are being met**, with improvements sustained pending formal withdrawal process. Initial CQC well-led feedback described as broadly positive (reports awaited).
- **Perinatal Mortality Review and neonatal death investigations:** PSII processes completed; Duty of Candour discharged; action plans in place with MNIST oversight.
- **National Patient Safety Alerts:** Fully compliant and in date.
- **SHMI within expected range**, with improving mortality indicators and strengthened triangulation through Medical Examiner processes.
- **C. difficile performance strong** and antimicrobial stewardship improving, with reduced antibiotic usage and enhanced IV-to-oral switching.
- **Emergency length of stay improvements sustained**, alongside improved discharge processes and reduced winter outbreak bed closures.

- **Maternity governance oversight strengthened**, including Board oversight of the Maternity Oversight Safety System and enhanced perinatal reporting clarity.

APPLAUD & APPROVALS: decisions made by the Committee

APPLAUD

- **JAG accreditation achieved in Endoscopy**, reflecting high standards of quality and patient safety.
- Development of the first maternity Health Needs Assessment in over a decade, providing robust evidence base for transformation.
- Rapid mobilisation to improve neonatal life support training capacity.
- Sustained improvement in the prostate cancer pathway, contributing to improved 62-day cancer performance.
- Constructive and learning-focused engagement during the Amos Review process.
- Strengthened executive and non-executive safety champion oversight across maternity and patient safety governance.

APPROVALS

- Approved 6/10 Maternity Incentive Scheme compliance declaration and associated improvement plan.
- Supported continuation of temporary suspension of the Home Birth Service pending restoration planning.
- Approved escalation and reporting arrangements relating to the BDO deteriorating patient audit follow-up.

Implications

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

Board assurance framework

BAF reference	**SR1**

Risks discussed

The Committee discussed the following risks: Several areas of the BAF specifically SR1

Recommendations

The Board of Directors is asked to:

- **Take assurance** from the areas outlined above.
- **Note the matters escalated under ALERT**, particularly maternity safety compliance, operational performance risks, CSSD non-conformances.
- **Support continued oversight** of maternity recovery, urgent and emergency care pressures, and governance transformation under SR1.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors/Committee

Date of Meeting	12/03/2026
Report title	Annual Report on Organ Donation Activity Gloucestershire 01/04/2024-31/03/2025
Sponsoring Director/Author	Prof Mark Pietroni Medical Director

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

Executive Summary

In 2024/25, from 14 consented donors the Trust facilitated 12 actual solid organ donors resulting in 27 patients receiving a life-saving or life-changing transplant.

In addition to the 12 proceeding donors there were 2 consented donors that did not proceed.

Additionally, 188 corneas were received by **National Health Service Blood & Transplant** (NHSBT) Eye Banks from your Trust.

The Trust referred 44 potential organ donors during 2024/25. There were no occasions where potential organ donors were not referred.

Previously considered by	Presented and discussed at quarterly Organ Donation Committee meeting

Recommendations:

Our priorities remain increasing consent rate and 100% **Specialist Nurse for Organ Donation** (SNOD) attendance.

Nationally further initiative to increase registrations on the **Organ Donation Registry** (ODR) and community engagement with organ donation.

Gloucestershire is already responding to the national call for greater engagement and community awareness. In early January 2026, the Trust launched a recruitment campaign inviting volunteers to support the work of the Gloucestershire Organ Donation Committee.

This generated an exceptional level of interest, with 17 people signing up to join the Committee, reflecting the strong local commitment to organ and tissue donation. Volunteers who will form a special sub-committee will support the Trust in raising awareness in schools, community groups and at public events, encouraging conversations about organ donation and promoting the gift of life.

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

Impact on any Strategic Risks?
Not applicable

Implications on:	
Equality, Diversity and Inclusion	Not applicable
Health Inequalities	Not applicable
Finance and Resource	Not applicable
Regulation/Legal	Not applicable
CQC-Key line of enquiry	Not applicable
Green Plan	Not applicable

Main Report
In 2024/25, from 14 consented donors the Trust facilitated 12 actual solid organ donors resulting in 27 patients receiving a life-saving or life-changing transplant.

In addition to the 12 proceeding donors there were 2 consented donors that did not proceed. Additionally, 188 corneas were received by **National Health Service Blood & Transplant** (NHSBT) Eye Banks from your Trust.

The Trust referred 44 potential organ donors during 2024/25. There were no occasions where potential organ donors were not referred.

A **Specialist Nurse for Organ Donation** (SNOD) was present for 16 organ donation discussions with families during 2024/25. There were 2 occasions where a **Specialist Nurse for Organ Donation** SNOD was not present.

Since April 2025 until now we had the following:
8 consented donors
6 proceeding donors (2 out of 8 consented donors had **Prolonged Time to Asystole** [PTA] making donation impossible)
Out of the 6 proceeding donors: 5 were **Donation After Cardiac Death** [DCD] and 1 **Donation After Brain Death** [DBD] where death is diagnosed by neurological criteria
14 families approached and 6 declines
1 missed referral (no donor potential)
1 consultant only approach (family declined)
20 organs retrieved
14 organs transplanted
6 organs not transplanted/offered for research.

Enclosures

Summary report 2024/25
Summary report April to September 2025

FOI: Public

Actual and Potential Deceased Organ Donation 1 April 2025 - 30 September 2025

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In the first six months of 2025/26, from 4 consented donors the Trust facilitated 2 actual solid organ donors resulting in 3 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

In addition to the 2 proceeding donors there were 2 consented donors that did not proceed.

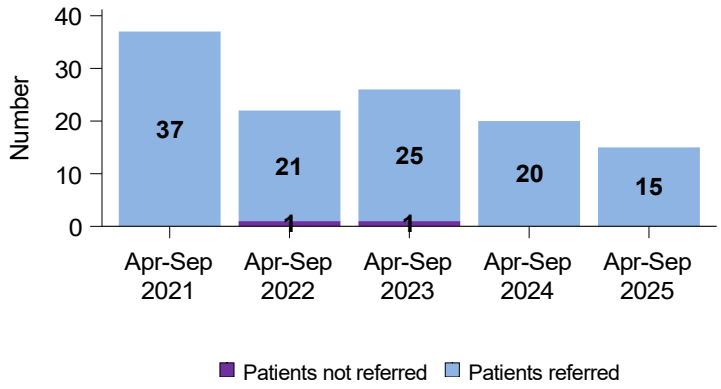
Additionally, 77 corneas were received by NHSBT Eye Banks from your Trust.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

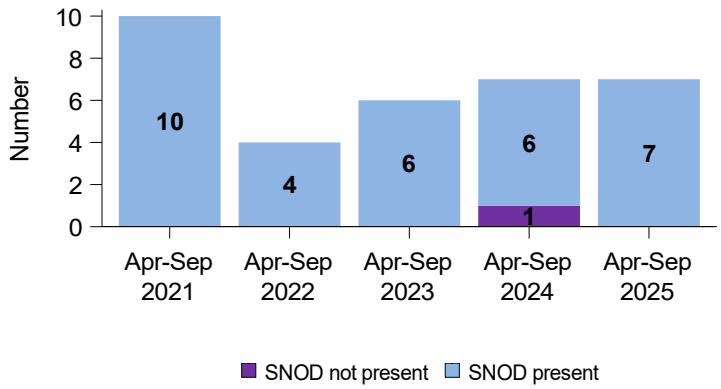


The Trust referred 15 potential organ donors during the first six months of 2025/26. There were no occasions where potential organ donors were not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



A SNOD was present for 7 organ donation discussions with families during the first six months of 2025/26. There were no occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2025 - 30 September 2025		
Deceased donors	68	726
Transplants from deceased donors	140	1,871
Deaths on the transplant list	15	210
As at 30 September 2025		
Active transplant list	613	8,114
Number of NHS ODR opt-in registrations (% registered)	2,918,021 (51%)**	28,629,458 (43%)
Number of NHS ODR opt-out registrations (% registered)	142,073 (2%)**	2,837,078 (4%)

*Regions are defined using the NHS region definitions
** % registered based on population of 5.71 million, based on ONS 2021 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers comparison with UK data,
1 April 2025 - 30 September 2025

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	1	906	14	2571	15	3192
Referred to Organ Donation Service	1	901	14	2416	15	3036
Referral rate %	*100%*	*99%*	*100%*	*94%*	*100%*	*95%*
Neurological death tested	1	604				
Testing rate %	*100%*	*67%*				
Eligible donors[2]	1	555	13	1775	14	2330
Medically suitable eligible donors[3]	1	555	6	1080	7	1635
Family approached	1	502	6	967	7	1469
Family approached of medically suitable eligible donor	1	502	6	948	7	1450
% approached of medically suitable eligible	*100%*	*90%*	*100%*	*88%*	*100%*	*89%*
Family approached and SNOD present	1	486	6	887	7	1373
% of approaches where SNOD present	*100%*	*97%*	*100%*	*92%*	*100%*	*93%*
Consent ascertained	0	331	4	537	4	868
Consent rate %	*0%*	*66%*	*67%*	*56%*	*57%*	*59%*
- Expressed opt in	0	201	4	351	4	552
- Expressed opt in %	*N/A*	*93%*	*80%*	*87%*	*80%*	*89%*
- Deemed Consent	0	103	0	155	0	258
- Deemed Consent %	*N/A*	*55%*	*N/A*	*45%*	*N/A*	*49%*
- Other*	0	27	0	30	0	57
- Other %*	*0%*	*54%*	*N/A*	*28%*	*0%*	*36%*
Actual donors (PDA data)	0	313	2	400	2	713
% of consented donors that became actual donors	*N/A*	*95%*	*50%*	*74%*	*50%*	*82%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

[3] Medically suitable eligible donor - An eligible donor with no DCD exclusions and not deemed unsuitable by the DCD screening process

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Actual and Potential Deceased Organ Donation 1 April 2024 - 31 March 2025

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2024/25, from 14 consented donors the Trust facilitated 12 actual solid organ donors resulting in 27 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

In addition to the 12 proceeding donors there were 2 consented donors that did not proceed.

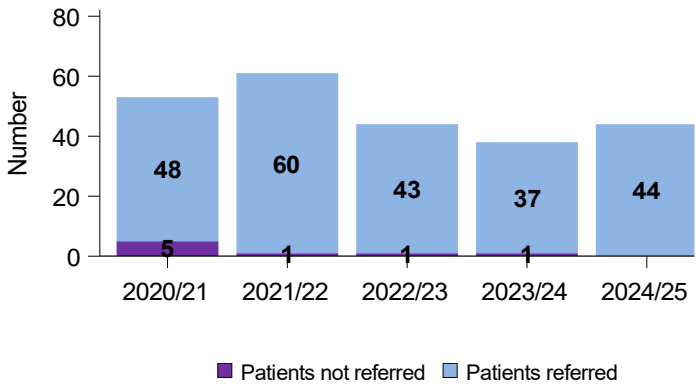
Additionally, 188 corneas were received by NHSBT Eye Banks from your Trust.

Best quality of care in organ donation

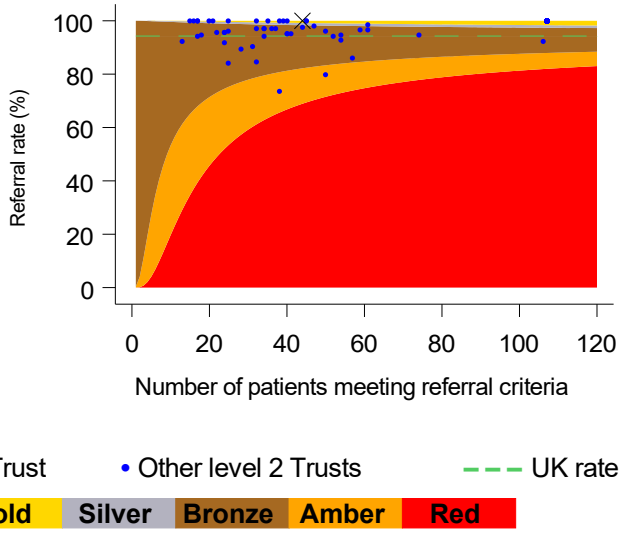
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



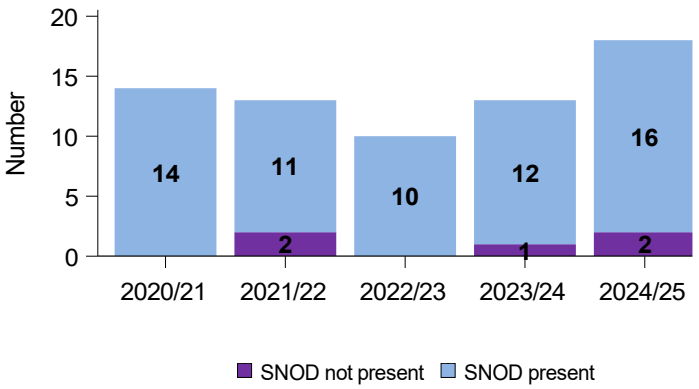
The Trust referred 44 potential organ donors during 2024/25. There were no occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant.

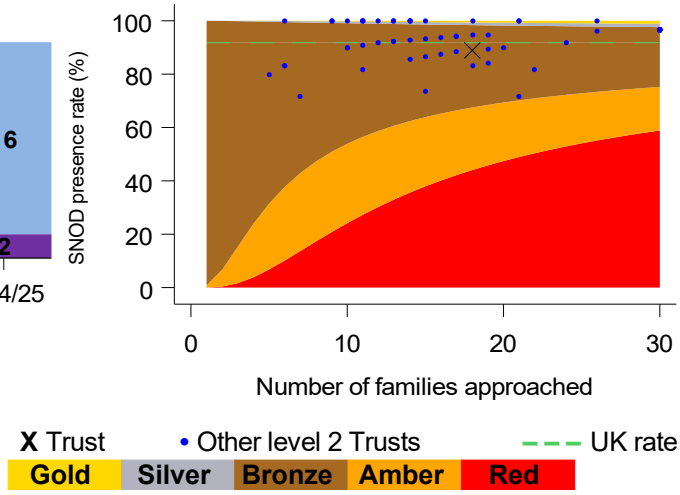
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 16 organ donation discussions with families during 2024/25. There were 2 occasions where a SNOD was not present.

When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2024 - 31 March 2025		
Deceased donors	150	1,403
Transplants from deceased donors	269	3,596
Deaths on the transplant list	39	463
As at 31 March 2025		
Active transplant list	634	8,096
Number of NHS ODR opt-in registrations (% registered)	2,889,155 (51%)**	28,383,991 (42%)
Number of NHS ODR opt-out registrations (% registered)	131,247 (2%)**	2,693,829 (4%)

*Regions are defined using the NHS region definitions
** % registered based on population of 5.71 million, based on ONS 2021 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2024 - 31 March 2025

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	9	1883	38	5503	44	6880
Referred to Organ Donation Service	9	1859	38	5118	44	6486
Referral rate %	G *100%*	*99%*	G *100%*	*93%*	G *100%*	*94%*
Neurological death tested	8	1356				
Testing rate %	B *89%*	*72%*				
Eligible donors[2]	6	1247	28	3735	34	4982
Medically suitable eligible donors[3]	6	1247	12	2077	18	3324
Family approached	6	1084	12	1827	18	2911
Family approached of medically suitable eligible donor	6	1084	12	1799	18	2883
% approached of medically suitable eligible	G *100%*	*87%*	G *100%*	*87%*	G *100%*	*87%*
Family approached and SNOD present	6	1050	10	1622	16	2672
% of approaches where SNOD present	G *100%*	*97%*	B *83%*	*89%*	B *89%*	*92%*
Consent ascertained	4	743	8	970	12	1713
Consent rate %	B *67%*	*69%*	B *67%*	*53%*	B *67%*	*59%*
- Expressed opt in	2	473	5	644	7	1117
- Expressed opt in %	*100%*	*94%*	*63%*	*82%*	*70%*	*86%*
- Deemed Consent	1	216	3	267	4	483
- Deemed Consent %	*33%*	*57%*	*100%*	*43%*	*67%*	*48%*
- Other*	1	54	0	59	1	113
- Other %*	*100%*	*55%*	*N/A*	*29%*	*100%*	*38%*
Actual donors (PDA data)	4	694	8	703	12	1398
% of consented donors that became actual donors	*100%*	*93%*	*100%*	*72%*	*100%*	*82%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

[3] Medically suitable eligible donor - An eligible donor with no DCD exclusions and not deemed unsuitable by the DCD screening process

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Date of Meeting	12th March 2026
Report title	Integrated Performance Report (IPR)
Sponsoring Director/Author	Chief Operating Officer (COO) Chief Medical Officer (CMO) Chief Nurse (CN) Director for People & OD (DfP&OD) Director of Finance (DoF)

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

Executive Summary

Urgent and Emergency Care (UEC)

January 2026 performance across Urgent and Emergency Care (UEC) was challenging as per expected seasonal variation but positively managed without the need to declare a CI as per last year and many other trusts regionally. The overall four-hour standard compliance did fall slightly from 64% 60.3% whilst the 12-hour performance saw a corresponding deterioration from 90% to 87.8%. All linked to expected seasonal challenges in patient flow during the peak winter period. Non-Admitted performance deteriorated from 68% to 62.6%, although admitted performance improved slightly from 52.8% to 53.6%, similar to the position in November.

Paediatric performance showed a positive trend in terms of a second month of reduced attendances linked to improved access to primary care via GHAC, however the paediatric 4hr performance dropped again 78.3% to around 76% for January, impacted by the reduced attendances and targeted staffing interventions. There are ongoing Improvement projects with a direct focus on process improvements in minors and paediatrics, with a focused sprint being prepared for the month of March linked to regional monies.

Ambulance handover times continues to be an area of success, although January did see an increase from 20 minutes to 22minutes in January, this represents a significant achievement given seasonal variation in demand and when considered against the picture across the wider SW region where multiple trusts went in to CIs directly linked to their ability to maintain flow

and enable ambulance handovers. To achieve this we must acknowledge meant a significant increase in the amount of corridor nursing, mainly within the emergency department, but also at times within our Medical Assessment Zone (MAZ) relating to increase in demand and high numbers of DTAs, without the necessary flow and discharges to balance this.

Winter pressures, high respiratory and Noro infection rates, and the closure of Ward 6B have compounded operational challenges, reinforcing the need for sustained system-wide focus on attendance and admission avoidance, alongside improved volume and timeliness of complex discharges.

RTT

RTT incompletes rose from 62,716 (69.22%) in December to 63,432 (68.44%) in January, primarily due to an increase of around 700 patients over 18 weeks, though 45-week breaches fell from 724 to 692. The Trust continues to outperform the Southwest region in RTT and 52-week incompletes, ending January with 21 reportable breaches (down from 30 in December). Of these, 3 were due to national corneal graft shortages, and 15 related to Upper GI, reflecting more urgent and gall bladder cases. One 65-week breach occurred in T&O due to a missed referral, but prompt surgery followed. Additional capacity planned in February and March via the Q4 elective sprint aims to further reduce breaches and waiting times.

DM01

January 2026 demonstrated a continued improvement in overall diagnostic performance, with a 1.79% improvement compared to December. The total waiting list reduced by just 103 patients, with the number of breaches reducing by 281 with the most significant reduction being in Echo's (-162) which has been an ongoing theme. Other modalities demonstrating a notable reduction in breaches include Neurophysiology (-76); Gastroscopy (-55); Flexi Sig (-46); and CT (-21). However, performance remains fragile and uneven across modalities:

<u>Positive Movements:</u>

- **ECHO:** Made the greatest gains in month with a reduction of 162 breaches and 311 patients off their waiting list. Waiting list and breach performance is now improved back to May/June 2025 levels.
- **Neurophysiology:** Have recovered the negative position in December, and made a 9.91% improvement on last month, representing a breach reduction of 76.
- **Endoscopy:** All endoscopy modalities demonstrated an improvement in overall percentage performance with Flexi Sigmoidoscopy (10.1%); Gastroscopy (8.7%); Cystoscopy (2.1%) and Colonoscopy (1.0%), noting that both Cystoscopy and Colonoscopy had a slight increase in the number of breaches (21 and 19 respectively).

<u>Areas of Concern:</u>

- **Sleep Studies:** For consecutive months the sleep service has experienced an increase in the number of breaches, with an increase of 32 in January (compared to an increase of 25 in December). This remains a symptom of an increase in referrals

CANCER

62 Days: Backlog at 227 patients (16 February), mainly Lower GI and Urology. January's unvalidated performance was 73.4% (above recovery trajectory but below the 85% target). December validated at 83.7%. Head and Neck improved to 100%; Breast, Skin and Urology achieved 85% in November.
31 Days: December validated at 94.8%, meeting minimum requirement but below the 96% national standard. Chemotherapy and Radiotherapy achieved their 96% targets, with chemotherapy at 98.3%.
28 Days: December was 74.9%; January dropped to 57.7%, mainly due to delays in Breast first OPA. Recovery expected by March to mid-April as booking improves.

Actions: Introducing escalation and coordination processes, increasing Skin Minor Ops capacity, demand-capacity modelling, and recovery plans for Breast and Skin. Performance may remain below trajectory early in 2026.

QUALITY

ALERT – Key Quality Risks

- **ED Patient Experience:** FFT positive responses have fallen, with a widening gap between CGH (strong) and GRH (weaker).
- **Infection Prevention:** *C. difficile* cases remain below trajectory but continue to rise nationally and regionally; environmental cleanliness and sampling timeliness remain areas of pressure.
- **Falls:** Five injurious falls this month with each case being taken through Patient Safety Incident Response Framework (PSIRF) processes to decide the learning response for each case.

ADVISE – Priority Actions Required

- **Strengthen patient experience governance** through divisional "experience of care" meetings that better integrate FFT, complaints, PALS and national survey insight.
- **Maintain enhanced IPC oversight**, continuing Trust-wide and system-wide actions on cleaning standards, antimicrobial stewardship and rapid isolation processes.
- **Continue QI initiatives** on falls and pressure ulcer prevention after the Quality Summits, including specialist reviews, simulation-based training, and improved Datix/EPR documentation.
- **Stabilise PALS and Complaints teams**, addressing workforce gaps to ensure timely responses and maintain public confidence.
- **Support PSIRF capacity**, ensuring Divisions and the Patient Safety Team have sufficient resource to complete timely learning responses.

ASSURE – Areas Stable and Under Control

- **Overall FFT** remains strong at >92% and above our average benchmark.
- **PALS** continues to exceed the 75% closure standard, maintaining ~90% within 5 days despite higher volumes.
- **Mixed-Sex Breaches** remain minimal and rare, linked to operational pressures rather than systemic failure.

- **Mortality (SHMI)** remains within expected limits across all cohorts, with continued improvement in 12-month rolling trend.
- **PSIRF Timeliness** met all required learning response deadlines in January, demonstrating improving safety governance.

APPLAUD – Notable Achievements.

- **Infection Control** recognised as having one of the best CDI rates in the Southwest ICB footprint.
- **PSIRF Maturity** continues to improve, with high compliance and broadened adoption of After Event Review (AER), Patient Safety Incident Investigation (PSII) and Multi-professional Review (MPR) approaches.

Previously considered by	*Reports into delivery groups*

Recommendations:

To NOTE the contents of the update.

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

Impact on any Strategic Risks?

QUALITY BAF RISK - Inability to deliver safe and effective services against regulatory and statutory requirements

Implications on:

Equality, Diversity and Inclusion	
Health Inequalities	
Finance and Resource	
Regulation/Legal	
CQC-Key line of enquiry	*Safety, caring, effectiveness, responsiveness and well led*
Green Plan	

Main Report
See attached IPR slides.
Enclosures
Integrated Performance Report (IPR)
FOI:

Integrated Performance Report (IPR)

January 2026

- 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	Dec-25	Jan-26
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%	17.3%	22.2%
		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%	10.0%	12.2%
	Elective Care	Total elective activity undertaken compared with 2019/20 baseline		111%	106%	111%	110%	107%	118%	108%	106%	117%	101%
		Total diagnostic activity undertaken compared with 2019/20 baseline		146%	142%	157%	140%	147%	149%	137%	142%	148%	137%
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	No Target	161	160	125	135	144	152	152	115	139	162
		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%	6.42%	7.16%
		Proportion of patients meeting the faster cancer diagnosis standard	75%	82%	83%	86%	84%	80%	78%	77%	76%	70%	57%
		Total patients treated for cancer compared with the same point in 2019/20	No Target	356	362	343	333	341	387	300	274	305	253
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		109.93%	104.98%	109.45%	110.16%	106.44%	120.22%	109.31%	107.88%	118.34%	101.60%
	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%	97.42%	97.45%	97.30%	97.49%
	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	0.980	0.957
		Summary Hospital -level Mortality Indicator Limits		Within	Within	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	37	14.1
		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	29.6	14.1

Watch Measures

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Watch Measures	Urgent Care	Total hours lost to ambulance handovers		1820	1099	910	753	668	489	547	524	425	500
		Average ambulance handover time	*< 40 minutes*	34	19	16	13	11	8	9	8	7	8
	Elective Care	78ww RTT	*0*	1	0	1	1	2	0	0	0	0	0
		65ww RTT	*0*	3	3	2	3	2	1	0	0	0	1
		52ww RTT	*0*	94	75	47	40	37	36	29	31	30	22
		Short notice (within 72h) cancellation rate – total	*<9%*	9.4%	8.7%	9.6%	10.7%	10.7%	15.9%	12.4%	11.0%	10.2%	10.6%
		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%	2.6%	2.7%
		Same Day Non-Clinical Cancellations		57	38	59	84	69	104	74	68	38	51
		Last minute cancellations for non-clinical reasons		64	64	60	75	84	53	92	62	58	30
		Cancellations not rebooked within 28 days		7	12	14	9	25	11	28	16	14	9
		Angiogram Waiting List Position		293	288	274	280	265	231	220	216	232	250
		Histopathology 10-day reporting	*90%*	56%	56%	49%	63%	63%	58%	52%	41%	38%	50%
	Flow	G&A Occupancy - CGH	*92%*	88%	89%	88%	86%	85%	87%	87%	86%	89%	91%
		G&A Occupancy - GRH	*92%*	95%	94%	92%	94%	94%	94%	95%	95%	94%	97%
		Daily Average of boarded patients	*0*	4	3	1	4	2	3	3	3	3	3
	Safe Care	VTE Assessment within 14 hours (%)	*95%*	92%	91%	92%	86%	90%	88%	88%	89%	88%	86%
		VTE assessment completed - excluding short stay (%)	*95%*	96%	96%	96%	91%	94%	93%	93%	94%	93%	93%
		Number of Category 2 pressure ulcers acquired as inpatient		15	19	11	11	21	11	24	11	15	15
		Smoking Status Compliance (%)	*95%*	97.11%	97.16%	97.09%	97.12%	97.54%	98.40%	98.56%	98.15%	98.01%	97.70%
		Severe Harm from Patient Medication Errors	*0*	2	1	0	0	1	0	0	0	0	1
	Cancer - Breast Screening	R/Length	*>=90%*	13%	37%	26%	29%	46%	28%	18%	17%		
		SCR to RR	*>=95%*	93%	99%	91%	99%	99%	99%	99%	99%		
		Technical Repeat	*<2%*	2.2%	2.3%	3%	3%	3%	3%	3%	3%		
		Technical Recall		0.20%	0.40%	0.20%	0.20%	0.00%	0.21%	0.07%	0.12%		
		DOFOA		73%	95%	90%	87%	100%	100%	95%	97%		

UEC: Performance

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

Highlights

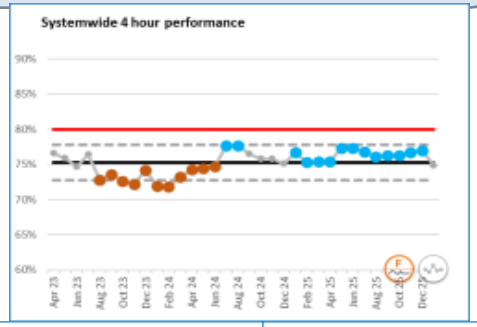
- 4-hour performance deteriorated from 64% to 60.3% in January
- 12-hour performance also fell from 90% to 87.8% in January

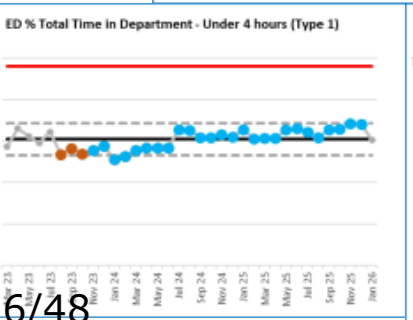
Areas of Concern

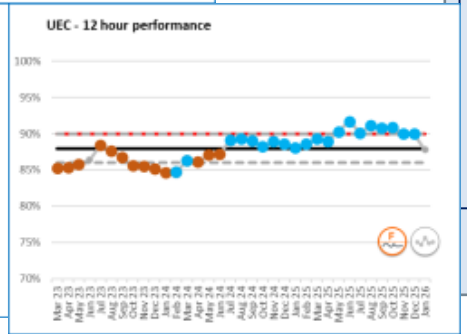
- Against improvement plans across key sub-areas all were missed in Jan (CGH narrowly)
- Quality improvement project continues across Non-Admitted activity and Minors

Looking Forward

- Renewed focus on QI project as we emerge from Christmas/New Year period
- Staff recruitment will improve streaming process adjacent to ED front door







Technical Analysis

Dip in 12-hour performance looks like a winter blip on the face of it – target will be to achieve improvement rapidly as we move into early spring

Planned Actions

Closer working between Operations and Nursing teams will seek to improve CGH performance from 90% to 95%.

Longer-term, success across Paediatrics will be driven by the appointment of some sub-specialist staff into this area (VCP approved for consultant role).

Quality Improvement group actions to approve processes in Minors include dedicated space for GP and EP staff in the department and improvong ths staffing levels to support a fast-track triage process adjacent to the ED front door.

UEC: Performance

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

Highlights

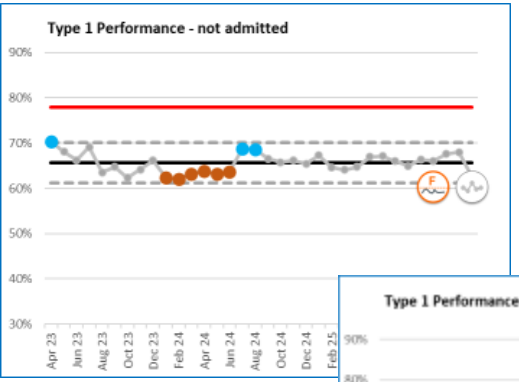
- Non-Admitted performance has fallen from 68% in Dec to 62.6% in Jan..
- Overall performance has worsened, from 64.1% in Dec, to 60.3% in Jan.

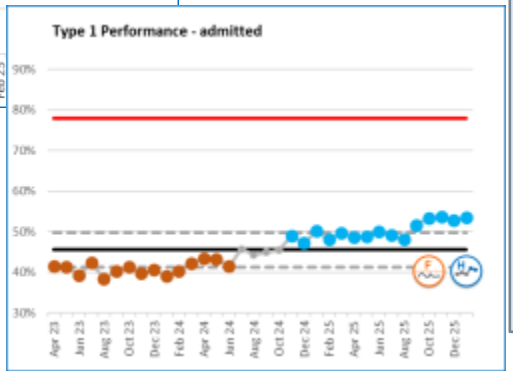
Areas of Concern

- Decision to close Ward 6B is not being balanced by a fall in NCTR patients (has risen)
- Level of attendance is in line with recent months; anecdotally acuity was higher in Jan.

Looking Forward

- Focus very much on ensuring waits to be seen by clinician retained at less than two hours – high correlation between this and delivering performance at 60+%





Technical Analysis

Detailed analysis of the month of February so far (first twelve days) shows a 100% correlation between delivery of average waits to be seen by a clinician of less than two hours and achieving a 4-hour performance of more than 60%.

Planned Actions

Quality Improvement project was paused in December due to staff leave and absences – has now restarted from January and a revised Action Log circulated.

Additional Matron presence at CGH continues to maintain performance at above 90%; further effort and links with Operations to escalate to 95+%

Additional staffing agreed to support fast-track triage near to the ED front door and a dedicated SDM in Minors as these actions should improve performance for Non-Admitted patients across the department.

UEC: Performance

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

Highlight

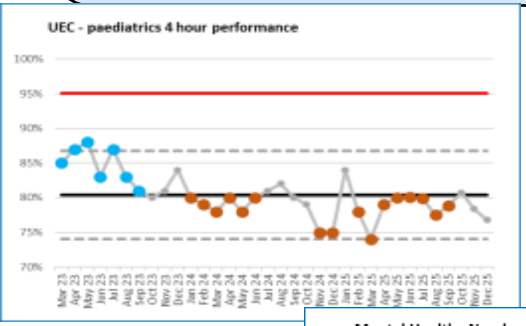
The number of paediatric attendances has fallen for the second month in succession, as has 4-hour performance amongst this group

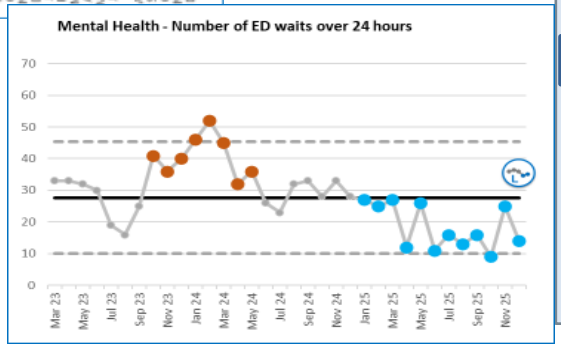
Areas of Concern

Significant challenges remain around getting patients into PAU sufficiently promptly; we continue to seek inter-divisional dialogue on this issue

Looking Forward

VCP now approved to provide a consultant in ED with specialist interest and skills in paediatric care





Technical Analysis

No significant change in volume of MH patients coming through the department in January whilst the number of paediatric patients has actually fallen. May reflect the type of presenting illnesses, but nothing in triage category to suggest that patients attending were sicker than in previous months.

Planned Actions

- Longer-term objective to develop staffing model to have s dedicated SDM within Paediatrics in ED;VCP approved
- Seeking to establish a dialogue across the System through the ICB regarding management of MH patients.

UEC: Average Handover Time

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

Highlights

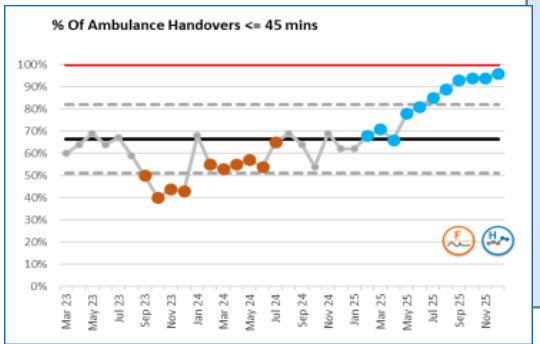
Average ambulance handover times have increased very slightly in January; from 20 minutes to 22 minutes.

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

The ongoing approach to managing ambulance handover times remains unchanged; in parallel, we will be seeking to make more effective use of Assessment Zone space to de-congest the department.



Technical Analysis

Average ambulance handover times remain well-controlled at present. Very marginal deterioration over January and th first half of February still sees average handover times will below the half-hour.

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
- Establish that the necessary staff have been recruited and training scheduled to support the development of a fast-track streaming process adjacent to the front-door in 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 has deteriorated, moving from 69.22% in December to 68.44% in January (-0.82%). The total incomplete waiting list increased from 62,716 to 63,432 (+716), all over 18 weeks.

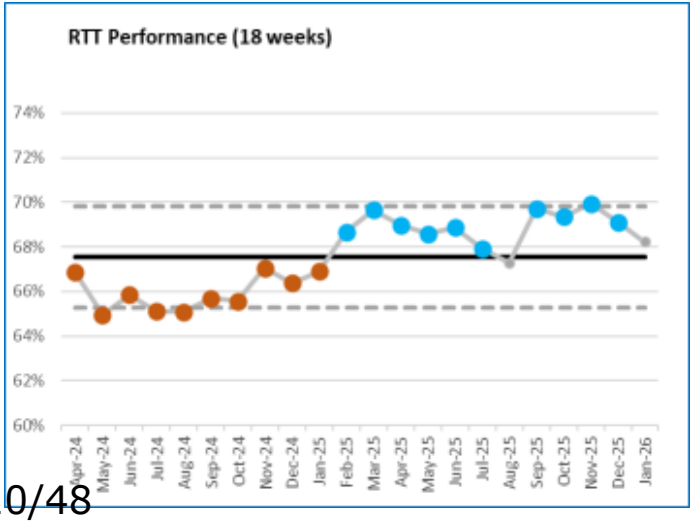
Technical Analysis

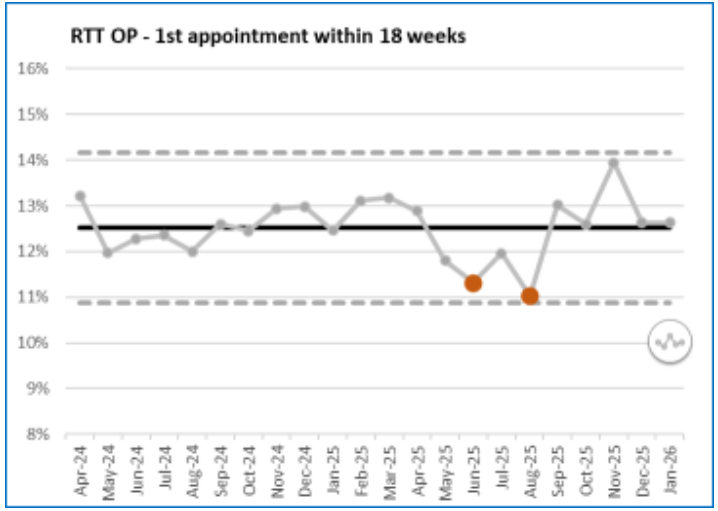
The deterioration in performance is across most specialties with the majority having increased. Only a handful of specialties have made reductions including; Ophthalmology; Respiratory, Dermatology, Rheumatology & Neurology.

There are 4,061 patients booked over 45 weeks currently of which 311 are over 52 weeks. Efforts to bring forward will be aligned with Q4 Sprint activity.

Planned Actions

- Divisions to provide a capacity plan to carve out additional new slots and reduce follow ups.
- Maintain a clear focus on 45 weeks+ elimination
- Undertake additional activity through Q4 Elective Sprint.
- Commence 5 week Validation Sprint (23/02)
- Re-initiate via ECH patient survey of all patients who will breach 18 weeks by 31/03/26





8 specialties remain below the target of 73.1% for 1st activity within 18 weeks, namely:

#1 ENT (52.5%)
#2 Dermatology (53.5%)
#3 Neurology (58.4%)
#4 Rheumatology (64%)
#5 T&O (66.6%)
#6 Gynaecology (67.6%)
#7 Other Paeds (68.8%)
#8 Oral Surgery (71.9%)

Elective: 45 Week Wait

Highlights

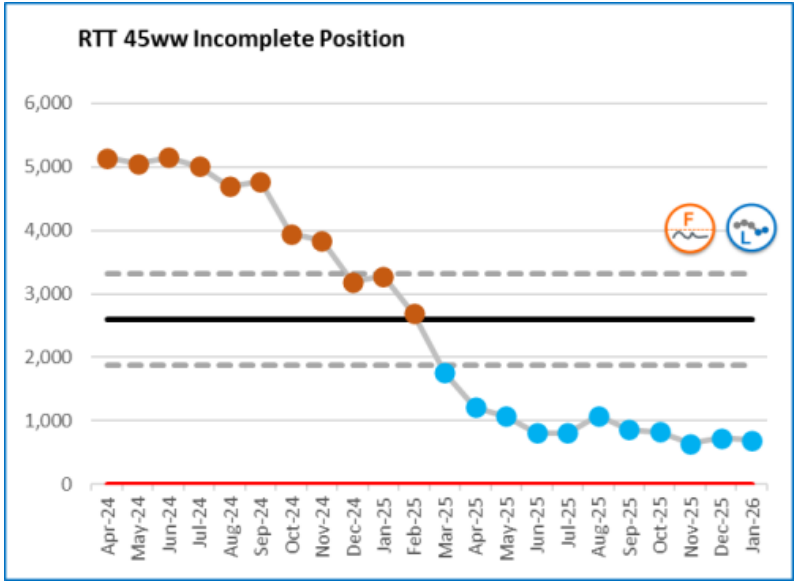
The number of 45 weeks has decreased since last month, from 724 in December to 692 in January.

Areas of concern

Continue to be Dermatology, Orthopaedics and Upper GI services due to volume. Both Dermatology and UGI have made reductions in month which has largely been supported by outsourcing.

Looking forward

Challenges will continue to exist with the 3 referenced services due to volume. However the 45 week position is anticipated to reduce prior to year-end, with additional capacity being made available through the Q4 elective sprint..



Technical Analysis

The finalised January month-end position confirmed a total of 692 x 45 week breaches. As referenced this is a reduction of 32 on last month. The majority of specialties remained static, with the only notable reductions being in Dermatology (- 50); and Upper GI (-13). Orthopaedics increased by 18.

Planned Actions

- Activity continues to flow to the new independent providers; Health Harmonie, Optimised Care, Modality Health and Pastel Health.
- Dermatology continue to IPT out to Modality Health. Triaging of patients has increased recently with an ambition to transfer out circa 500 patients.
- Outsourcing GI services (lap choles) commenced in January & will continue.
- Orthopaedics/Spines continuing to transfer patients to the Nuffield
- Q4 Elective Sprint commenced, together with validation sprint and ECH initiatives

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

Standard: 85%

Highlights

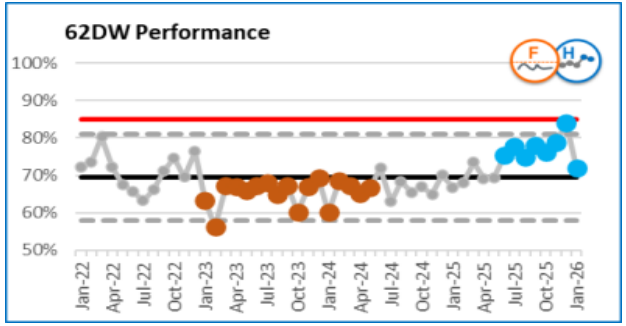
Achievement of 84% by Breast, Haem, Skin in December-25.
We have also seen a massive improvement in urology 62 Days with Prostate performance at 93% for Dec

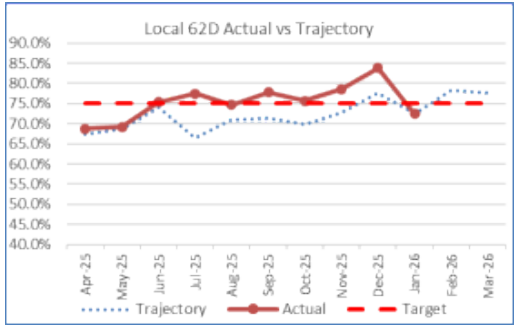
Areas of concern

Validated 62 Day standard for December is at 84% 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
January-26 unvalidated is showing 73.1% 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
We are also expecting to see a reduction in Breast performance due to the impact of seeing patients for first diagnostic significantly later in their pathway





Technical Analysis

This is 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 (28 Day FDS) % with trajectory

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

Highlights

28 Day for January is currently at 57 %but we expect February to be above 70% .
Continued increase in Urology 28-day performance

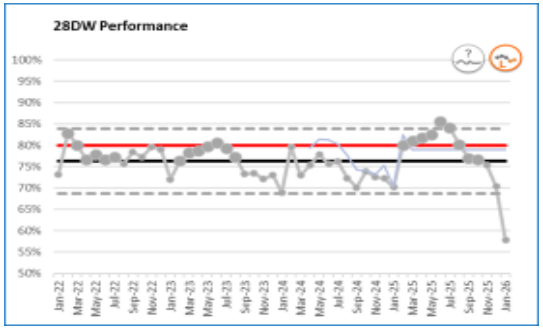
Areas of concern

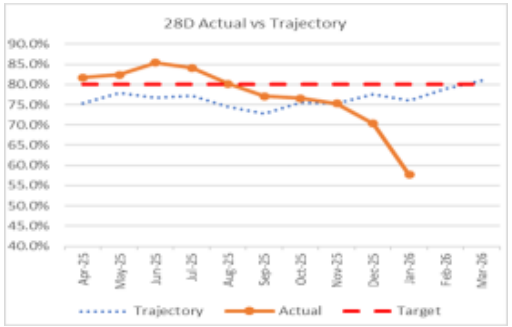
Operational capacity issues
Breast is currently booking first OPA's at day 28+ and is a real risk to overall Trust compliance with 28 day performance as similar to Skin.

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 however we recognise that performance will be impacted within December, January and February





Technical Analysis

Unvalidated 28 Day standard for January 2025 is currently at 57% and we will 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
- Additional Skin Minor Ops capacity to be delivered through Agile
- D&C modelling of first OPA capacity to book in line with BPTP
- Additional 2WW Breast Capacity and senior oversight on recovery

Cancer 62 Day Backlog Position

Highlights

- 204 on backlog as of 09/02
- Improved compliance in Skin and Gynaecology

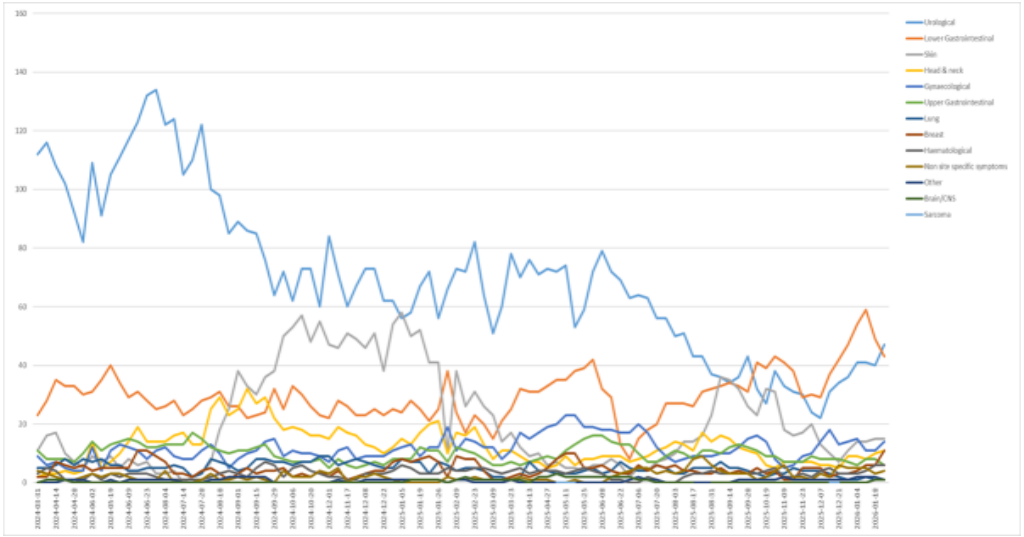
Areas of concern

- 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
- We may see an increase in the Breast backlog posiiton as a knock-on effect of delays to first appointment

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 Urology 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 – January 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		
	Nov-25	Dec-25	Jan-26	Nov-25	Dec-25	Jan-26	Nov-25	Dec-25	Jan-26	Nov-25	Dec-25	Jan-26
Acute leukaemia										100.0%		
Brain/CNS	92.9%	100.0%	100.0%	100.0%	100.0%	71.4%	75.0%	100.0%				
Breast	8.9%	4.2%	6.0%	86.5%	55.1%	23.0%	96.5%	97.4%	90.3%	90.9%	98.1%	82.0%
Gynaecological	87.2%	94.8%	90.6%	54.0%	59.4%	64.3%	95.9%	90.7%	71.0%	84.6%	65.4%	36.4%
Haematological	88.9%	81.8%	95.0%	58.3%	33.3%	35.0%	100.0%	100.0%	100.0%	94.4%	73.5%	82.6%
Head & neck	92.8%	89.2%	92.1%	84.1%	87.3%	75.5%	96.7%	100.0%	85.2%	53.3%	100.0%	84.6%
Lower GI	92.1%	92.9%	94.2%	76.0%	74.6%	68.8%	84.3%	81.8%	58.6%	45.6%	58.8%	36.6%
Lung	96.4%	95.5%	91.3%	92.6%	89.3%	92.0%	90.7%	89.1%	80.8%	56.0%	72.7%	58.8%
Other						100.0%	100.0%	100.0%	100.0%	77.8%	81.8%	100.0%
Sarcomas							100.0%	100.0%	100.0%	0.0%		0.0%
Skin	71.3%	79.8%	70.5%	64.2%	69.4%	76.5%	96.4%	96.0%	95.1%	93.4%	92.6%	89.7%
Non site specific symptoms	8.3%	5.6%	0.0%	22.2%	23.7%	13.8%						
Testicular	100.0%	90.9%	100.0%	100.0%	83.3%	80.0%						100.0%
Upper GI	98.4%	96.8%	98.5%	94.4%	93.1%	91.8%	100.0%	94.5%	95.1%	77.3%	82.7%	76.7%
Urological	94.7%	96.8%	94.3%	59.5%	64.3%	56.9%	96.5%	96.0%	74.8%	76.1%	88.8%	77.8%
Trust Total	72.9%	73.6%	67.8%	74.8%	70.6%	59.0%	95.6%	94.6%	84.2%	78.7%	84.0%	72.1%

Screening Programmes: Breast Screening

Highlights

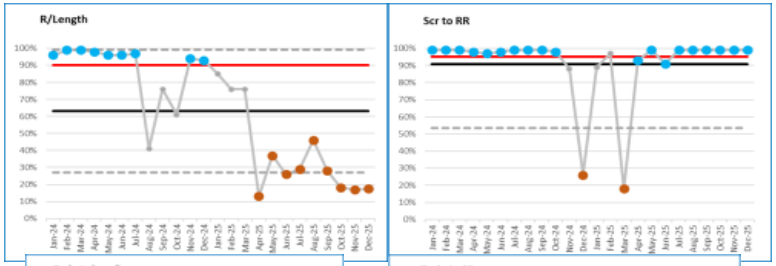
- Reduction of backlog to 5866 at start of Feb from a peak of 10,016 at the start of November 2025, 59% reduction in backlog in 3 months.
- Additional capacity of 500 in Feb with 600 planned in March
- Successful implementation of screening at Nuffield.

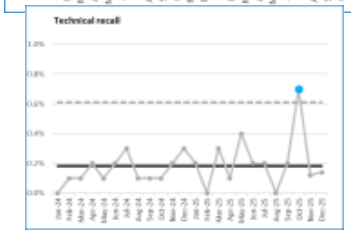
Areas of concern

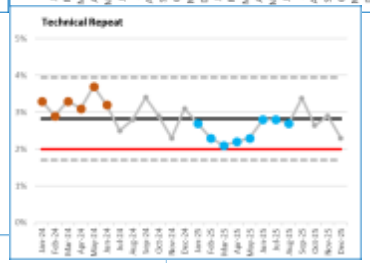
- Limited capacity due to inadequate numbers of radiographers,
- Reliability of mobile units due to increased throughput, combined with equipment moving towards end of life. Robin has had several days of downtime.

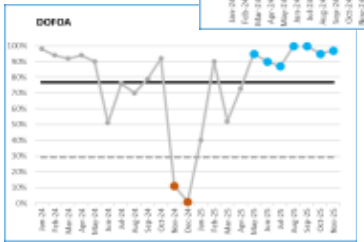
Looking forward

- B6 Mammographer recruited and will start on 1st April 2026.
- Final review by NHSE of the long-term sustainability business case.
- Mobile unit moving to Moreton-in-Marsh only 11 weeks behind (previous GP surgery 20 weeks behind, reduction in 9 weeks).









Technical Analysis

- Current backlog is 5866, which is a reduction of 320 from last month. Reduction has slowed due to cancellations of some sites due to staff sickness and equipment failure and due to a practice merger resulting in some patients being screened at 24 months.
- Current round-length has dropped to 36 months + 20weeks for longest waiters, although some areas (those screened in Cheltenham) are being screened at 36 months.
- Recovery is projected by July 2026, however without recurrent funding this cannot be maintained.

Planned Actions

- 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.
- Continuing a 7-day service with Cancer Alliance / NHSE funded Sunday clinics, which have supported with accelerated recovery of the backlog.

Diagnostics: Performance Trend

Highlights

Improvement of 1.79% compared to December .Waiting list reduction of just 103 patients, although breaches reduced by 281.

Areas of concern

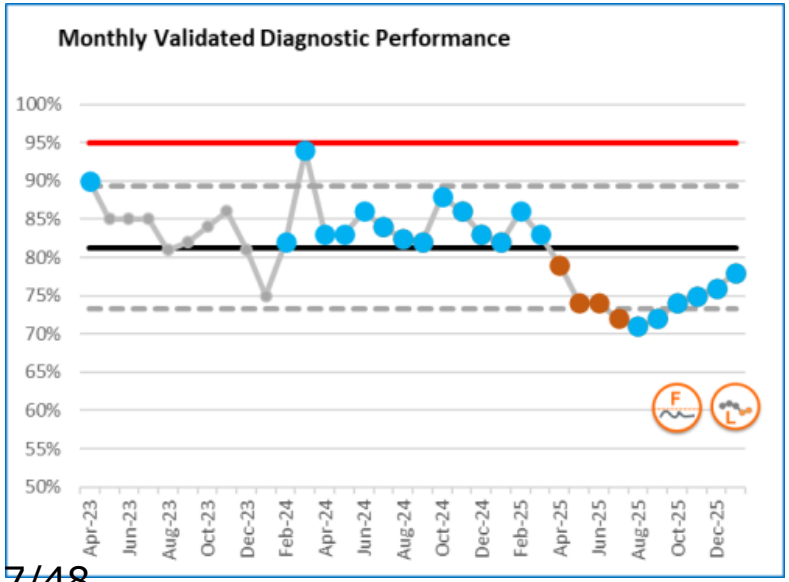
Sleep Studies – for consecutive months the service have experienced an increase in breaches, with the position doubling in January (from 27 to 59). Although small numbers recovery is required.

Majority of all other specialties demonstrated positive progress

Looking forward

CT performance will continue to improve.

ECHO will continue to improve whilst 3rd party support is available. Continuing recruitment programme.



Technical Analysis

Five modalities demonstrated notable improvements in breaches, namely ECHO (-162); Neurophysiology (-76); Gastroscopy (-55); Flexi Sigmoidoscopy (-46) and CT (-21).
Sleep Studies experienced a small increased in breaches increasing from 27 in December to 59 in January (+32).

Planned Actions

- **Neurophysiology** has recovered the negative position in December and made a 9.91% improvement on last month representing a reduction of 76 breaches
- **Endoscopy** - Additional recovery funding generated through Cancer Transformation and Community Diagnostic Centre funds. Additional weekend lists commencing in December 2025 and ongoing. 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.
- **Sleep Studies** - recovery actions sought, noting that breaches have been influenced by increase referrals in latter part of 2025, and impacted by Bank holidays and absence.

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	2025-12-01	2026-01-01
Audiology - Audiology Assessments	99.38%	98.98%	99.22%	99.22%	98.27%	99.76%	99.66%	99.65%	99.88%	100.00%
Barium Enema	83.55%	99.08%	100.00%	100.00%	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%	30.78%	28.52%
Colonoscopy	67.16%	72.55%	64.09%	51.96%	45.87%	48.34%	51.27%	50.60%	48.91%	50.00%
Computed Tomography	92.83%	91.28%	90.81%	89.75%	86.15%	88.47%	89.11%	87.28%	87.07%	88.64%
Cystoscopy	45.18%	38.97%	33.40%	28.29%	36.31%	28.36%	32.75%	36.93%	39.83%	41.96%
DEXA Scan	100.00%	100.00%	100.00%	99.77%	100.00%	100.00%	100.00%	99.82%	100.00%	100.00%
Flexi sigmoidoscopy	74.47%	61.40%	51.05%	45.05%	40.29%	42.34%	41.69%	38.54%	37.40%	47.55%
Gastroscopy	86.10%	80.38%	75.00%	77.54%	74.81%	73.63%	71.75%	73.81%	73.77%	82.48%
Magnetic Resonance Imaging	77.59%	76.09%	85.26%	91.42%	99.17%	98.90%	99.10%	97.84%	99.11%	99.02%
Neurophysiology - peripheral neurophysiology	40.88%	43.82%	35.68%	53.05%	56.86%	60.87%	62.28%	75.14%	59.76%	69.67%
Non-obstetric ultrasound	99.68%	99.93%	99.49%	99.18%	99.40%	99.47%	99.64%	99.91%	99.63%	99.36%
Respiratory physiology - sleep studies	98.26%	90.38%	96.73%	96.43%	97.90%	94.22%	96.27%	99.22%	91.69%	82.23%
Urodynamics - pressures & flows	76.09%	100.00%	75.81%	87.50%	100.00%	100.00%	100.00%	100.00%	91.67%	100.00%

Flow Summary

Highlights

Demand continues to increase with higher numbers of emergency admissions, despite a reduced bed base. Supported by an overall reduced emergency LOS.

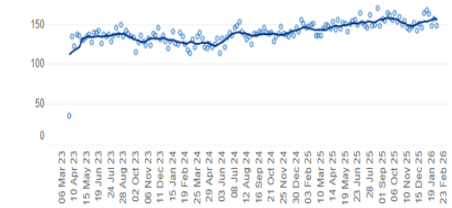
Areas of concern

Reduction in numbers of simple or pathway 0 discharges alongside a reduced numebr of discharges at weekends. Both reducing from around August/September 2025

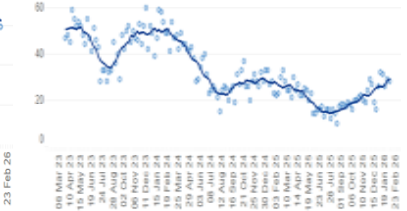
Looking forward

Normal seasonal variation will be having an impact, ongoing work around flow should support further improvements and reduction in ED congestion.

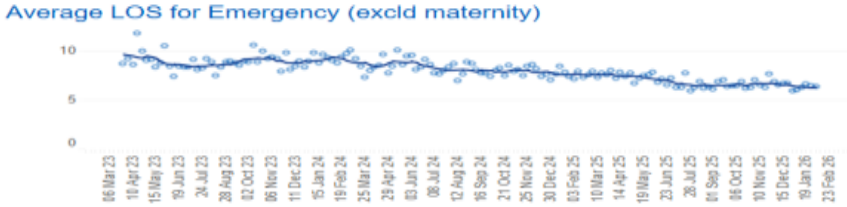
Emergency Admissions



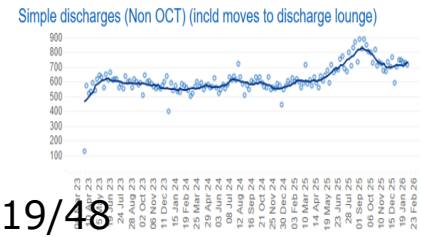
Number of patients in ED waiting for DTA @6pm



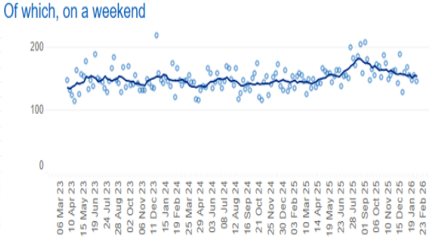
Average LOS for Emergency (excld maternity)



Simple discharges (Non OCT) (incld moves to discharge lounge)



Of which, on a weekend



Technical Analysis

Demand during the winter periods up as per normal seasonal variation, but concern also seeing a continued upward tradjectory. Driven through admission both through ED and improved SDEC patwhays. Corresponds with high demand and need also within the elective pathway. This is in the context of having significantly reduced the bed base over the past 12 months. Challenges within the system with higher-than-average number of conveyances and subsequent admissions comparable to our regional and national peers.

Planned Actions

Focus through the CVOF work to understand discharge profiles and impact of potentially higher levels of acuity and dependency amongst patients, along with improved admission avoidance/short stay meaning the patients admitted tend to be more complex. Consideration of 7 day clinical services to improve flow throughout the weekend which significantly impacts Mon-Weds, alongside the embedding of CLDs.

Discharge Ready Summary

Highlights

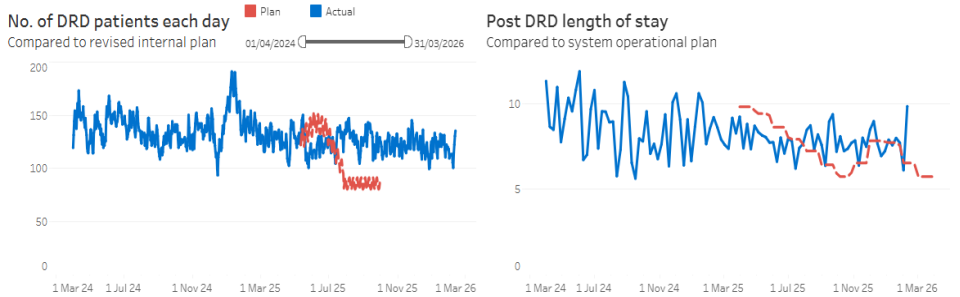
In month increase in DRD as per expected seasonal variation, but significantly lower than previous winter surges.

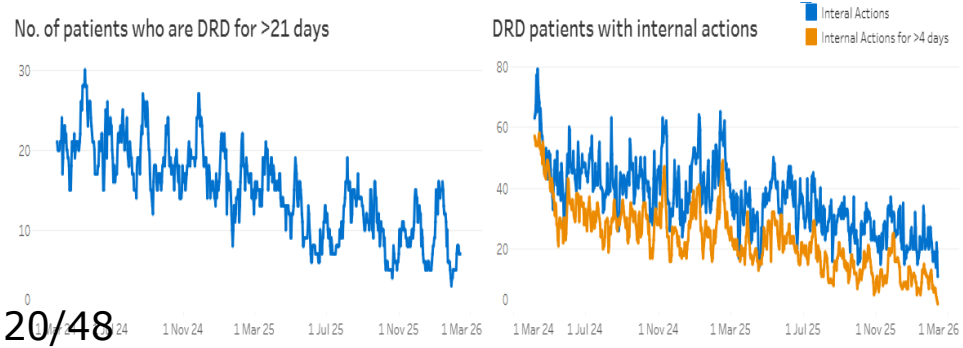
Areas of concern

Demand for pathway 1-3 discharges increasing, so overall number diven more through demand than flow. Overall delays both internal and external significantly improved.

Looking forward

Ongoing work through system portfolio and wider DRD improvement workstreams to further reduce DRD LOS and delays which will support reduced numbers.





Technical Analysis

Data represents an expected seasonal variation associated with winter and increased demand of onward care. Notably the increase was significantly lower than in previous years linked to pre Christmas planning. Longer delays for DRD patients and been significantly reduced in line with national expectations, supported but much improved internal processes and removal of internal delays.

Planned Actions

System agreed target of 87 DRD patients with further improvements being discussed through this years planning rounds. Focus on improving pathway 1-3 discharges over the weekend and Mondays/Tuesdays as typically lower days based on current data.
System now agreed pathway 1 weekly provision across GHC and GCC, including the increase of starts to 80 per week. This should see a net reduction in our number of patients delayed awaiting pathway 1 specifically.

Delay Related Harm Summary

Highlights

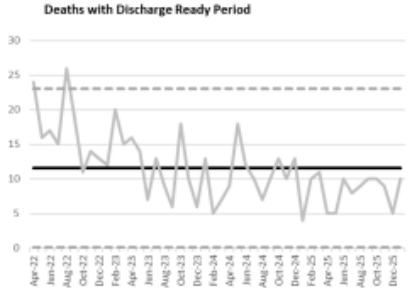
The number of patients reverting to CTR having DRD has climbed, but is within normal seasonal variation and is significantly below the deterioration seen in previous years.

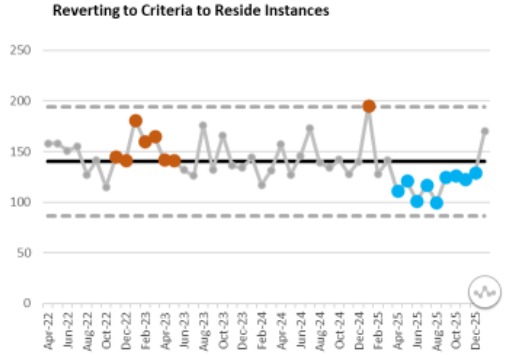
Areas of concern

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

Ongoing cross system work around improved processes and capacity across discharge pathways to meet the system agreed trajectories.





Technical Analysis

Change in line with expected seasonal variation with no particular concern comparatively to previous months. Overall, still a key focus with need to continue to reduce DRD delays and associated risk.

Planned Actions

Agreed additional DCA capacity to support better pathway 1 flow. Operationally being embedded with some challenges around workforce. The introduction of this should significantly improved DRD associated bed delays within pathway 1 with a knock on benefit to flow within pathway 2.
Alongside this new pathway 2 bed base being commissioned to replace current bed base which is restricted in its ability to take the more dependent level of patient now accessing pathway 2.

Quality Metrics

(Safety, experience and effectiveness)

Quality of Care: FFT Positive Response

Highlights

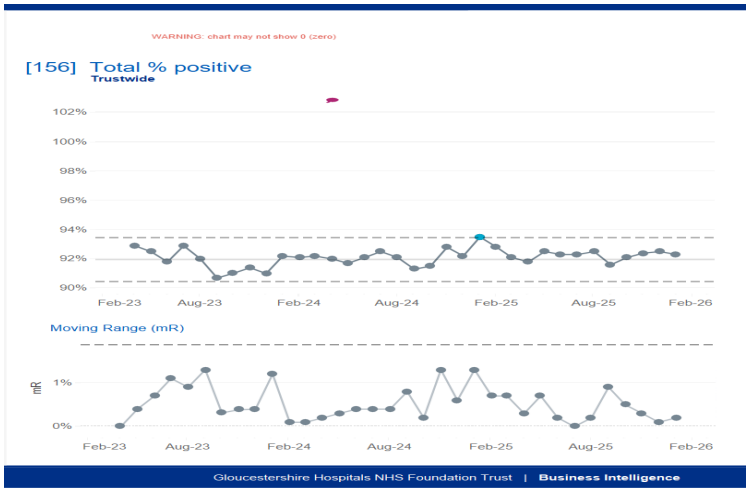
FFT positive score remains above average. Slight increase from previous month and our position at the same point in the previous year.

Areas of concern

We have seen a decrease in positive score for ED (to 73% from 77%) with an increasing, significant difference in score between our ED's (CGH 90% and GRH 65%).

Looking forward

Our overall position did not reduce in January (which would have been in line with previous trends.



Technical Analysis

The overall Friends and Family Test (FFT) score has remained static at 92.3% in Jan and remains above average. Slight decreases across both ED impacts on the overall position due to the much higher responses.

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

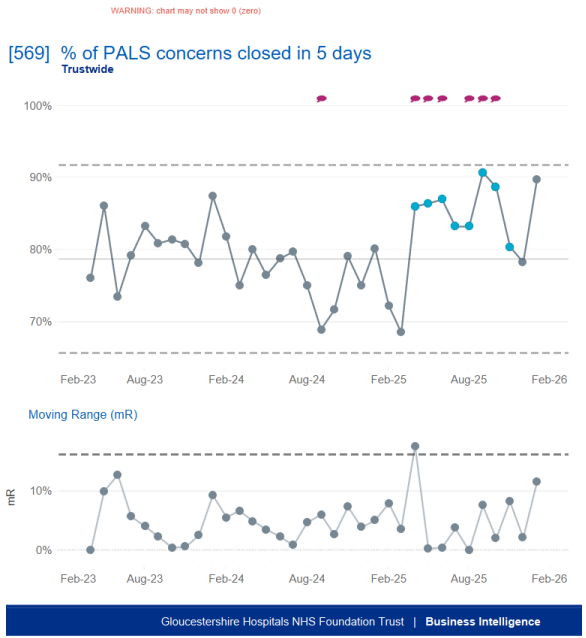
Closure rate maintained above target (75%) at 90%. Position remains positive.

Areas of concern

Volume of cases increased. Long term sickness continues with two members of the team currently off, this has been compounded by annual leave.

Looking forward

We have seen an increase in cases through January and we have been able to close them within the KPI.



Technical Analysis

The PALS team have increased the closure rate to 90% of concerns being closed in 5 working days and remain 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.

Planned Actions

Workload distribution continues to be reviewed to support PALS staff including support from the wider Patient Experience Team. The PALS and wider patient experience team have been successfully supporting medical students (3 counties) to undertake a short placement with the service to support their wider learning.

Patient Care: Mixed Sex Breaches

Highlights

Mixed sex accommodation breaches remain low and are an exception

Areas of concern

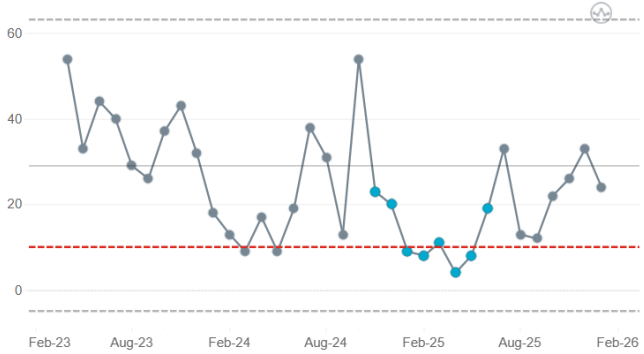
Delays in transferring out of Critical Care and Recovery create MSA breaches

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

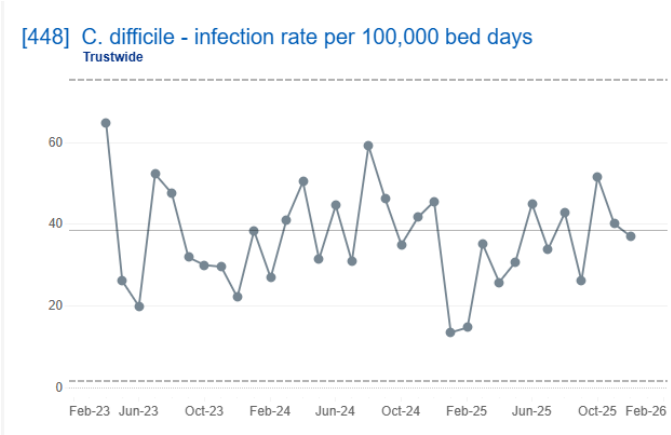
The annual CDI threshold for 2025-2026 has been set 97; we have had 79 cases since April 2025- December 2025; we are 1 case under trajectory

Areas of concern

Ward/ environmental and equipment cleanliness e.g. mattresses and beds and estate condition. More samples were also sent in response to increased Norovirus rates.. Prompt isolation of patients with diarrhoea

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 79 trust apportioned cases of *C. difficile;* we are currently under 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. Efficacy audits are also now re-established as joints with IPC and estates

Safety Priority: Patient Falls

Highlights

Number of falls within the trust remain low and number of falls of injurious falls also remains static. 5 falls resulted in injurious harm and will be reviewed through PSIRF processes.

Areas of concern

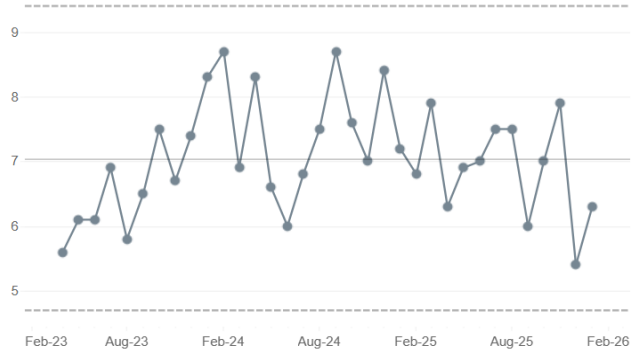
Falls remain a challenge for the Trust, due to the acuity of the patients, increased controls on the use of enhanced care and the length of time for discharge due to capacity in community services

Looking forward

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

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

Trustwide



Technical Analysis

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

Planned Actions

Improvement focus is on specialist review of patients who have fallen twice during admission, if appropriate. A comprehensive training package has been launched by the Falls Team and is being very well attended; this is a key focus for us.
Quality improvement programmes continue, with Datix development and EPR documentation near completion. Immediate Post falls forms for both Nursing and Medical staff now live and in use – data to be gathered mid February

Safety Priority: Pressure Ulcers Cat 3

Highlights

We continue to use the Patient Safety Incident Framework (PSIRF) to learn and improve when safety incidents are reported.

Areas of concern

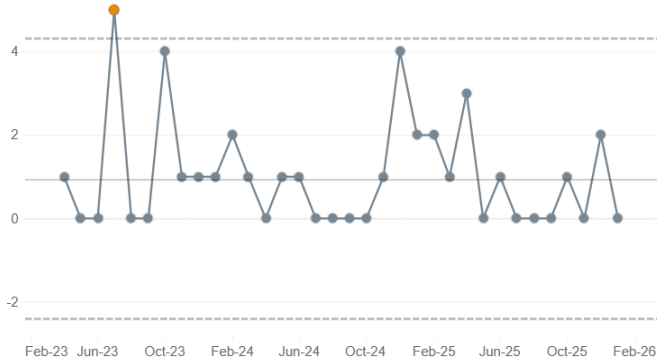
Numbers are low and we continue to learn from each case reported.

Looking forward

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

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

Trustwide



Technical Analysis

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Planned Actions

Improvement focus continues 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.

Mortality – SHMI National Data

Highlights

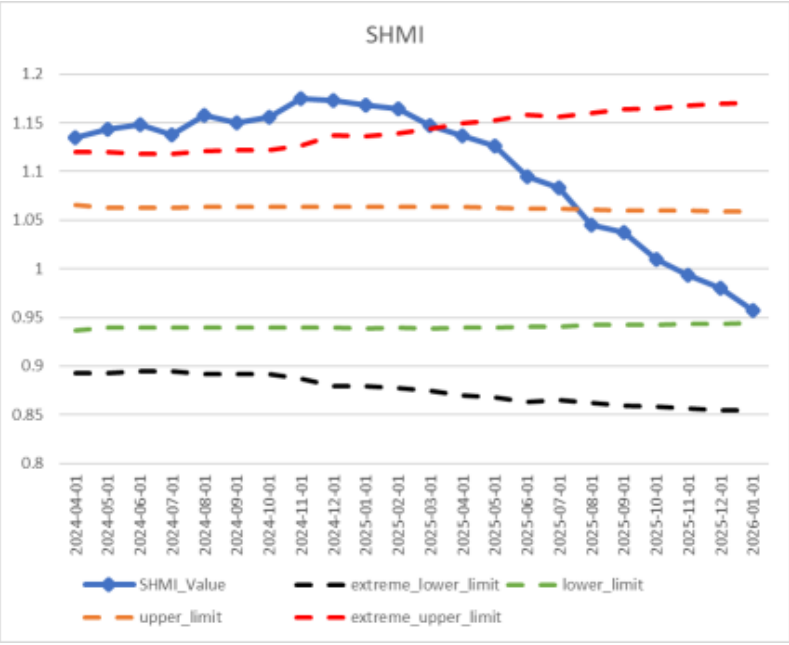
Latest SHMI (NHS Digital) = 0.9568
(data upto Aug 2025)

Areas of concern

Sustainability of coding work – moving to Business As Usual without need for remedial coding work after EPR upgrade 02/26

Looking forward

SHMI remaining in expected limits



Technical Analysis

Continued fall in 12m rolling SHMI

In/Out of hospital, CGH/GRH and weekend admissions all now within expected range

Planned Actions

SHMI Sustainability Action Plan ongoing:

EPR change: Active / Inactive Health Issues implemented 02/26
New Coding policies for CKD / CSVD / Dementia under consultation
QI projects in AMU to improve CKD diagnosis and recording

PSIRF (Patient Safety Incident Response Framework) Learning Responses

Highlights

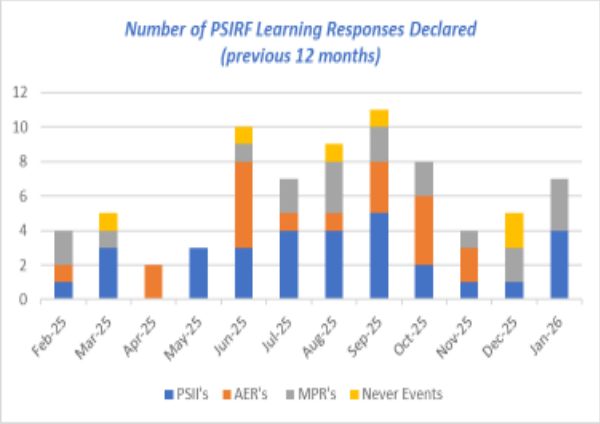
75 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 6.25 per month. All Learning Responses in January were completed in required timescales.

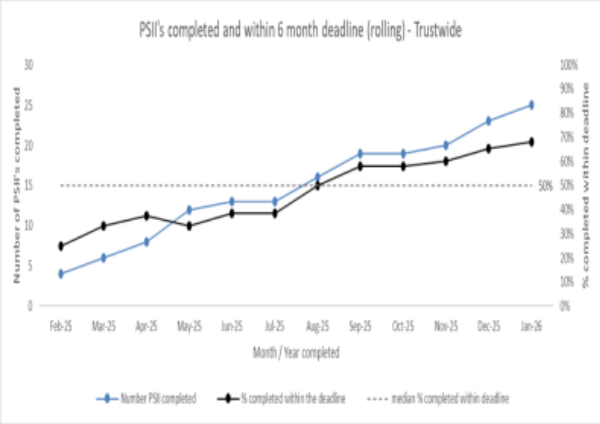
Areas of concern

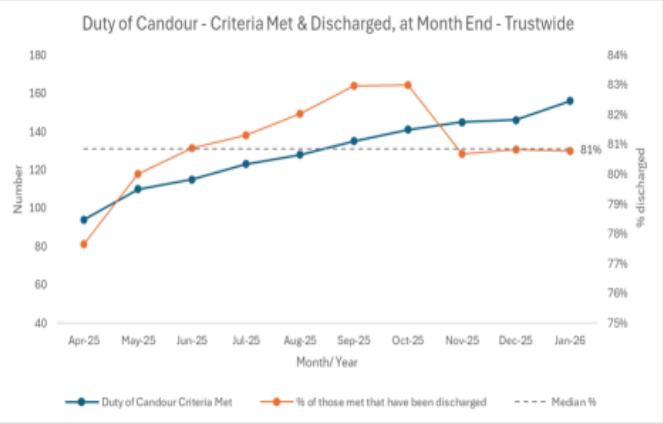
Timeframes within which learning responses are completed. Median on time for PSII's remained at 50%, for AER's at 62% and MPR's improved to 71%.

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:

Resource: Implementation of the Quality Governance Framework

Never Events: The Surgical Division has implemented a comprehensive programme of actions to strengthen patient safety and reduce recurrence risk.

Complaint Performance 2025/2026

Highlights

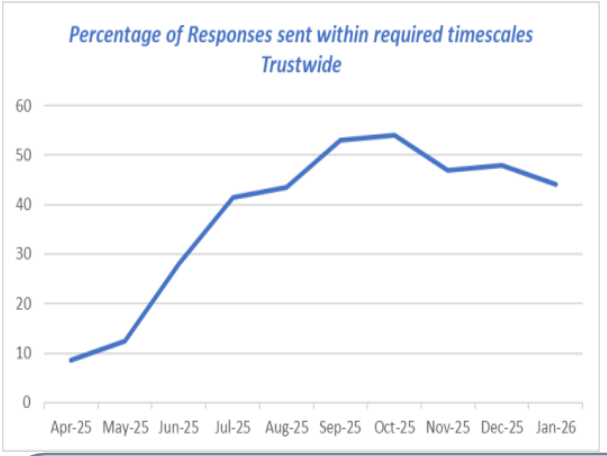
The Trust wide commitment to improve response timeframes has enabled a significant backlog to be cleared and evident improvement in the percentage of responses being sent within required timeframes.

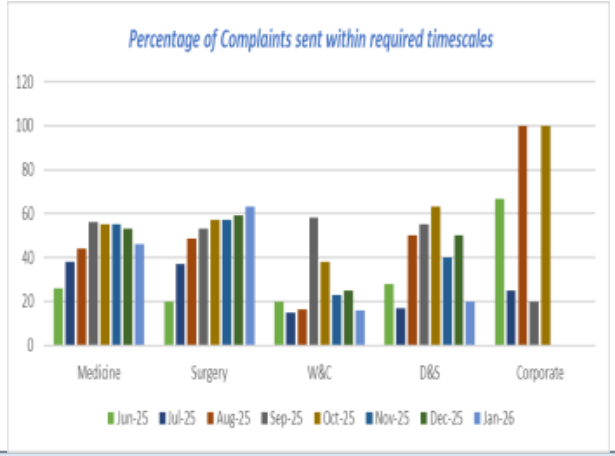
Areas of concern

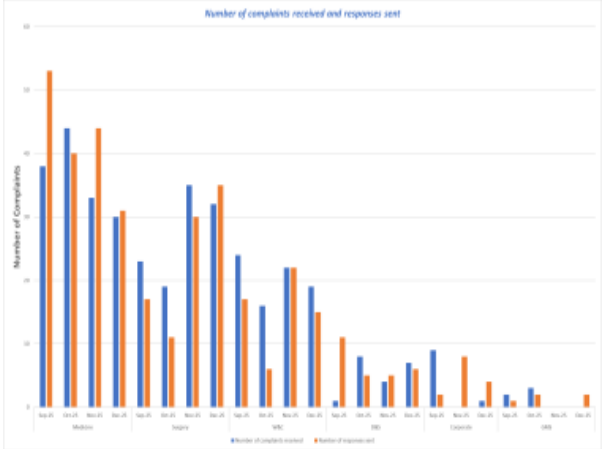
Workforce gaps in the Head of Complaints and Complaints Manager (W&C, D&S, Corporate) posts are impacting performance across the Trust. The Complaint Improvement Programme is on hold.

Looking forward

The new Complaint Framework has been piloted in multiple specialties. This will be implemented Trustwide when workforce gaps are addressed.







Technical Analysis and Planned Actions:The percentage of responses sent within required timescales in January 2025 was 44%. Performance had increased to 54% in October but has reduced slightly in November, December and January Factors affecting performance are largely related to workforce; annual leave/sickness in October and vacancies in November, December and January 2025. The drivers for sustained improvement are successful recruitment and the ongoing 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 to the Executive team on progress with actions. There are currently 15 complaints in this category. Workforce gaps are being partially covered by additional hours and bank work.

Use of Resources Metrics

Financial Metrics

Highlights

Revenue is £0.1m favourable to planned deficit of £0.1m.
Agency spend is £0.1m higher than NHSE target.
Bank spend is £0.16m lower than NHSE target
FSP is £5.9m adverse to plan. Capital spend is £18.6m behind plan. The Trust is holding 14 days operating cash.

Areas of concern

Recurrent delivery of FSP continues to be the main area of concern. In year shortfall is £5.9m, with a recurrent shortfall of £11m.

Capital spend continues to be behind plan.

Looking forward

The Trust and ICS are reporting breakeven positions in line with plan for 2025/26.
The internal financial position is breakeven which is in line with plan.

	Metric		Month 7			Month 8			Month 9			Month 10		
			Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
NHS England Oversight Metrics	Revenue (deficit)/surplus	Ytd £'000s	2,628	416	-2,212	-300	-3,607	-3,307	-325	-897	-572	-83	35	118
		Forecast £'000s	0	0	0	0	0	0	0	0	0	0	0	0
	Agency spend against NHSE target		-530	-1,133	-603	-747	-248	499	-492	-1,410	-918	-550	-637	-87
	FSP	Ytd £'000s	22,638	17,493	-5,145	26,418	20,708	-5,710	30,147	25,243	-4,904	34,134	28,191	-5,943
		Forecast £'000s	41,775	41,775	0	41,775	41,775	0	41,775	34,563	-7,212	41,775	34,694	-7,081
	Capital vs budget plan	Ytd £'000s	19,585	9,946	-9,639	26,191	12,520	-13,671	30,807	16,502	-14,305	38,410	19,812	-18,598
		Forecast £'000s	55,638	55,082	-556	55,638	55,082	-556	55,638	55,099	-539	55,638	55,385	-253
	Nos days operating cash		5	19	14	5	16	11	5	13	8	5	14	9
	BPP - nos invoices paid in 30 days		95%	99%	4%	95%	97%	2%	95%	96%	1%	95%	92%	-3%
	Bank spend against NHSE target		-2,900	-3,257	-357	-2,659	-3,840	-1,181	-3,151	-3,997	-846	-3,017	-2,851	166

Risks

The Trust financial position is faced with significant risks including:

- FSP delivery.
- Further industrial action in response to pay award.
- Operational impact of winter pressures
- 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.

M10 Revenue Position

Highlights

The Month 10 in month position is £0.9m surplus which is £0.7m favourable to plan. The YTD position is £40k surplus which is £0.1m favourable to plan. The YTD plan is £0.1m deficit.

Areas of concern

- FSP £5.9m gap, with a recurrent gap of £11m.
- Maternity cover (in addition to funded element c.50%) £1.m

Looking forward

The Trust and ICS are reporting breakeven positions in line with plan for 2025/26.
The internal financial position is breakeven which is in line with plan.

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	(71,061)	(73,546)	(2,486)	(695,275)	(713,389)	(18,115)
Pay	44,550	41,785	(2,765)	426,397	427,705	1,308
Non Pay	26,253	30,823	4,570	268,961	287,048	18,086
Total	**(258)**	**(938)**	**(680)**	**84**	**1,363**	**1,280**
Donated Assets/Impairments/	**0**	**(12)**	**(12)**	**0**	**(1,401)**	**(1,401)**
Adjusted (surplus)/deficit	**(258)**	**(950)**	**(692)**	**83**	**(40)**	**(121)**

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 FSP gap, 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.

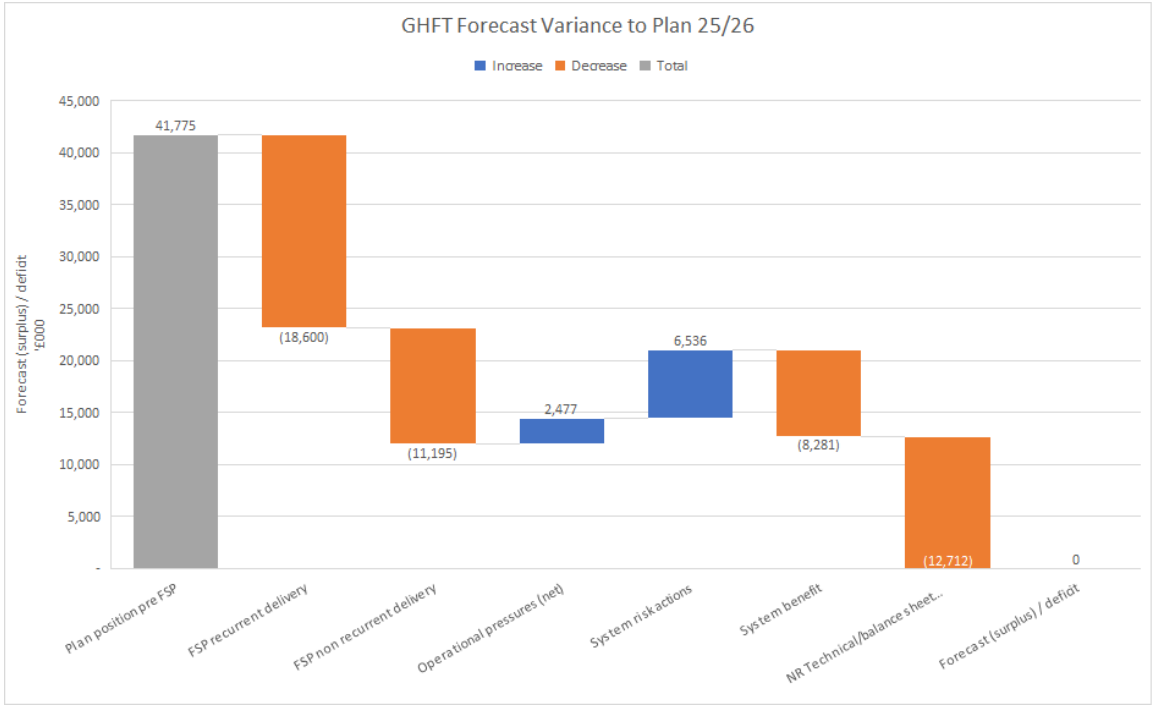
Forecast Outturn and Drivers

The 25/26 position is being managed through non recurrent income and recovery actions. This has enabled the Trust to cover current pressures and industrial action.

As a result of this additional funding, the Trust is now forecasting a breakeven position which is in line with plan.

Despite the forecast breakeven position, the Trust will end the year with a significant underlying deficit. This is because we are managing our cost pressures using one off benefits and are forecasting to deliver c.54% of our recurrent FSP target.

This means that we will continue to have an underlying deficit in 26/27, the majority of which is driven by shortfall in recurrent FSP which has been accumulating for the last few years.



M10 Pay

Highlights

Pay is overspent by £1.3m.

This includes £1.9m unfunded maternity cover.

Areas of concern

Non delivery of FSP continues to be a significant pressure. The gap is £1.6m but this includes £3m non-cash releasing savings. If these are excluded, the pressure is £4.6m.

Looking forward

On the face of it, all workforce groups are underspent if maternity cover is removed. However, there remains a £4.6m FSP pressure which has not been met. Underspends are helping to support the pressure but this is assumed to be non recurrent until posts are removed.

Summary Pay Position (Trust Only)	M10 YTD Plan £000s	M10 YTD Actuals £000s	M10 YTD Variance £000s
Infastructure	67,915	65,655	(2,260)
Medical & Dental	133,999	134,594	596
Nursing	166,332	165,862	(470)
Other Clinical Staff	62,992	61,360	(1,632)
Total (excl reserves)	**431,238**	**427,472**	**(3,767)**
Reserves (FSP & Other Staff)	**(964)**	**(84)**	**880**
Divisions (FSP target & vacancy factor)	(3,877)	317	4,194
Adjusted (Surplus)/Deficit	426,397	427,705	1,308

Summary Pay Variance (Trust Only)	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Total
Infrastructure	(3,081)	290	134	103	136	157	(2,260)
Medical & Dental	153	495	1,038	(929)	(395)	233	596
Nursing	110	(143)	3,564	(2,598)	(527)	(875)	(470)
Other Clinical Staff	49	(1,599)	(130)	114	(94)	28	(1,632)
Other Staff Sub	(43)	797	1,767	880	788	886	5,075
YTD Variance	(2,813)	(161)	6,373	(2,430)	(91)	429	1,308

Technical Analysis (further info on following slides)

Nursing underspend of £470k, of which £943k is due to unfunded maternity cover.

Medical staffing overspend of £0.6m of which £0.54m 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£3m is within corporate, primarily CIO.

Planned Actions

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

M10 Nursing Pay

Highlights

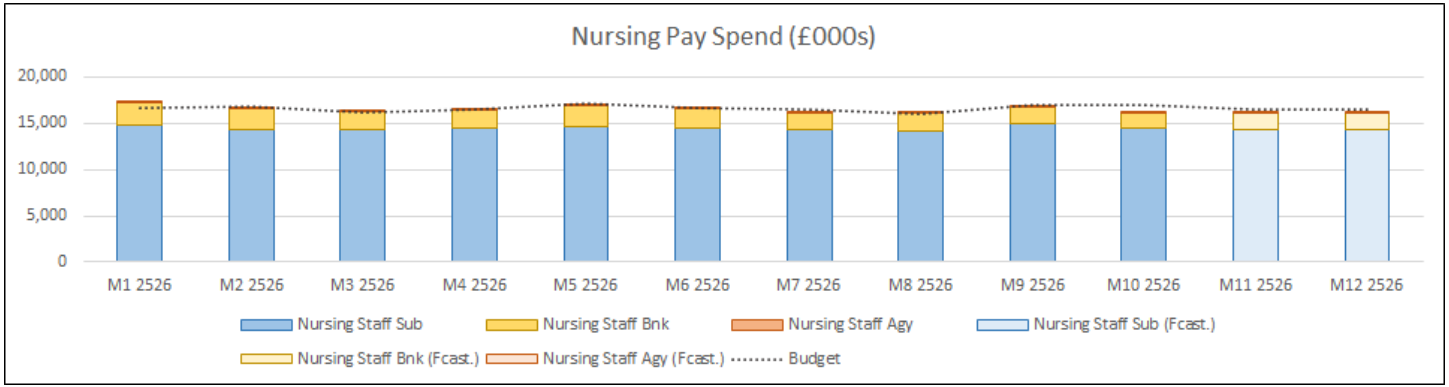
The Month 10 YTD nursing position is £496k underspent of which £943k is unfunded maternity leave cover. YTD spend is £165.9m against a budget of £166.3m.

Areas of concern

Agency has increased slightly but is now at £60k per month which is a significant change from 24/25. Bank costs have reduced but this is expected to increase again in M11 due to operational winter pressures.

Looking forward

Temporary staffing levels continue to be high, particularly bank. Both bank and agency spend is required to reduce even further in 26/27 to meet new NHSE targets.



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 now in place.

M10 Medical Pay

Highlights

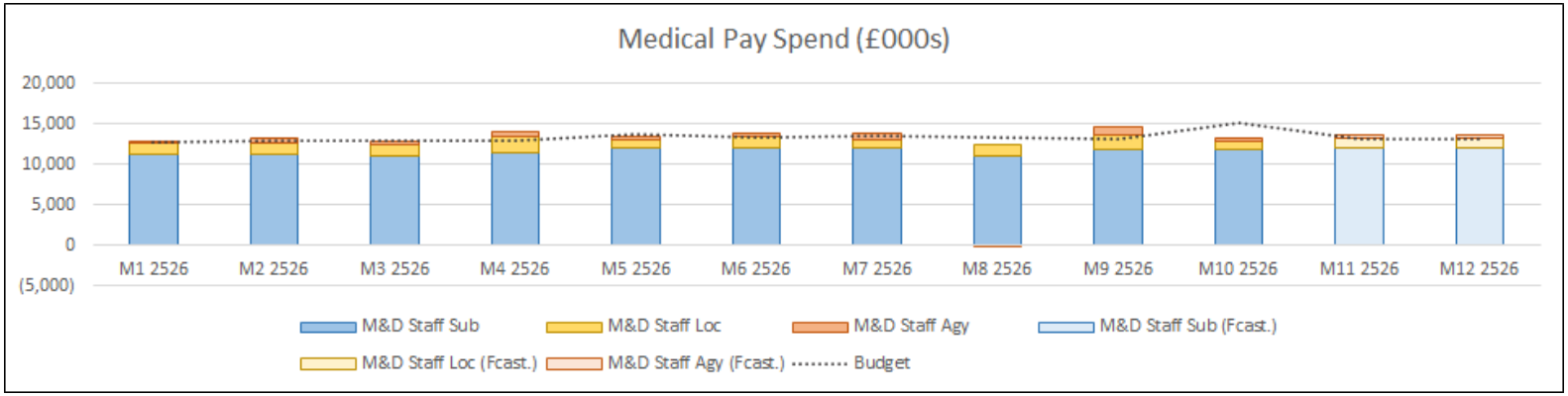
Medical staffing overspend of £0.6m of which £0.54m is unfunded maternity cover. It also includes a one off £700k benefit from some of the annual leave accrual dropping out.

Areas of concern

Agency has reduced and is slightly below run rate. Prior month contained a catch up of prior-period invoices. Concern is that there remain some very high cost temporary doctors that have a significant impact on run rate if not closely monitored and managed with a robust exit plan.

Looking forward

Medical pay is forecast to be c£1.8m 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

M8 position was particularly low spend due to annual leave accrual being released from the balance sheet.

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.

M10 Non Pay

Highlights

The non pay position is £18m overspent, reducing to £7.8m overspend after excluding passthrough drugs and IFRIC12 & donated assets.

Areas of concern

FSP gap of £3.6M is a significant driver of the variance and is contributing to the underlying deficit due to inability to deliver recurrent savings..

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	19,322	-17,548	4,999	**6,772**
Drivers of variance				
IFRIC12 & donated assets		1,401		**1,401**
Pass through drugs and devices	8,600		211	**8,811**
System wide savings not being delivered			5,348	**5,348**
FSP gap	2,584		1,079	**3,663**
Clinical supplies in divisions	1,788			**1,788**
Release of 3% productivity reserve			-426	**-426**
Non Passthrough drugs	2,901	79	0	**2,980**
Reserves slippage			-1,213	**-1,213**
SABA bad debt provision release		-3,500		**-3,500**
Interest Receivable & Payable + finance costs		-2,825		**-2,825**
Car parking (offset by income)		348		**348**
Other	3,450	-1,738		**1,711**
Total YTD Variance	19,322	-6,234	4,999	**18,086**

Technical Analysis

Pass through drugs are driving a pressure, although partly offset by £5m income overperformance. In theory the costs of passthrough drugs should be completely recovered from commissioners. We have reviewed how the costs and income are flagged in the pharmacy system and have a process in place 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 (£2.3m) and clinical supplies in divisions (£1.5m). 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 take place weekly, with drugs being discussed on a fortnightly basis, alternating with discussing staffing costs.

M10 Capital Position

Highlights

As at of the end of January (M10), the Trust had goods delivered, works done or services received totalling £20.1m, against a planned spend of £39.0m, equating to a variance of £18.9m behind plan.

Areas of concern

- There are many schemes in the programme without an approved business case.
- In year deliverability risk potentially impacting on outturn this year and knock on impact into next year.

Looking forward

At M10, the Trust is externally reporting a breakeven forecast in line with the current gross capital spend allocation of £56.9m but internally reporting a £2.9m forecast underspend. This position includes £6.5m of previously agreed mitigations within Estates. There are a further £5.9m of agreed mitigations not currently reflected in the forecast to address the underspend position plus any further slippages that may materialise.

	Year to Date			Forecast		
in £000's	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	8,534	5,491	3,044	11,500	11,120	380
DIGITAL - IFRS16	0	0	0	101	101	0
MEDICAL EQUIPMENT	3,837	2,428	1,409	7,019	5,746	1,274
MED EQUIP - IFRS16	2,268	902	1,366	1,398	1,390	8
ESTATES	14,376	10,191	4,186	24,158	19,643	4,515
ESTATES - IFRS16	291	146	145	516	446	70
SLIPPAGE RESERVE	730	0	730	(4,471)	0	(4,471)
NBV OF ASSET DISPOSALS	0	(44)	44	(44)	(44)	0
Total Charge against Capital Allocation (incl. IFRS 16)	**30,037**	**19,114**	**10,923**	**40,178**	**38,402**	**1,776**
NAT PROG: CIR FUNDING	4,854	378	4,476	9,710	9,711	(1)
NAT PROG: CDC PATHWAY OPTIMISATION	0	0	0	42	42	0
NAT PROG: CONST STANDARDS FUNDING - DIAGNOSTIC	2,927	0	2,927	1,242	657	585
NAT PROG: DIGITAL DIAGNOSTICS	300	26	274	944	800	145
NAT PROG: CANCER FUNDING	0	0	0	2,916	2,916	(0)
IFRIC 12	443	442	1	533	533	0
DONATIONS VIA CHARITABLE FUNDS	492	171	321	1,339	939	400
Total Expenditure against Additional Funding	**9,016**	**1,017**	**7,999**	**16,726**	**15,597**	**1,129**
Gross Capital Spend Total	**39,053**	**20,131**	**18,921**	**56,904**	**53,999**	**2,905**
Less Donations and Grants Received	(492)	(171)	(321)	(1,339)	(939)	(400)
Less PFI Capital (IFRIC12)	(443)	(442)	(1)	(533)	(533)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	295	295	0	353	353	0
Total Capital Departmental Expenditure Limit (CDEL)	**38,412**	**19,812**	**18,600**	**55,386**	**52,881**	**2,505**

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 financial year totalling £57.1m. Since the plan, the Trust has received additional national programme capital of c£0.7m, a further £2.0m of system capital has been allocated for the UEC incentive scheme and a reduced ask against the constitutional standards funding by £3.0m.

Planned Actions

Project progress is being regularly discussed. The project leads need to submit formal forecasts each month. These are submitted through the Programme Area / Executive Lead to ensure oversight and ownership of positions. 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 capital finance team are setting up regular sessions throughout Q4 to meet with GMS and Digital leads to monitor and support in delivery of the 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 Group 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

Cash balances are reducing and are facing constraint if FSP schemes are not delivered. This would mean that a range of options to deliver one off cash balance increases would be needed but would leave an underlying challenge.

Looking forward

	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	30,488	31,218	27,328	27,327	28,394	23,272	20,140	34,979	32,244	26,671	40,564	30,568	34,197	21,708	19,496
Receipts																	
SLA Income	63,925	64,048	66,959	62,938	65,675	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	5,915	7,581	20,211	5,523	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	2,452	2,296	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	2,318	3,052	2,088	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	74,733	79,888	87,846	76,148	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)	(27,940)	(27,846)	(28,636)	(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)	(21,391)	(21,430)	(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)	(28,733)	(37,325)	(27,754)	(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)	(78,064)	(86,601)	(77,881)	(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	10,041	0	16,777	0	0	0	0	0	0	0	0	0	0	0	0
Capital Payables	(1,411)	(2,618)	(2,597)	(13,855)	(11,576)	(9,153)	(531)	(1,957)	(900)	(1,004)	(744)	(2,544)	(749)	(3,290)	(6,033)	(3,020)	(3,230)
	(1,411)	(2,618)	7,444	(13,855)	5,201	(9,153)	(531)	(1,957)	(900)	(1,004)	(744)	(2,544)	(749)	(3,290)	(6,033)	(3,020)	(3,230)
Net Cashflow	(7,686)	(5,949)	730	(3,890)	(2)	1,067	(5,122)	(3,132)	14,838	(2,735)	(5,573)	13,893	(9,996)	3,629	(12,488)	(2,212)	(10,456)
Closing Balance	36,437	30,488	31,218	27,328	27,327	28,394	23,272	20,140	34,979	32,244	26,671	40,564	30,568	34,197	21,708	19,496	9,041
Number of days operating cash held	16	13	14	12	12	12	10	9	15	14	12	18	13	15	9	8	4

Technical Analysis

- The cashflow shows income at the current FOT and expenditure is based on current run rates. Achievement of FSP targets will increase cash.
- Trust held 20 days operating cash (c£2.3m per day) at the end of April – at the end of March 2026 this would be equivalent to 12 days. Expenditure does not include any payment in relation to legal claim.

Planned Actions

- The Trust is looking to keep performance at 95%, whilst protecting local suppliers, as a measure of managing its cash balances
- A discussion is being held with TLT members to consider options outlined in the draft cash strategy.

Workforce

Workforce Performance Indicators

Highlights

- Sickness absence is still rising
- Temporary staffing (agency and bank) has fallen across this financial year

Areas of concern

- Temporary staffing, particularly agency above the workforce plan for 2025/26
- Appraisal compliance better this year but still consistently below target

Looking forward

- Continued focus on temporary staffing reductions in the multiyear plan
- Reductions from staffing changes for WCP largely not driven by additional staff leaving, so unlikely to affect the turnover figures

KPI (Trust)	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Turnover	11%	8.78%	8.95%	8.71%	8.54%	8.40%	8.34%	8.64%	8.13%	8.03%	8.73%	8.48%	8.47%
Vacancy	8%	7.41%	7.21%	7.30%	7.34%	7.48%	7.45%	7.99%	6.85%	6.87%	6.96%	7.29%	7.09%
Sickness	4%	4.34%	4.19%	4.37%	4.37%	4.62%	4.39%	4.39%	4.40%	4.41%	4.43%	4.47%	
Appraisal	90%	81%	81%	82%	82%	83%	84%	84%	84%	83%	82%	83%	82%
Essential Training	90%	89%	90%	90%	90%	90%	91%	91%	91%	90%	90%	91%	91%
Agency FTE	-	81.50	108.26	94.46	90.35	84.28	85.37	67.04	71.40	57.46	59.46	61.62	61.00
Agency % of Establishment	2%	1.00%	1.30%	1.05%	1.00%	0.93%	0.96%	0.75%	0.80%	0.64%	0.67%	0.69%	0.69%
Bank FTE	-	637.20	639.27	650.32	572.59	568.92	577.05	609.63	565.42	517.18	508.44	497.47	489.63
Bank % of Establishment	7%	7.90%	7.90%	7.24%	6.33%	6.29%	6.47%	6.83%	6.35%	5.80%	5.72%	5.60%	5.53%

Technical Analysis

- There is a complex interplay between turnover, vacancy and workforce transformation programmes; for example, reductions in establishment for WCP can lower the vacancy rate, while staff in post can be influenced by factors such as staff retention. Caution should be taken when interpreting the vacancy against the target.
- Establishment is updated on ESR from the Ledger.
- Sickness absence is reported 1 month in arrears, as it is not all uploaded to ESR until ~20th each month

Actions

Actions for areas of focus are described on subsequent slides

Sickness Absence

Highlights

- Overall trust absence is up compared to previous 12 months (+0.2%)
- Mental health makes up the largest proportion of absence reasons across all staff groups except M&D, where respiratory is now higher

Areas of concern

- Increase in absence rate driven by Add Prof., Clinical Services and Healthcare Scientists
- Women & Children has highest absence rate among the divisions, driven by Nursing & Midwifery
- Mental health comprises a third or more of absence cases for Add Prof., AHPs and Estates & Ancillary

Looking forward

- Rollout of Medical e-rostering may result in higher reported absence rates, based on experience in of rollouts other trust's.
- The medium term plan specifies that the trust should improve its sickness rate year on year.

		WTE	Trend				Division (Past 12 months)					Top 5 Absence Reasons (latest 12 months)**				
		Latest	Prev. 12m	Last 12m	Difference	Trendline	Corporate	D&S	Medicine	Surgery	W&C	Mental Health	Musculoskel	Respiratory	Gastrointest	Urinary/Gynae
	Trust	7503.36	4.3%	4.5%	0.2%		3.9%	4.4%	4.5%	4.5%	5.1%	24.8%	17.9%	16.0%	10.5%	4.7%
ESR Staff Group	Add Prof Scientific & Tech	239.38	2.9%	3.7%	0.8%		*	3.5%	5.7%	3.7%	*	35.1%	6.5%	15.3%	8.8%	3.9%
	Additional Clinical Services	1283.78	5.8%	6.7%	0.9%		5.8%	6.7%	6.2%	7.9%	5.1%	24.0%	21.9%	15.4%	12.7%	5.1%
	Administrative and Clerical	1583.03	4.3%	4.4%	0.1%		3.8%	4.5%	4.8%	5.4%	4.6%	27.7%	16.9%	14.6%	8.2%	3.9%
	Allied Health Professionals	476.60	3.2%	3.2%	0.0%		*	3.0%	*	3.8%	*	33.0%	15.2%	21.9%	10.3%	3.9%
	Estates and Ancilliary	31.97	6.2%	6.2%	0.0%		*	7.9%	*	*	*	36.2%	21.8%	9.8%	8.7%	2.4%
	Healthcare Scientists	269.75	2.7%	3.6%	0.9%		*	3.7%	4.3%	2.8%	*	24.7%	16.2%	18.2%	7.8%	4.1%
	Medical and Dental	1099.57	2.0%	2.1%	0.1%		0.7%	1.8%	2.4%	1.8%	2.0%	13.5%	8.8%	15.0%	6.1%	0.3%
	Nursing & Midwifery	2519.28	4.9%	4.8%	-0.1%		4.4%	5.2%	4.5%	4.2%	6.0%	23.7%	18.3%	16.8%	11.4%	6.0%

Technical Analysis

- This analysis shows trend (left), variation by division and staff group (centre) and by staff group and reason (right). Some divisions have few staff in specific staff groups, so their absence is masked * due to limited data.
- When interpreting figures, compare the first row against the values beneath to see variation above/below the trend or average.

Actions

- New Sickness (Health & Attendance) Policy approved, HR no longer supporting Stage 1 but absence management training will be provided to managers.
- The HRBPs are analysing areas with the high levels of MH (Stress) cases across their divisions to look at themes/potential links and root causes these will be presented in Divisional EPRs

Workforce - Appraisal

Highlights

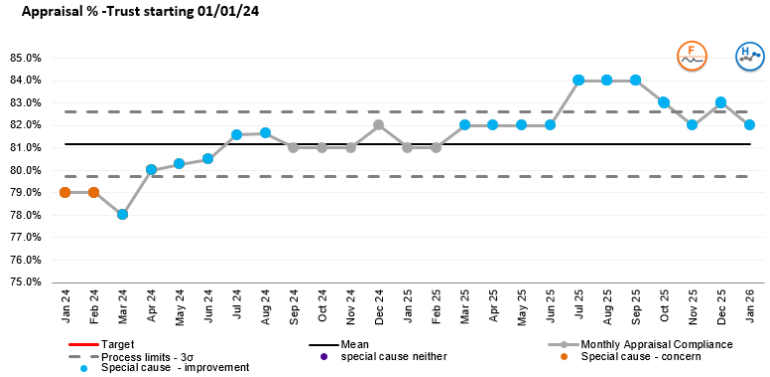
- TLT Paper provides a deep dive into the data and requests a new framework be approved to ensure better accountability for those with lowest compliance.
- Staff survey 2025 data now paired with ESR data to analyse compliance and quality together.

Areas of Concern

- Services/line managers' report that appraisals are not feasible to complete. Underlying causes need further investigation to ensure full implementation of the process and consistent use of standardised documentation.

Looking forward

- Internal Audit of Appraisals planned Q4
- Appraisal outreach programme scheduled April 2026



Staff Group / Date	31-Jan-26
Add Prof Scientific and Technic	90%
Additional Clinical Services	83%
Administrative and Clerical	76%
Allied Health Professionals	84%
Estates and Ancillary	80%
Healthcare Scientists	83%
Medical Staff - Consultants	86%
Medical Staff - SAS	83%
All Medical Staff	85%
Nursing and Midwifery Registered	84%
GHT Total	82%

Division / Date	31-Jan-26
Corporate Division	74%
Diagnostic & Specialty Division	86%
Medicine Division	84%
Non-Division	58%
Surgery Division	86%
Women & Children Division	73%
GHT Total	82%

Technical Analysis

The current appraisal compliance rate is 82%, remaining below the 90% target. A deterioration in Women & Children cost code from 68% - 50% in the last month, brings down the W&C Division to being the lowest compliance, which requires exploration and potentially additional support. Non-division have a recovery plan in place and have improved from 47% to 58%, and with some assurances that all 19 staff in this directorate have appraisals planned.

Planned Actions

- A paper has been produced for TLT Jan 2026, which was stood down, but gives some recommendations for monitoring and a new approach to accountability which requires discussion at TLT when rearranged.
- Bespoke support from the People Development team to be established within non division and service lines with a consistent compliance of less than 60%.
- ESR self-service team commitment to develop more accessible and user friendly guidance to support accurate recording not yet actioned.
- Compliance reports are not accessed by a named representative in each cost code and so a line-by-line sifting is underway.

Workforce - Bank

Highlights

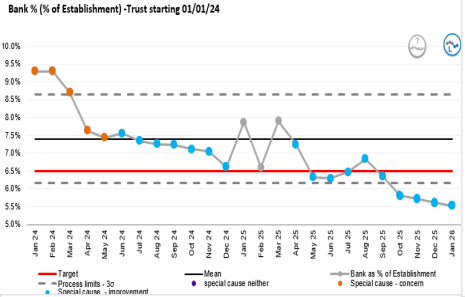
- The Trust target of 6.5% has been achieved in month 10.
- Reduction of RN/HCSW (31 WTE) in M10 compared with M9.
- M10 is 49 WTE lower than M10 for 24/25.
- M10 has seen a reduction of 15 WTE Locum use for medics

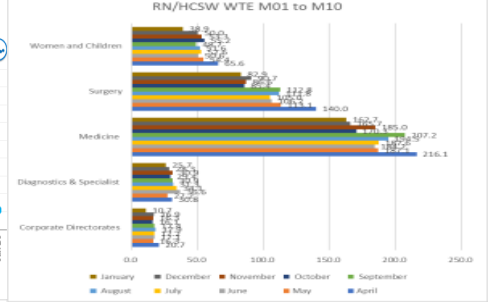
Areas of concern

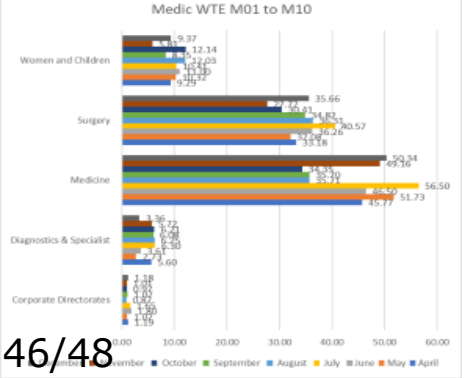
- Overall WTE and £ use of bank is not yet at the trust reduction target of 15% in M10 for the FY.

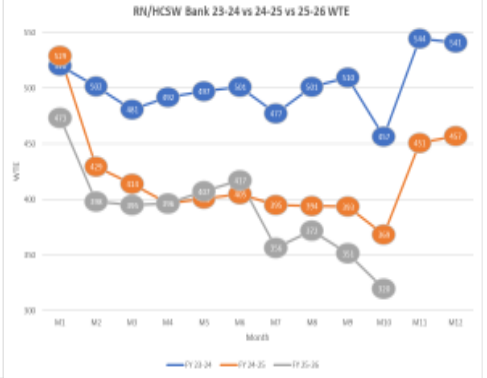
Looking forward

- 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 M11 will also see a similar WTE use for FY 25/26.
- If future IA is taken, the trust can expect increases in Medic WTE as displayed in the data in this slide









Technical Analysis

- The trust has seen a reduction in temporary RN/HCSW Staffing of 31 WTE (M10 351 to M9 320 WTE).
- In comparison with M10 of 24/25 FY, there has been a reduction of 49 WTE RN/HCSW
- **Medicine** is the highest user of Bank & Locum staff.
- Top 3 users in M9 ED, COTE and Acute. However, ED & Acute have reduced temporary staffing use compared to M9
- **ED** (72.14 to 66.28 WTE), **COTE** (30.21 to 33.21 1WTE) Acute (30.73 to 20.72 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

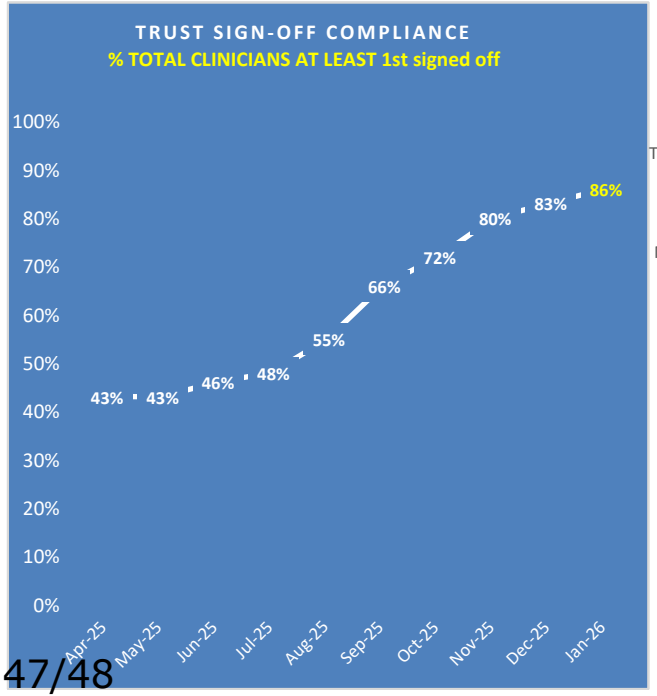
- Job Planning has this year been included in PWR reporting and is also an NHS England Improvement Programme
- The medical e.rostering work is providing a helpful lever as up to date job plans are required for e.rostering
- The October 2025 target of over 60% of job plans signed off by 1st October has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

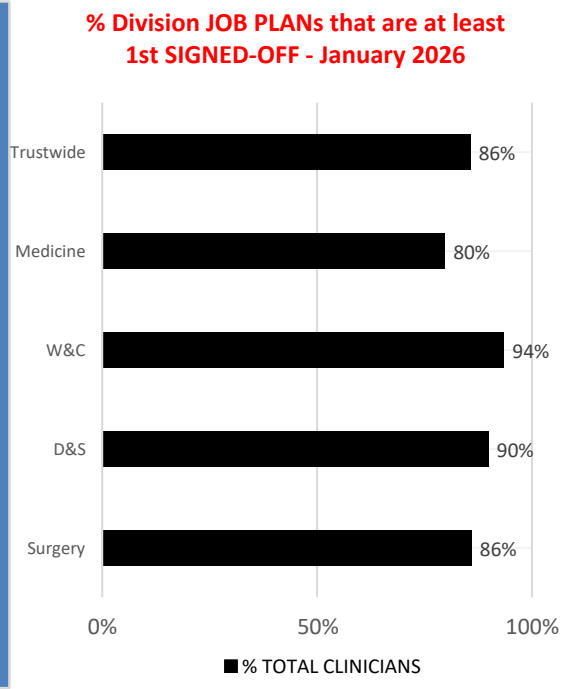
Areas of concern

- 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

Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Date of Meeting	12th March 2026
Report title	Learning from Death's Report
Sponsoring Director/Author	Professor Mark Pietroni, Medical Director & Director of Safety Dr Charles Candish, Associate Medical Director (Safety) Jo Mason-Higgins, Acting Associate Director of Safety

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

Executive Summary

This Learning from Death's report provides assurance of the governance systems in place for reviewing deaths and in addition demonstrates compliance with the National Guidance on Learning from Deaths.

This report covers the period April to June 2025 and is an update from the previous report.

ALERT

Prolonged Emergency Department waits (>8 hours prior to admission) continue to be associated with higher mortality, particularly for older patients. While this risk is reducing, it remains a point of focus.

Data quality dependencies remain, including reliance on remedial coding. Electronic Patient Record (EPR) enhancements to maintain improvements in co-morbidity capture and influence mortality indicators have been delayed to Feb 26.

Consistency of learning capture from Structured Judgement Reviews (SJRs) varies across divisions.

Communication themes continue to feature in a small proportion of bereaved family feedback. Timeliness of learning from Learning Disability Deaths (LeDeR) remains constrained by national processes.

ADVISE

Key priorities:

Maintain a system-wide focus on reducing Emergency Department (ED) waits, particularly for patients most vulnerable to harm, alongside continued development of alternatives to ED attendance if admission needed.

Ensure delivery of planned EPR and coding improvements to sustain improvements in reported mortality indicators and strengthen confidence in data quality.

Reinforce divisional accountability for learning from deaths, with particular emphasis on translating review findings into demonstrable improvement actions.

Continue to strengthen communication and engagement with families.

Support ongoing work to optimise direct admission pathways, which are contributing positively to mortality outcomes.

Encourage continued exploration of proportionate feedback mechanisms for LeDeR learning that respect family wishes while supporting staff learning.

ASSURE

Evidence that mortality governance and learning systems are effective.

The Trust's SHMI continues to improve, with all national mortality indicators within expected range and positive external feedback from NHS England.

All deaths are independently reviewed through the Medical Examiner system, providing assurance of compliance with national Learning from Deaths guidance.

Structured Judgement Reviews exceeded the national standard, with 17.7% of adult deaths reviewed in the quarter.

Minimal care concerns were identified, and no deaths required escalation to harm review panels during the reporting period.

Family feedback remains consistently positive at 77% trust-wide, with strong themes of compassionate care and staff professionalism.

Learning from serious incidents and Patient Safety Incident Response Framework (PSIRF) investigations is subject to robust oversight through established Trust safety governance arrangements.

The Bereavement and Medical Examiner model is recognised as high-quality and aligned with future national expectations.

Previously considered by	Hospital Mortality Group (HMG) – 11th February 2026 Quality & Performance Committee – 26th February 2026

Recommendations:
The board are asked to NOTE the report.

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

Impact on any Strategic Risks?
BAF Risk - Quality, Safety & Delivery Risk

Implications on:	
Equality, Diversity and Inclusion	No Major changes
Health Inequalities	Development in Progress
Finance and Resource	No current impact
Regulation/Legal	The report ensures compliance with the National Guidance on Learning from Deaths.
CQC-Key line of enquiry	SAFE AND WELL-LED
Green Plan	No Impact

Main Report

LEARNING FROM DEATHS BOARD REPORT (public) – Q1: April – June 2025

S1. Aim

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 This report covers the period April to June 2025 and is an update from the previous report.

S2. Learning From Deaths

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties.

Serious incident/Patient Safety Incident Investigation (PSII) review and implementation of action plans. (Appendix 1 for QPC only).

c. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. Death's that trigger a Structured Judgment Review (SJR) are entered on to the Datix system to support the SJR process.

2.3 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through individual speciality and divisional processes. The main learning from Structured Judgement Reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some themes continue to be identified which are in common with known areas of quality. Divisional learning is presented to HMG on a rolling basis. Presentations are available for review, as required

2.4 All specialties receive individual monthly data on SJR performance and report to Hospital Mortality Group (HMG) on a rolling basis where performance is reviewed. Most SJRs are undertaken within 2 months. There were 503 adult deaths in the quarter with 121 (17.7%) reviewed via Structured Judgement Review (SJR); one death was identified as a complaint.

2.5 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. Feedback from bereaved families is largely positive.

2.6 Family feedback is analysed by the End of Life Improvement Group and triangulated with the (NACEL) national end of life survey/audit data and recommendations.

2.7 All Serious Incidents (SIs) and Patient Safety Incident Investigations (PSII's) have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups. Summary reports on closed action plans are included in the report. (Appendix 1).

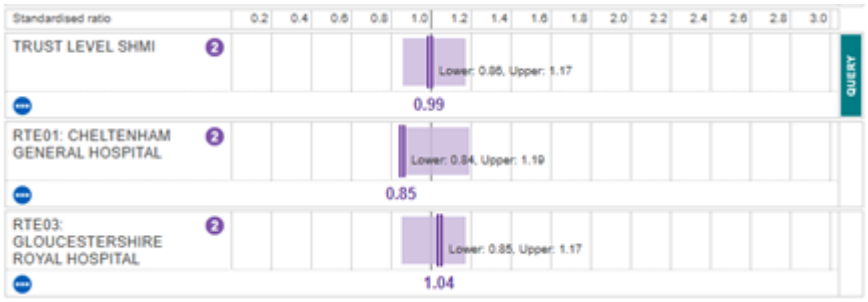
2.8 Deaths outside the SJR process are included in the table in Appendix One

S3. Mortality Data

3.1 SHMI Review

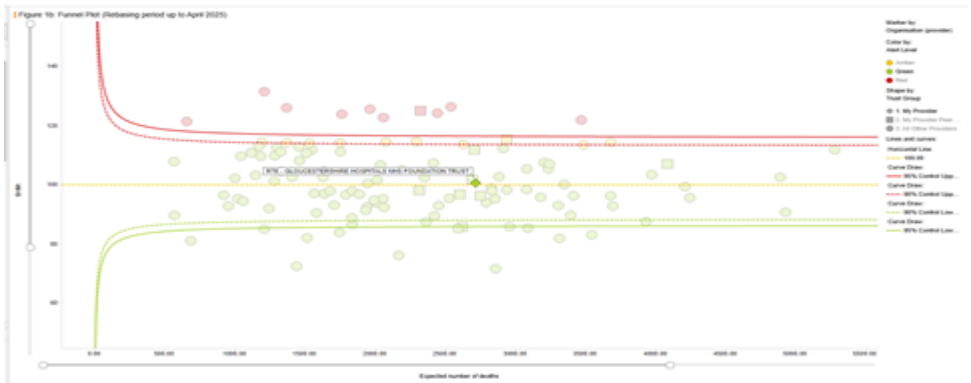
The Summary Hospital Mortality Index (SHMI) is a ratio of observed and expected deaths.

NHSE Previewer Data (Published Nov 2025)



- SHMI was as expected at 0.99 (1.04 at GRH and 0.85 at CGH)
- SHMI has fallen for 12 consecutive months and is within expected range
- Actual deaths are also falling

National Funnel Plot



HED data Published Sep 25

- HMG Hedlines | Gloucestershire Hospitals NHS Foundation Trust | - Model Hospital Recommende | Show Only

Create your own indicator sets here: | Create new Peer Groups here: | Search:

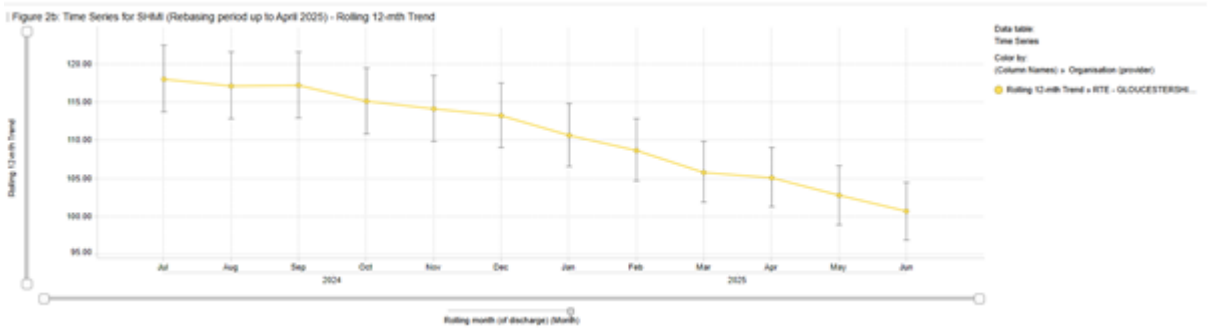
Custom Indicator Set: HMG Hedlines	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025)	100.65 (Jul 2024 - Jun 2025)	102.74 (Jun 2024 - May 2025)	-2.09	104.34	100.54	Within expected range
SHMI - In-hospital (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025)	96.62 (Jul 2024 - Jun 2025)	98.75 (Jun 2024 - May 2025)	-2.13	101.55	100.22	Within expected range
SHMI - Out-of-hospital (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025)	109.64 (Jul 2024 - Jun 2025)	111.69 (Jun 2024 - May 2025)	-2.05	110.63	101.32	Within expected range
SHMI - Weekend mortality (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025)	114.24 (Jul 2024 - Jun 2025)	115.67 (Jun 2024 - May 2025)	-1.43	111.96	107.08	Within expected range
SHMI - Weekday mortality (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025)	96.85 (Jul 2024 - Jun 2025)	99.09 (Jun 2024 - May 2025)	-2.24	101.97	98.56	Within expected range

All indicators are within expected range.

SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025)	101.10 (Jun 2025)	92.35 (May 2025)	8.75	100.60	99.77	Within expected range

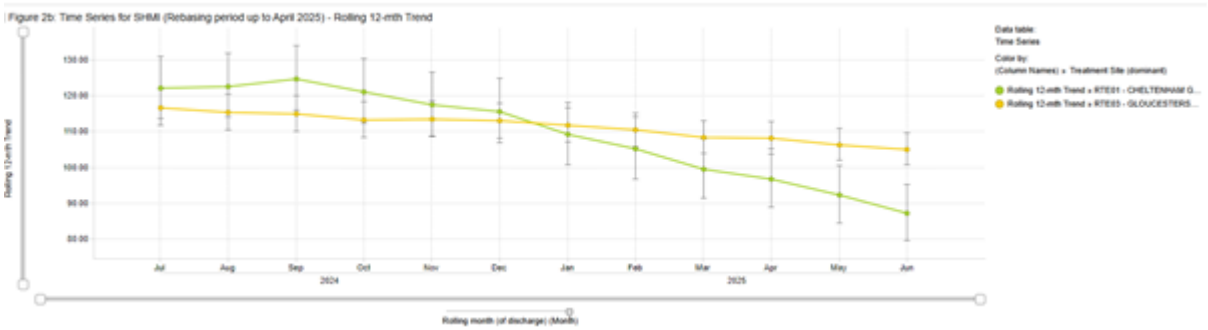
- Monthly SHMI increased in June 25 which likely shows the impact of no remedial coding during that month. EPR changes to improve comorbidity capture have been delayed which is an ongoing risk.

Rolling 12 Month SHMI Trend – Trust wide:



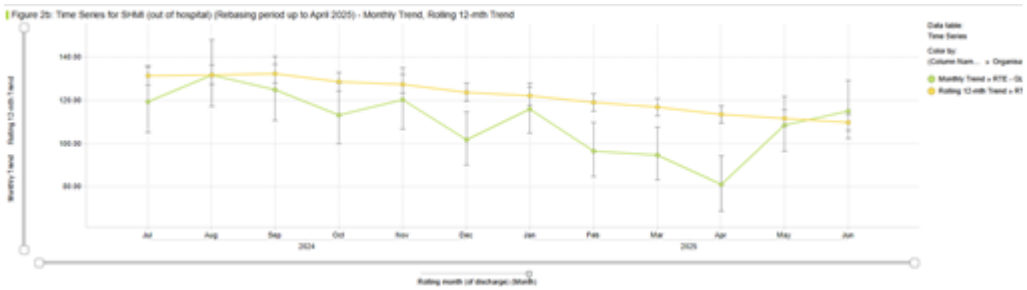
By Site:

12 month rolling data shows falling trend at GRH and CGH. CGH lower than GRH on last 6 data points



SHMI-Out of Hospital 30 Day Mortality:

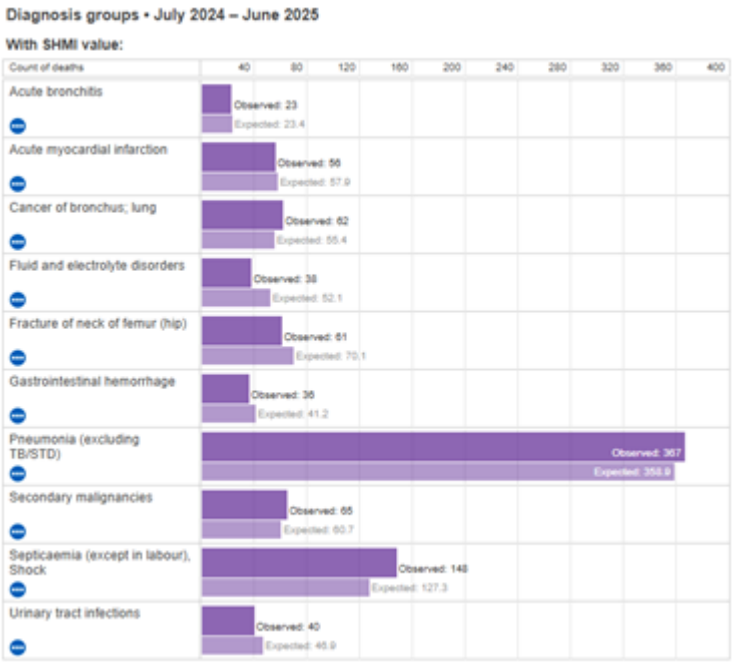
12 month rolling data shows a falling trend since Sep 2024



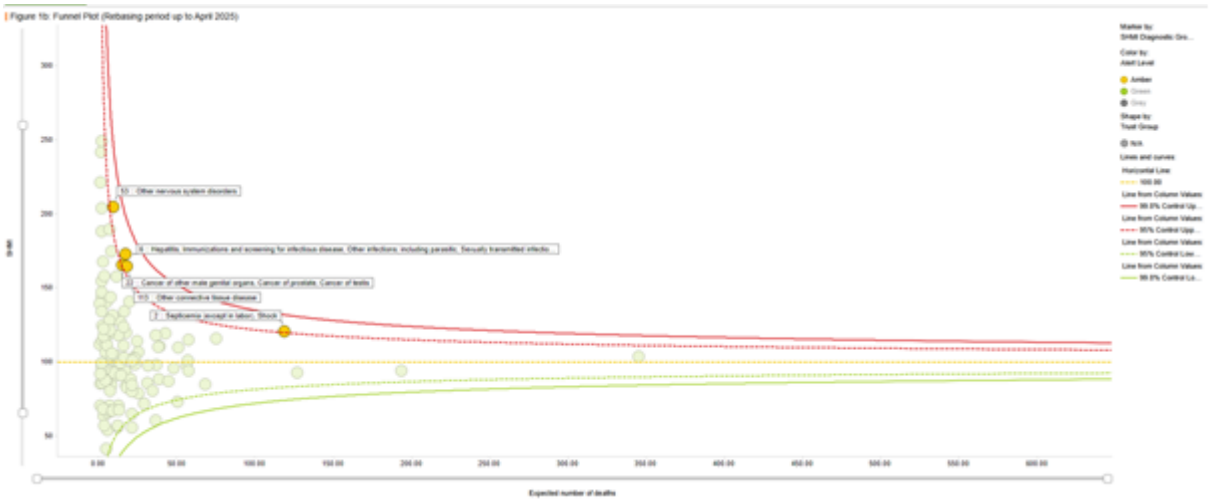
3.2 Deaths by SHMI Diagnostic Group

NHSE Previewer Jul 24-Jun 25 by Diagnosis Groups with a SHMI Value

All “as expected”:



HED shows 4 amber alerts



Group 22 relates to advanced prostate cancer. A clinical audit by Oncology showed no care concerns. The sepsis alert relates to a subset of codes “sepsis of unknown origin” and highlighted a cluster of deaths in April 2025. The patients involved have been referred to the Sepsis Group and are in the process of a clinical audit.

Observed v Expected Deaths-VLAD

SHMI Category	SHMI (12-months)	Discharges	Observed Deaths	Expected Deaths	Lives Saved
2 :: Septicemia (except in labor), Shock	120.52	575	143	118.65	-24.35
6 :: Hepatitis, Immunizations and screening for...	172.91	1,473	30	17.35	-12.65
77 :: Aspiration pneumonitis; food/vomitus	115.75	228	87	75.16	-11.84
22 :: Cancer of other male genital organs, Can...	165.35	431	25	15.12	-9.88
53 :: Other nervous system disorders	204.51	768	19	9.29	-9.71
30 :: Secondary malignancies	115.02	351	66	57.38	-8.62
107 :: Skin and subcutaneous tissue infections	140.70	1,721	28	19.90	-8.10
82 :: Acute and chronic tonsillitis, Diseases of ...	110.32	3,494	43	38.98	-4.02
123 :: Joint disorders and dislocations; trauma...	109.92	1,199	42	38.21	-3.79
98 :: Other gastrointestinal disorders	114.21	887	28	24.52	-3.48
92 :: Biliary tract disease	97.65	2,043	31	31.75	0.75
93 :: Liver disease; alcohol-related	80.68	272	28	34.70	6.70
65 :: Congestive heart failure; nonhypertensive	92.82	997	118	127.13	9.13
66 :: Acute cerebrovascular disease	93.99	1,255	182	193.63	11.63
37 :: Fluid and electrolyte disorders	73.11	917	37	50.61	13.61
94 :: Other liver diseases	60.40	639	22	36.42	14.42

Green box highlights those diagnostic groups with fewer than expected deaths and this is growing

Business Intelligence Dashboard-Actual Deaths

Ongoing downward trend in actual hospital inpatients deaths in 2024 and 2025

3.3 Data Quality

SHMI contextual indicators

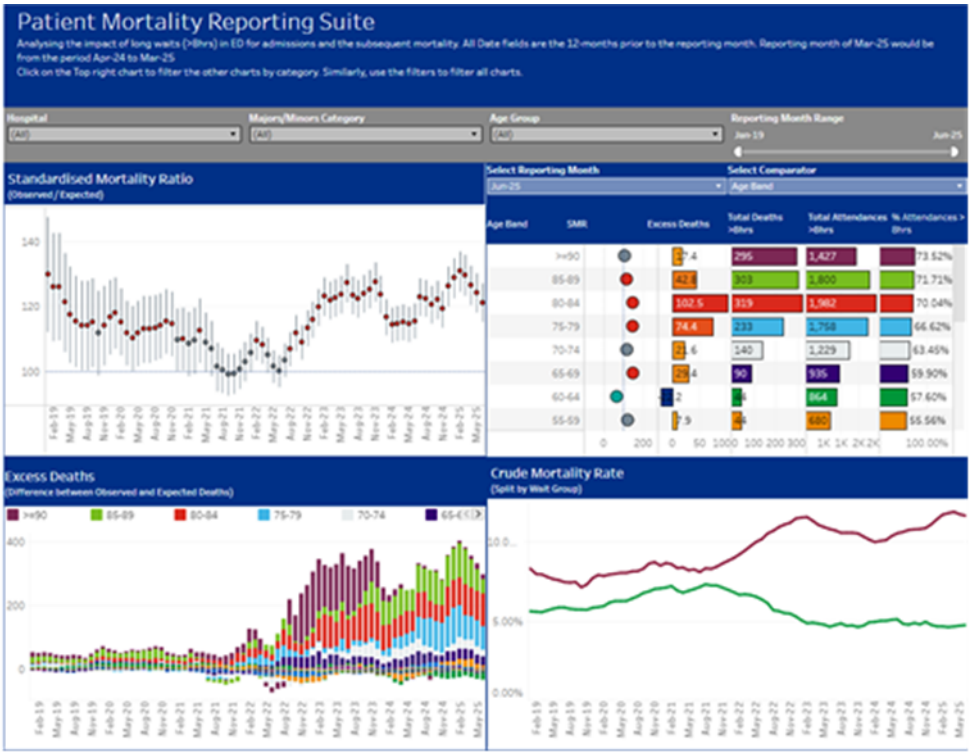
Indicator	Value	England average
Primary diagnosis coding		
Percentage of provider spells with an invalid primary diagnosis	0.0	3.5
Percentage of provider spells with a primary diagnosis which is a symptom or sign	15.0	15.4
Depth of coding		
Mean depth of coding for elective admissions	5.8	6.6
Mean depth of coding for non-elective admissions	5.7	6.2
Palliative care		
Percentage of provider spells with palliative care coding	1.5	2.1
Percentage of provider spells with palliative care treatment specialty coding	0.0	0.1
Percentage of provider spells with palliative care diagnosis coding	1.5	2.1
Percentage of deaths with palliative care coding	42.0	45.0
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	42.0	44.0
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	66.0	68.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	34.0	32.0
Percentage of provider spells with site of treatment change		
Percentage of provider spells with site of treatment change	0.0	1.0

- We have a slightly lower than national rate of palliative care recording
- A higher-than-average deaths outside of hospital within 30 days of discharge is good indicator that people are being helped to spend last days in a less acute setting
- No invalid primary diagnosis codes and number of Symptom Codes (R codes) is lower than average which is a good quality indicator for our coding
- Coding depth remains below national average
- Remedial coding has continued and EPR changes to improve co-morbidity capture are planned for Feb 26.

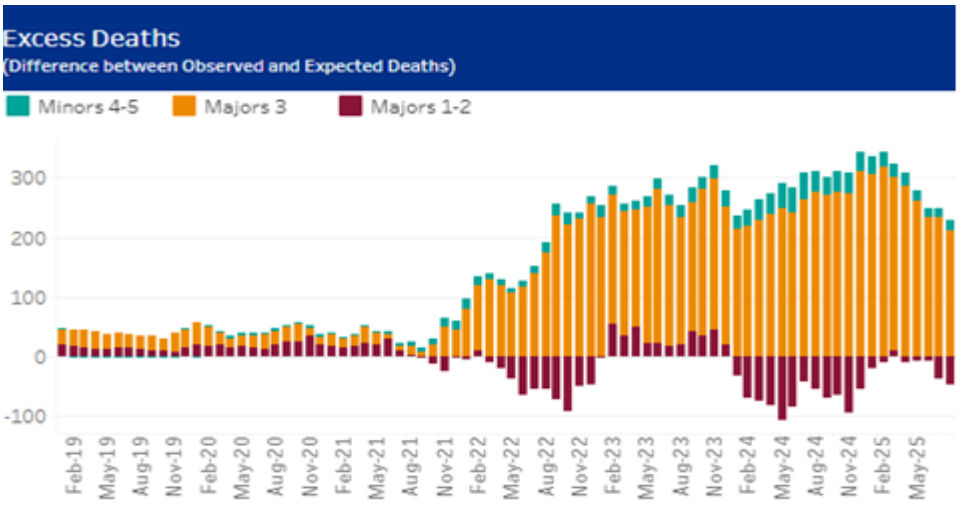
3.4 Delay Related Harm and Admission pathways

Overall numbers of excess deaths associated with prolonged waits in ED have been falling since Feb 25. The over 70's contribute approximately 80% of this excess mortality. Mortality rates between the 2 wait groups continues to diverge for this cohort, with crude mortality at 11.6% in those waiting >8hrs compared to 2.7% in those <8hrs.

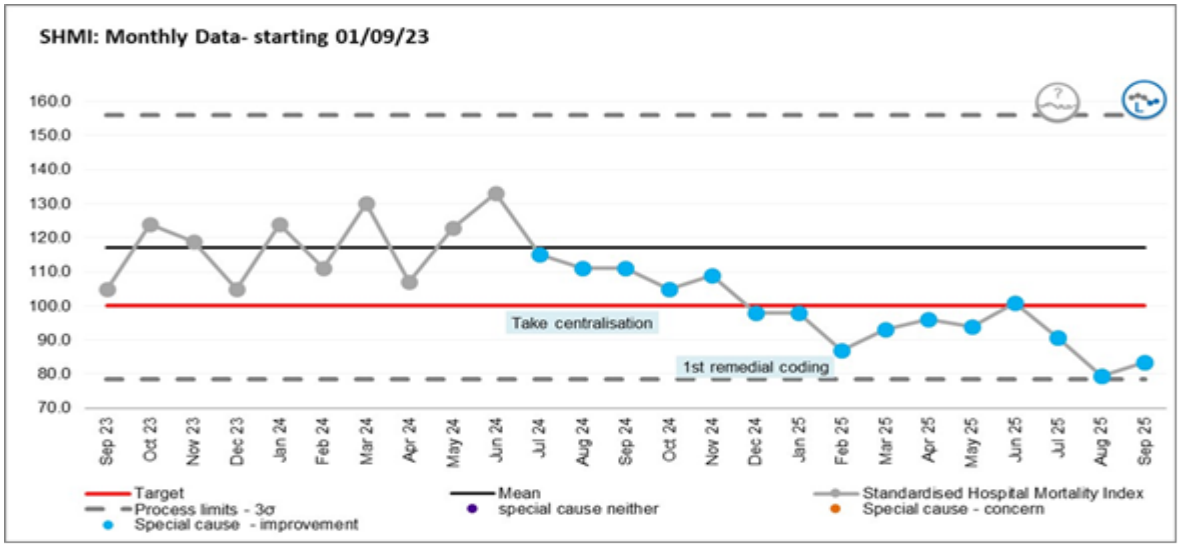
There is a sign of the gap narrowing between the groups.



This excess mortality is relevant to those patients Triaged at 3 in ED rather than 1,2 and 4,5



As well as improvements to data quality the centralization of the medical take to GRH is also contributing to the SHMI improvement:



Direct admission pathways (Medical Assessment Zone, Frailty) have a lower-than-expected SHMI.

3.5 Conclusion:

- 12 month rolling SHMI for the Trust at end of June 2025 is “As Expected” and below 100.
- NHSE Mortality Insights visit on 9th July 2025 gave very positive feedback to the Trust on this progress.
- Ongoing Quality Improvement work involving clinical and coding teams have shown data improvements which have led to increases in calculated mortality risk hence reduction in monthly SHMI.
- Remedial coding and EPR changes are currently still required to maintain these improvements to SHMI.
- Despite this significant reduction in SHMI, there remains an excess mortality associated with > 8 hour ED waits for admission. This excess mortality is however falling. Centralization of the medical take, and admission pathways avoiding ED are also likely to be contributing to this improving picture.

S4. Mortality Quarterly Dashboard: Quarter 1 (April – June 2025)

Mortality Review (Structured Judgment Review SJR) Data

The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They continue to ensure all deaths are recorded in real time.

The following provides mortality data from April to June 2025; including the total number of deaths, reviews conducted under the Structured Judgement Review (SJR) methodology, and the identification of issues in care across various clinical divisions.

There were 503 adult deaths in the quarter with 121 (17.7%) reviewed via Structured Judgement Review (SJR); one death was identified as a complaint.

Activity Group	Discharging division	Speciality	Total Deaths	Total SJRs	SJR Rate	review (Trigger present)	triggered by Concerns	triggered without Concerns	Deaths as Harm Complaints
ED	**Medical - ED**	180 - Emergency	33	31	93.9%	26	0	26	0

IP	**D&S**	303 – Cl Haem	2	0	0.0%				
		370 – Me oncology	2	1	50.0%	1	1	0	0
		800 - Clinical Onc	19	3	15.8%	3	1	2	0
		811 - IR	1	0	0.0%				
	Medical	300 – Gen Med	106	11	10.4%	11	3	8	0
		301 - Gastro	4	0	0.0%				
		302 - Endo	3	0	0.0%				
		307 - Diabetology	1	0	0.0%				
		320 - Cardiology	14	4	28.6%	4	2	2	0
		328 - Stroke	31	2	6.5%	2	1	1	0
		340 - Respiratory	53	4	7.5%	4	1	3	0
		361 - Renal	21	1	4.8%	1	0	1	0
		400 - Neurology	3	1	33.3%	1	0	1	0
		430 - Geriatric	100	9	9.0%	8	5	3	0
		180 – A&E	1	0	0.0%				
	Surgical	100 – Gen Surg	15	1	6.7%	1	0	1	0
		104 - Colorectal	4	0	0.0%				
		106 - Upper GI	6	1	16.7%	1	0	1	0
		107 - Vascular	4	0	0.0%				
		110 – T&O	14	4	28.6%	4	0	4	0
		120 - ENT	1	0	0.0%				
		192 - Critical care	49	10	20.4%	10	4	6	0
		108 - Spinal	1	1	100.0%	0	0	0	0
		101 - Urology	5	4	80.0%	4	1	3	0
	Women & Children	422 - Neonatology	1* NB – death under 24 weeks not reportable through MBRRACE	0	0.0%				

		502 - Gynaecology	1	1	100.0%	1	0	1	1
SDEC	**Surgical**	100 – Gen Surg	1	0	0.0%				
		104 - Colorectal	1	0	0.0%				
		106 – Upper GI	1	0	0.0%				
Total			**503**	**89**	**17.7%**	**82**	**19**	**63**	**1**

4.1 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach is embedded within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.2 Minimal care problems were identified this quarter. Overmedicalisation and treatment issues were reported. No deaths were escalated to harm review panels following SJR.

4.3 The Trust met the overall 10% death review standard. Completion of key learning messages remains low across divisions, though showing quarter-to-quarter improvement

5. Family Feedback from Bereavement team

The following summarises the category of family feedback in the period 1st April 2025 to 30th June 2025 as captured by the bereavement team:

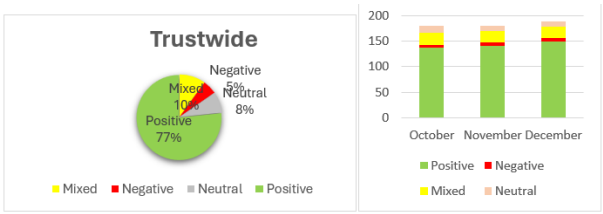
5.1 Summary

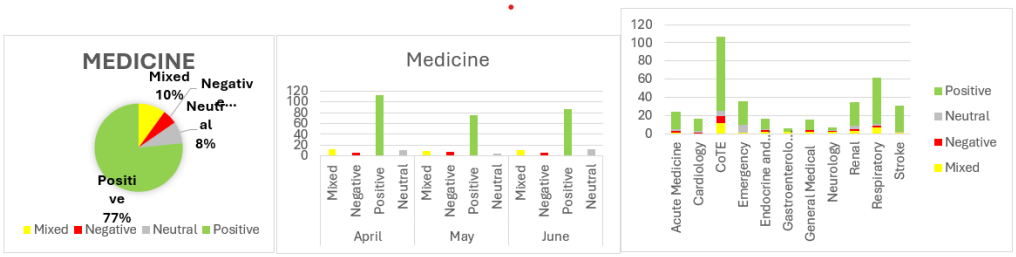
Feedback for Q1 2025/2026 at GHFT shows trust-wide positive patient care feedback steady at 77%, with a slight 1% increase in negative feedback. The Medical Division maintained positive feedback levels with 19 staff being praised. The division saw a 2% rise in negative comments, highlighting communication issues in Renal Medicine.

The Surgical Division experienced a 1% increase in positive feedback and a 1% decrease in negative feedback. Diagnostics and Specialties noted an 11% rise in positive feedback and a 2% increase in negative feedback within Oncology.

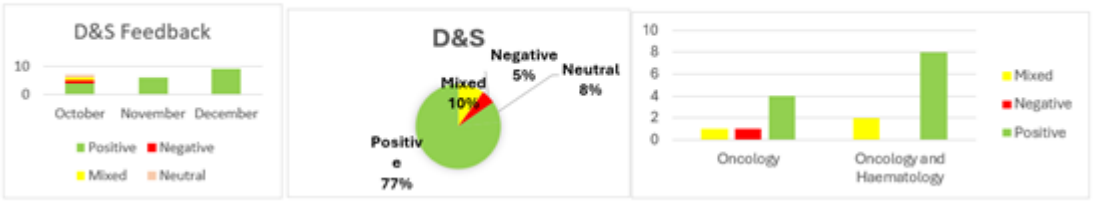
There was no feedback received by the bereavement team for Women's & Children's Division, in this quarter. Family feedback is collected through the (PMRT) Perinatal Mortality Review Tool, process.

Overall, positive trends focused on good care and considerate staff, while negative trends primarily involved communication and nursing contact, with several referrals made to PALS across specialties.





The Diagnostics and Specialties Positive feedback decreased by 11% and the negative feedback increased by 2%.



The Surgical Positive feedback remained the same and the negative feedback decreased by 1%.

5.2 Medicine Top 5 Specialties Positive and Negative Trends

Acute

Positive Trends	Negative Trends
Good Care Provided	No Trend
All staff were lovely	
A number of staff were named individually	

Care of the Elderly

Positive Trends	Negative Trends
Good Care Provided	No Trend
Kind and considerate staff	
19 Staff individually named	

Renal

Positive Trends	Negative Trends
Good Care Provided	Communication

Respiratory

Positive Trends	Negative Trends

Good Care Provided	No Trend
5 Staff individually named	

Gen Med

Positive Trends	Negative Trends
Good Care Provided	No Trend

5.3 Surgical Top Specialties Positive and Negative Trends

Surgical

Positive Trends	Negative Trends
Good Care Provided	Communication
6 staff individually named	

Trauma & Orthopaedics

Positive Trends	Negative Trends
Good care provided	Communication
8 Staff individually named	

5.4 D&S Specialty Positive and Negative Trends

Oncology

Positive Trends	Negative Trends
Excellent Care	No Trend
3 staff individually named	

5.5 Family Feedback Conclusion

The feedback has been combined for April to June 2025 and shows trust-wide positive patient care feedback steady at 77%, with a slight 1% increase in negative feedback.

6. LeDeR Report

On average there are 1 – 2 deaths per month of a person with a Learning Disability, but this average does mask peaks and troughs. All deaths of patients with a Learning Disability and/or Autism (confirmed diagnosis) are reported to LeDeR. The Learning Disability Team also contribute time to assisting reviewers with interpretation of notes of people who had been in hospital, but died elsewhere.

LeDeR reviews usually do not reach the QA panel until at least 6 months after the person has died, as it takes that long for the reviewers to be able to interview family and carers and to review professionals' notes and then write their report. Feedback on deaths of people with LD or autism will therefore not reach staff involved for at least 6 months. Even then, feedback can only be shared if family have given permission for this, and whether they give this consent or not is variable. In the majority of cases to date in 2024/2025 consent has not been given. The LeDeR QA panel have been questioning how helpful this is to staff and are looking at ways of feeding back to staff without sharing disproportionately.

There has been variation in numbers of deaths throughout 2024/2025, in that the 'odd' quarters have had high numbers of deaths and the 'even' quarters had low numbers of deaths. LeDeR have completed reviews on 4 of the 5 deaths in Q4. Three of these were graded as 'good', one

was graded 3 ‘fell short of expected level impacting on health and longevity’. This related to care inside and outside the hospital.

All Q1 deaths have been graded as either good or excellent care, with the exception of one case still awaiting coroner feedback. 2 of the 4 deaths in Q2 have concluded LeDeR reviews – one of these was graded excellent and the other was graded ‘adequate’ because that person’s final care home was sub-optimal, not because of hospital care. Only 5 of the 11 deaths in Q3 have concluded LeDeR reviews. These were all graded ‘adequate’ or ‘good’. One of the reviews graded ‘adequate’ was a lady who was in the Emergency Department at GRH for an excessively long time. The other death graded ‘adequate’ was related to out-of-hospital care.

Relatives of these patient cohorts regularly comment that they would like side rooms as bays are too noisy. The LeDeR QA panel are well aware that our supply of side rooms is very limited and Infection Control has first call on them. Relatives consistently comment very positively on the support they receive from the Learning Disability Liaison Nurses and the Palliative Care team, as well as the bereavement calls which are made by both ED and DCC.

7. Conclusions

7.1. All deaths are reviewed within the Trust via the independent Medical Examiner Service.

7.2. There is good local learning from concerns in care and ensuring these are being reflected within specialties.

7.3 Learning from safety incidents that meet the criteria for serious incidents and PSIRF learning responses, is monitored and assured through SERG; Safety Experience and Review Group. Summaries of learning from those incidents (where the patient has subsequently died) are found in Appendix 1 (for QPC only).

7.4. It is clear that the positive feedback is consistently high regarding the care provided. A review of the Trust’s process for feeding back (to families) findings of SJR continues. It is recognised that proactive feedback may improve experience and reduce concerns and complaints. Piloting of the approach continues.

7.5. The 12 month rolling SHMI for the Trust continues to fall and is “As Expected”. Improvements in data quality, centralization of the medical take and increasing direct admission pathways are the drivers for this improvement. Continued focus on limiting prolonged ED waits prior to admission is recommended.

Enclosures

Only for Quality and Performance Committee

FOI: Public (no PID)

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 12th March 2026

Title		ADVISE, ALERT, ASSURE and APPLAUD Report of the meeting of the XX Committee held on XX
Board member lead(s)		Marie-Annick Gournet and Claire Radley
Written by		Marie-Annick Gournet
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	
	Discussion	
	Note	X

Purpose of report

To present an update to the Board of Directors from the meeting of the XX Committee held on XX (quorate).

This committee meets insert frequency 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.

- **Workforce Reduction & Temporary Staffing Interdependency Risk -** The planned 507 WTE reduction over three years alongside a 34% bank and 85% agency reduction is central to financial recovery. Delivery assumptions rely on transformation, productivity gains and system readiness. Failure to realise these assumptions may compromise safe staffing, operational resilience and statutory duties.
- **Senior Workforce Gaps in Maternity Services – Sustainability Risk -** While interim oversight arrangements are in place, vacancies in key senior maternity roles are not sustainable long term. Prolonged gaps increase risk to clinical governance resilience, regulatory assurance and safe service delivery within a high-risk core service.
- **Persistent Workforce Inequalities (Staff Survey 2025) -** Continued disparities affecting ethnic minority and disabled staff pose risk to the Trust's statutory Equality

duties, cultural stability, retention and engagement. Focused divisional action plans and follow-up assurance are required.
- **Cultural Fragility & Psychological Safety -** Ongoing fear of detriment, bullying/incivility indicators and variable leadership engagement risk undermining retention, medical engagement and stability during organisational contraction.

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

Live issues under active management with potential to escalate

- **Immigration Rule Changes – Emerging Workforce Risk -** Risk assessments underway regarding healthcare support workers and visa-dependent roles. While no immediate service impact is confirmed, there is potential future risk to staffing resilience and continuity of care. Full impact briefing to follow.
- **Medical Recruitment & Time-to-Hire Sustainability -** Consultant recruitment benchmarking and KPI strengthening underway. Sustained improvement is required to mitigate vacancy risk in hard-to-recruit specialties.
- **Supreme Court Ruling (Biological Sex) – Workforce & Policy Implications -** Emerging corporate risk relating to policy alignment, inclusion practice and employment implications. Impact assessment and risk clarity to follow.

ASSURE: inform the board where positive assurance has been received

- **Improved Recruitment Position:** Recruitment risk score reduced (16→12) reflecting improved vacancy rates and successful consultant appointments, strengthening workforce stability.
- **Audit & Workforce Control Improvements:** Workforce controls and payroll audits nearing closure; strengthened oversight of secondary employment and overpayments; e-rostering controls embedding into business as usual.
- **Enhanced Speak Up Governance:** Improved triangulation between Freedom to Speak Up and Report Support and Learn, with KPI reporting to enhance transparency and organisational listening.

APPLAUD: Positive achievements and strength

- **Recruitment Transformation Programme:** Modernised recruitment systems, improved candidate experience and strengthened time-to-hire monitoring.
- **Medical Rostering Rollout:** Progress contributing to locum reduction, compliance monitoring and improved workforce data integrity.

Implications

Strategic Aims to which the paper relates (tick as appropriate)

Patient experience and voice	X
People, culture and leadership	X
Quality, safety and delivery	X
Digital first	X

Board assurance framework

BAF reference	**SR**

Risks discussed

The Committee discussed the following risks:

- Workforce Sustainability (including efficiency, productivity and workforce controls)
- Cultural Risk and Psychological Safety
- Recruitment & Retention Risk
- Immigration / Visa Impact Risk (emerging)
- Supreme Court Ruling (Biological Sex) Risk (emerging)

Recommendations

The Board of Directors is asked to take:

Take assurance from progress in recruitment improvement, audit closure and strengthened workforce governance; and

Note and monitor closely the significant delivery risks associated with immigration changes, the interdependent risks relating to workforce reduction, temporary staffing controls, maternity senior vacancies, workforce inequalities and cultural stability.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	12 March 2026
Report title	Pay Gap Reports
Sponsoring Director/Author	Claire Radley – Director for People & OD Emily Bestwick – EDI Coordinator

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

Executive Summary

This report outlines the Trust's Gender, Ethnicity and Disability Pay Gaps for 2025 and highlights where inequalities remain in our workforce.

- The Gender Pay Gap has increased to a 26.5% mean and 17.8% median gap, both in favour of men. Much of this is driven by high-value Clinical Excellence Awards within the Medical and Dental workforce.

Mean hourly gender pay gap:
- Men: £29.38
- Women: £21.58
- Difference: £7.80
- Percentage gap:
  £7.79 ÷ £29.38 ≈ **26.5%**

Median hourly gender pay gap:
- Men: £23.60
- Women: £19.40
- Difference: £4.20
  £4.20 ÷ £23.60 ≈ **17.8%**

- When Medical and Dental staff are excluded, the pay gap reduces significantly, showing near equal mean pay and a median gap in favour of women.

Mean difference: £0.71 = **3.6% gap**
Median difference: –£0.88 = **5.0% gap in favour of women**

- Although reporting on Ethnicity and Disability Pay Gaps is not mandatory, the Trust chooses to publish this information to support transparency and improvement.

- The Ethnicity Pay Gap is 1.2% in favour of ethnic minority staff, continuing a positive trend.

Mean hourly ethnicity pay gap:
- EM: £23.54
- White: £23.26
- Difference:£0.28
  £0.28 ÷ £23.26 ≈ **1.2%**

Median hourly ethnicity pay gap:
- EM: £20.46
- White: £19.79
- Difference: £0.67
- £0.67 ÷ £19.79 ≈ **3.4%**

- The Disability Pay Gap is 13.1% in favour of non-disabled staff, reflecting lower numbers of disabled colleagues in higher-banded roles.

Mean hourly disability pay gap:
- Disabled: £20.29
- Non-disabled: £23.34
- Difference: £3.05
  £3.05 ÷ £23.34 ≈ **13.1%**

Median hourly disability pay gap:
- Disabled: £20.43
- Non-disabled: £23.37
- Difference: £2.94
  £2.94 ÷ £23.37 ≈ **12.6%**

- Women, ethnic minority staff and disabled staff are all underrepresented in senior roles, which contributes to pay gaps across the Trust.

The Trust remains committed to reducing these gaps. Key actions include improving inclusive recruitment, strengthening staff networks, supporting progression, enhancing use of cultural ambassadors, and improving access to reasonable adjustments.

Previously considered by	EDI Steering Group – 19 February 2026 People & OD Delivery Group – 10 March 2026 Due at People & OD Committee – 14 April 2026

Recommendations:
The Board are asked to endorse the report for publication by 31 March 2026, and to note the actions to deliver improvements.

Strategic Aims (tick as appropriate)	
Patient experience and voice	
People, culture and leadership	✓

Quality, safety and delivery	
Digital first	

Impact on any Strategic Risks?
BAF 03 - 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.

Implications on:	
Equality, Diversity and Inclusion	Supports a fairer, more supportive environment that should gradually narrow the Gender, Ethnicity and Disability Pay Gaps by improving access to senior roles, reducing barriers to progression, and enhancing retention.
Health Inequalities	N/A
Finance and Resource	N/A
Regulation/Legal	This report confirms compliance with the requirement for all employers with 250 or more employees on the designated snapshot date each year to calculate, report and publish their gender pay gap data, in accordance with the Equality Act 2010.
CQC-Key line of enquiry	N/A
Green Plan	N/A

Main Report

1. Executive Summary

1.1. This report outlines the Trust's Gender, Ethnicity and Disability Pay Gaps for 2025 and highlights where inequalities remain in our workforce.

1.2. The Gender Pay Gap has increased to a 26.5% mean and 17.8% median gap, both in favour of men. Much of this is driven by high-value Clinical Excellence Awards within the Medical and Dental workforce.

1.3. When Medical and Dental staff are excluded, the pay gap reduces significantly, showing near equal mean pay and a median gap in favour of women.

1.4. The Ethnicity Pay Gap is 1.2% in favour of ethnic minority staff, continuing a positive trend.

1.5. The Disability Pay Gap is 13.1% in favour of non-disabled staff, reflecting lower numbers of disabled colleagues in higher-banded roles.

1.6. Women, ethnic minority staff and disabled staff are all underrepresented in senior roles, which contributes to pay gaps across the Trust.

1.7. The Trust remains committed to reducing these gaps. Key actions include improving inclusive recruitment, strengthening staff networks, supporting progression, enhancing use of cultural ambassadors, and improving access to reasonable adjustments.

2. Introduction

2.1. The Equality Act 2010 requires public sector organisations with over 250 employees to publish their Gender Pay Gap each year. Although reporting on Ethnicity and Disability Pay Gaps is not mandatory, the Trust chooses to publish this information to support transparency and improvement.

2.2. We are committed to creating a fair and inclusive workplace where all colleagues feel respected and valued. Understanding our pay gaps helps us identify where inequalities exist and where further action is needed. Reducing these gaps remains a key priority, and we will continue to take meaningful steps to support equal access to development, progression, and opportunity.

2.3. At the time of reporting, the Trust employed 9,382 staff across a range of roles. Most staff, except Medical and Very Senior Managers, are paid through Agenda for Change, which supports consistent and equitable pay practices.

3. Gloucestershire Demographics (Census 2021)

- 51.1% of the population of Gloucestershire is female.
- 48.9% of the population of Gloucestershire is male.
- 6.9% of the population of Gloucestershire is ethnically diverse.
- 16.8% of the population of Gloucestershire is Disabled under the Equality Act.

4. What Are Pay Gaps

4.1. Pay gaps show the difference in average earnings between different groups of people. This includes gender, ethnicity, and disability. Pay gaps are usually shown as the difference between the mean or median hourly pay of one group compared to another.

4.2. The mean hourly pay gap shows the average difference in pay between one group and another, for example men and women. It is calculated by adding up everyone's hourly pay within each group and dividing by the number of people. The gap shows how much more or less, on average, men are paid compared to women across the organisation.

4.3. The median hourly pay gap compares the middle-earning person in one group and the middle-earning person in another group in the organisation, for example disabled and non-disabled. If you lined up all staff that declare disabilities hourly pay from lowest to

highest and did the same for staff that declare no disability, the median is the hourly pay rate in the middle of each line. The gap shows the difference between these two middle values and gives a good indication of typical pay differences between two groups.

4.4. Pay gap reporting helps organisations understand how different groups are represented across roles and pay levels. It also shows how well the organisation is supporting fair progression and equal access to opportunities.

5. What Is the Difference Between Pay Gaps and Equal Pay

5.1. Pay gaps are not the same as equal pay. Equal pay is a legal requirement. It means people must be paid the same for the same work, similar work, or work of equal value. It is unlawful to pay someone differently because of their gender, ethnicity, disability, or any other protected characteristic.

5.2. Pay gaps, however, look at the average pay of whole groups across the organisation. A pay gap can highlight patterns in recruitment, progression, working hours, or representation at senior levels. While a pay gap may sometimes point to unfair practices, this is not always the case. It often reflects wider structural issues that need attention and improvement.

6. What Pay Elements are included?

6.1. The statutory calculations have been carried out using the standard national Electronic Staff Record (ESR). In accordance with NHS Employers guidance, Clinical Excellence Awards and the methodology for awarding them have been classified as bonuses. Pay includes basic salary, fully paid leave (such as annual leave, sick leave, maternity, paternity, adoption, or parental leave), Bonus pay and shift pay. Most staff except medical staff and very senior managers were on the Agenda for Change pay scales.

<u>Gloucestershire Hospitals Gender Pay Gap 2025</u>

7. Key findings from March 2025 are as follows:

- The Mean Gender Pay Gap is 26.5% (£7.79) in favour of men, reflecting a 3.2% increase from 23.3% in 2024.
- The Median Gender Pay Gap is 17.8% (£4.20) in favour of men, reflecting a 0.6% increase from 17.2% in 2024.
- Excluding Medical and Dental staff, and Clinical Excellence Awards (CEAs), the pay gap shifts significantly.
- The Mean Gender Pay Gap reduces to 3.6% (£0.71) in favour of men.
- The Median Gender Pay Gap reduces to 5.0% (£0.88) in favour of women.

Gender Grouping Summary	Mean Hourly Rate 2025	Change since 2024	Median Hourly Rate 2025	Change since 2024
Women	£21.58	Increase of £1.64 since 2024	£19.40	Increase of £1.36 since 2024
Men	£29.38	Increase of £3.39 since 2024	£23.60	Increase of £1.81 since 2024

7.1. This highlights the impact of bonus payments within the Medical and Dental workforce, where high-value Clinical Excellence Awards (CEAs) continue to be a major factor.

7.2. Local CEAs were discontinued in 2020, and the associated budget was equally shared across substantive consultants, regardless of their working hours. Only a small number –

fewer than 10 – now receive national CEAs, but their value continues to influence the overall pay gap.

7.3. Nationally, the Gender Pay Gap has been decreasing over the past decade and stood at 6.9% in April 2025.

8. Trust's Gender Pay Gap summary:

- The Trust's Mean Gender Pay Gap is 26.5%.
- The Trust's Median Gender Pay Gap is 17.8%.
- The Trust's Mean Bonus Gender Pay Gap is 43.5%.
- The Trust's Median Bonus Gender Pay Gap is 66.7%.
- The proportion of men receiving a Bonus payment is 67%.

8.1. The proportion of women receiving a Bonus payment is 33%.

8.2. The proportion of men and women for all staff in each Quartile (Quartile 1 represents our lowest paid staff and Quartile 4 represents our highest paid staff):

- Quartile 1: 82.8% (1924 headcount) women and 17.2% (399 headcount) men
- Quartile 2: 82.5% (1952 headcount) women and 17.5% (414 headcount) men
- Quartile 3: 82.2% (1946 headcount) women and 15.8% (364 headcount) men
- Quartile 4: 63.1% (1503 headcount) women and 36.9% (880 headcount) men

9. Workforce Overview

9.1. Pay data is sourced from the national Electronic Staff Record (ESR). As of this date, GHNHSFT data shows that percentages of women and men remained the same as in 2024, at 78.1% (women) and 21.9% (men). This report fully complies with the Equality Act 2010 regulations, including the GPG Information Regulations 2017.

9.2. For this report the numbers have all been rounded to 1 decimal place. This may mean that the accumulative figures add up slightly more of less than 100.

Workforce Data	2025 Headcount	2025%	2024 Headcount	2024%	% Difference
Total Workforce	9382		9192		Increase of 2.1% compared to 2024
Men	2057	21.9%	2010	21.9%	% stayed the same compared to 2024
Women	7325	78.1%	7182	78.1%	% stayed the same compared to 2024

9.3. The Trust's workforce increased by 2.1% from 2024 to 2025, rising from 9,192 to 9,382 staff. The proportions of men and women in the workforce remained unchanged, with 21.9% men and 78.1% women in both years.

10. Gender Pay Gap – All Staff

Difference in Pay	Gender Pay Gap	Compared to 2024
Mean hourly pay for men £7.79 higher than women	Gender Pay Gap of 26.5%	Increase of 3.2% *(23.3% in 2024)*
Median hourly pay for men £4.20 higher than women	Gender Pay Gap of 17.8%	Increase of 0.6% *(17.2% in 2024)*

10.1. The data shows that men earn more than women on both measures. The mean Gender Pay Gap is 26.5%, an increase of 3.2% from 2024. The median Gender Pay Gap is 17.8%, which is 0.6% higher than the previous year.

11. Gender Pay Gap - Excluding Medical and Dental Staff

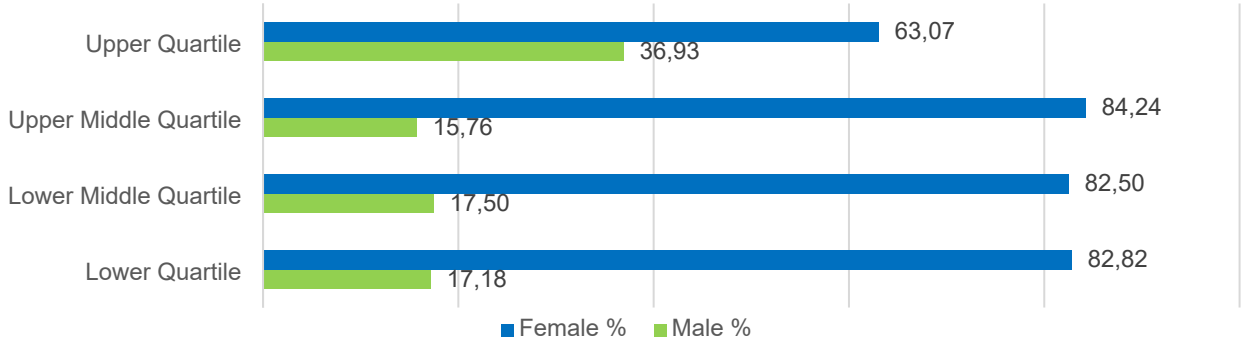
Difference in Pay	Gender Pay Gap	Compared to 2024
Mean hourly pay for men £0.71 higher than women	Gender Pay Gap of 3.6%	Increase of 1.28% *(0.62% in 2024)*
Median hourly pay for men - £0.88 higher than women	Gender Pay Gap of -5.0%	Decrease of 0.3% *(-5.03% in 2024)*

11.1. Among non-medical staff, the mean pay gap is 3.6% in favour of men, an increase from last year. The median pay gap is 5.0% in favour of women, showing a slight decrease compared to 2024.

12. Pay Quartiles

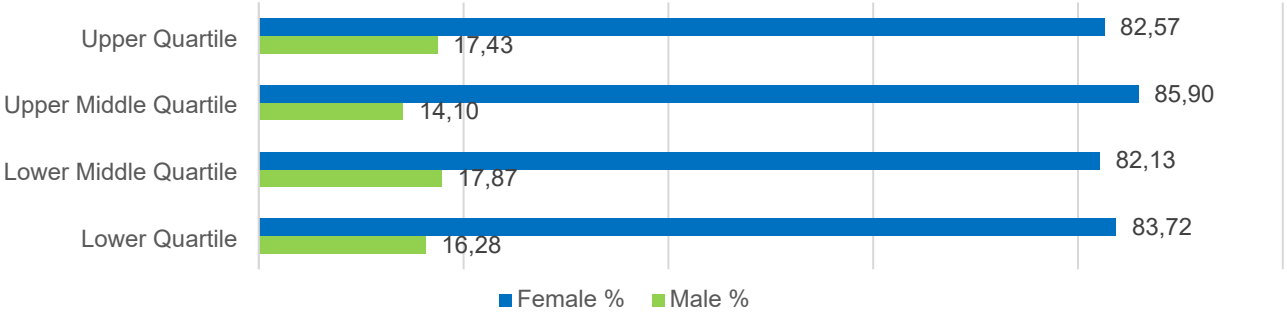
12.1. We are required to split the workforce into quartiles (blocks of 25%) split by pay and show proportions of men and women.

12.2. **Percentage of Gender in Pay Quartiles – All Staff**



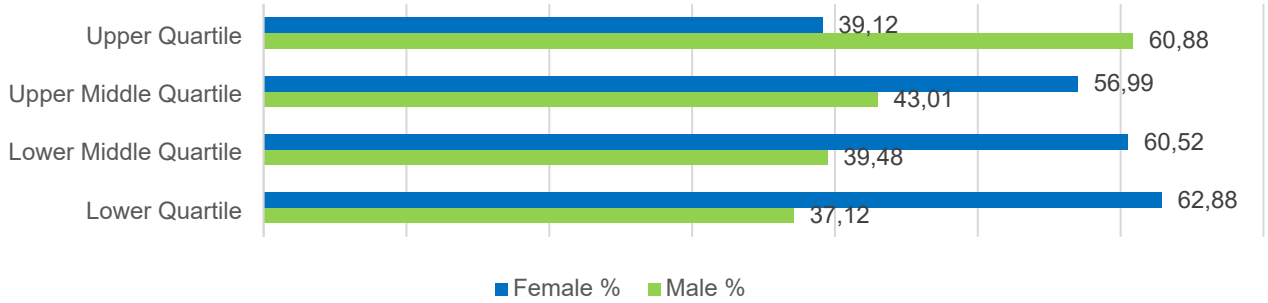
12.3. The chart shows that women make up the majority of staff in all pay quartiles. Representation is highest in the lower and middle quartiles, where women account for more than 82% of staff. In the upper quartile, the gender imbalance decreases, with women making up around 63% and men 37%. This pattern indicates that men are proportionally more represented in higher-paid roles than in lower-paid ones.

12.4. **Percentage of Gender in Pay Quartiles - No Medical Staff**



12.5. The chart shows that women make up a strong majority of non-medical staff in every pay quartile. Across all four quartiles, women consistently represent more than 82% of staff. This indicates that the gender distribution is broadly similar at all pay levels for non-medical roles, with men making up a much smaller proportion throughout.

12.6. **Percentage of Gender in Pay Quartiles - Medical Staff Only**



12.7. Across all medical staff pay quartiles apart from the Upper Quartile, women make up the majority. Female representation increases toward the lower quartiles, with women accounting for around 63% in the lowest quartile. In the upper quartile only males outnumber females, with 61% male and 39% female.

13. Bonus Payments

13.1. The Trust operated an annual Local Clinical Excellence Award (LCEA) round for eligible consultants. This recognises and rewards individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS. However, this was stopped in 2020 and the budget for CEAs was split equally between substantive consultants. Of note, this was not done pro rata – less than fulltime staff received the same amount as full time staff. Local CEAs were abolished as part of the pay negotiations resulting in a new consultant contract. There are fewer than 10 consultants in the Trust who receive a national CEA, but these awards are very large and still significantly contribute to the gender pay gap.

13.2. In 2025, 163 bonus payments were made to Medical and Dental staff. 111 (68%) of these were awarded to men and 52 (32%) awarded to women.

13.3. Mean Bonus Pay Gap: Male consultants earned an average bonus of £13,080.83 compared to £7,389.36 for women – a 43.5% pay gap.

13.4. Median Bonus Pay Gap: The median Bonus for men was £9,048.00, and for women was £3,015.97, which gives a 66.7% pay gap.

14. Gender Pay Gap Conclusion

14.1. Men earn **26.5% more on average** (mean).

14.2. Men earn **17.8% more at the midpoint** (median).

14.3. The biggest reason is that high-value Clinical Excellence Awards (bonuses) are received mostly by senior male consultants.

14.4. When medical staff are removed, the gap almost disappears.

14.5. Women make up most employees (78%), but are over-represented in lower-paid roles and under-represented in higher-paid and medical roles

14.6. This creates a structural pay gap.

Gloucestershire Hospitals Ethnicity Minority Pay Gap 2025

15.1. Data reported as of 31 March 2025, unless otherwise indicated.

15.2. For this report, the term "Ethnic Minority" (EM) will be used to refer to our Black and Asian staff. This terminology has been chosen for consistency within the report; however, we acknowledge the evolving discussions around language and inclusivity.

16. Key Findings from March 2025 are as follows:

- The mean Ethnicity Pay Gap is 1.2% (£0.28) in favour of EM staff, which is a 2% reduction from 3.2% in 2024.
- The median Ethnicity Pay Gap is 3.4% (£0.67) in favour of EM staff, which shows a 1.85% reduction from 5.25% in 2024.

16.1. As of March 2025, 23.7% of staff at GHNHSFT identified as being from an EM background, 66.1% of the workforce is White, and 10.18% had their ethnicity recorded as unknown.

16.2. The table below shows the average and median hourly rates for different ethnic origins groups as follows.

- Please note: **NULL** - indicates no data was entered. **Not Stated** - indicates that the person chose not to disclose the information.

Ethnic Origin Grouping Summary	Mean Hourly Rate 2025	Change since 2024	Median Hourly Rate 2025	Change since 2024
EM	£23.54	Increase of £1.36 since 2024	£20.46	Increase of £0.98 since 2024
NULL	£22.58	Increase of £3.73 since 2024	£19.05	Increase of £2.94 since 2024
Not Stated	£23.13	Increase of £2.37 since 2024	£21.01	Increase of £2.03 since 2024
Other	£24.69	Increase of £0.37 since 2024	£21.82	Increase of £0.02 since 2024
White	£23.26	Increase of £1.77 since 2024	£19.79	Increase of £1.29 since 2024

16.3. This shows that our EM staff earn a mean hourly rate of £23.54, whilst White staff earn a mean hourly rate of £23.26. This gives a difference of £0.28, representing a pay gap of 1.2% in favour of EM staff.

16.4. The median hourly rate for EM staff is £20.46, compared to a median hourly rate of £19.79 for White staff. This gives a difference of £0.67 and a pay gap of 3.4% in favour of EM staff.

16.5. The mean hourly rate for NULL is £23.85 and the median is £20.66.

16.6. The mean hourly rate for Not Stated is £23.13 and the median is £21.01.

16.7. The mean hourly rate for Other is £24.69 and the median is £21.82

16.8. Staff who declare their ethnicity in the 'Other' category earn the highest on average, with those not stating their ethnicity the earning the lowest on average.

17. Pay Quartiles

Quartile	Asian	Black	Mixed	NULL	Not Stated	Other	White British	White Other
1	197	115	50	77	88	25	1,653	119
2	436	139	44	170	153	41	1,261	125
3	423	121	29	73	143	48	1,351	125
4	338	117	61	110	142	45	1,415	155

17.1. White British staff are the largest ethnic group across all pay quartiles, with Asian individuals following. Black staff have smaller representation, peaking in Quartile 2, and

the Mixed group peaks in Quartile 4. A significant number of staff haven't stated their ethnicity, particularly in Quartiles 2, 3 and 4. There are fewer people in the "Other" category, with their numbers remaining relatively consistent across the quartiles 2, 3 and 4.

18. Ethnicity Local Clinical Excellence Awards Bonus Payments 2025

18.1. 163 bonus payments were made to medical and dental staff: in 2025. There are 138 (85%) white consultants, compared to 24 (15%) EM Consultants and 1 (1%) of those did not state their ethnicity.

19. Ethnicity Pay Gap Conclusion

18.2. The Ethnicity Pay Gap at March 2025 is 1.2% in favour of ethnic minority (EM) staff. EM staff have a slightly higher average hourly rate than White staff. This may reflect factors such as longer time at the top of pay bands and a higher likelihood of working unsocial hours, which attract enhanced pay.

18.3. White staff are more likely to progress into higher-banded roles, though often entering these bands at lower incremental points. The combination of band position and working patterns may help explain the current difference in average pay.

18.4. For bonus payments, 85% of consultants receiving awards were White, and 14% were from EM backgrounds, showing that most consultant roles continue to be held by White staff.

18.5. Further analysis is needed to understand the factors behind this distribution, including recruitment, progression, and retention.

<u>Gloucestershire Hospitals Disability Pay Gap 2025</u>

19.1. Data reported as at 31 March 2025, unless otherwise indicated.

20. Key Findings from March 2025 are as follows:

- The mean Disability Pay Gap (DPG) is 13.1% (£3.05) in favour of non-disabled staff.
- The median Disability Pay Gap (DPG) is 12.6% (£2.94) in favour of non-disabled staff.

21. Disability Grouping Definitions:

Yes	No	Prefer not to answer	Unspecified	Not declared
Selected one of the following: • Learning disability/difficulty • Long standing illness • Mental Health Condition • Physical Impairment • Sensory Impairment • Other	Selected no	Selected prefer not to answer	Selected 'Yes – Unspecified' meaning they are declaring an unspecified disability	Have not selected any of the above/have not answered

21.1. The table below shows the average and median hourly rates for different ethnic origins groups as follows. As this is the first year, we have analysed the Disability Pay Gap data, there is no comparison with previous years data.

Disability Grouping Summary	Mean Hourly Rate	Median Hourly Rate
No	£23.34	£23.37
Not Declared	£21.87	£22.01
Prefer Not To Answer	£19.07	£19.10
Unspecified	£25.29	£25.56
Yes	£20.29	£20.43

21.2. This shows that our disabled staff earn a mean hourly rate of £20.29, whilst non-disabled staff earn a mean hourly rate of £23.34. This gives a difference of £3.05, representing a pay gap of 13.06% in favour of non-disabled staff.

21.3. The median hourly rate for disabled staff is £20.43, compared to a median hourly rate of £23.37 for non-disabled staff. This gives a difference of £2.94 and a pay gap of 12.6% in favour of non-disabled staff.

- The mean hourly rate for Not Declared is £21.87 and the median is £22.01.
- The mean hourly rate for Prefer Not to Answer is £19.07 and the median is £19.10.
- The mean hourly rate for Unspecified is £25.29 and the median is £25.56.

21.4. Staff who declare their disability status as 'unspecified' earn the highest on average, with those preferring not to answer having the lowest earnings on average.

22. Pay Quartiles

22.1. This data shows the distribution of individuals in different disability declaration group across four pay quartiles (1 to 4). These quartiles represent salary bands, with Quartile 1 being the lowest and Quartile 4 being the highest. The numbers show how many individuals from each disability declaration group are in each quartile.

Quartile	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
1	1,409	375	22	339	178
2	1,452	371	11	408	124
3	1,441	401	9	365	94
4	1,463	290	5	555	70

22.2. Non-disabled staff are the largest group across all pay quartiles, with second largest being either unspecified or not declared depending on quartile. The unspecified group peaks in Quartile 4, whereas numbers that have not declared peak in Quartile 3. The number in both the prefer not to answer group and those answering yes to having a disability decrease as the quartiles increase.

23. Disability Local Clinical Excellence Awards Bonus Payments 2025

23.1. 163 bonus payments were made to medical and dental staff in 2025. There are 7 (4%) that have declared a disability, compared to 82 (50%) who have declared they have no disability, with 72 (44%) of those not declaring their disability status, and 2 (1%) with an unspecified disability declaration.

24. Disability Pay Gap Conclusion

24.1. The 2025 Disability Pay Gap for Gloucestershire Hospitals NHS Foundation Trust is 13.1% in favour of non-disabled staff.

24.2. Disabled staff are underrepresented in higher-banded roles and more likely to work in lower-banded, frontline, or part-time positions, which can reduce average earnings. Some

colleagues may also face barriers to progression, including limited access to development opportunities or challenges securing workplace adjustments, as reflected in staff survey feedback. Non-disabled staff are more likely to hold senior roles, which contributes to the overall gap.

24.3. Publishing this data helps the Trust identify where improvement is needed and focus on creating a more inclusive and supportive environment for disabled colleagues. Our priority is to strengthen access to development, progression pathways, and appropriate adjustments so that all staff can thrive and progress equitably within the organisation.

25. Recommendations and Actions

1	**Inclusive recruitment** An Inclusive Recruitment task and finish group has been established, and work is underway to identify recruitment barriers, including EDI-related issues, and implement improvements to deliver fairer, more inclusive hiring. This is key in removing barriers for applicants from groups affected by pay gaps to move into more senior roles, in turn reducing inequalities.
2	**Inclusion Champions** Formalise the Inclusion Champion role and operating model through a task and finish group, which is scheduled to start in March 2026. This will be followed by a Trust-wide campaign to grow the champion workforce. By ensuring the Inclusion Champion role is effective and used consistently will reduce barriers preventing applicants from groups that are currently affected by the pay gap moving into more senior roles.
3	**Cultural ambassadors** At present the Trust has 11 Cultural Ambassadors trained. Moving forwards, we aim to agree a consistent Trust approach for involvement in Employee Relations and recruitment processes. Additional Cultural Ambassadors may be needed to meet demand. As above, by ensuring more inclusive hiring it would remove progression barriers for staff who are from groups affected by pay gaps.
4	**Inclusion Networks** Strengthen the purpose, governance and impact of all Inclusion Networks, supported by external expertise (Eden Charles). Prioritise dedicated funding for Network Chairs. The Networks provide staff with peer support, allow staff access to developmental and educational opportunities, and aim to give staff an active voice within the Trust. Improving the impact of the Networks would improve staff experience, impacting retention of staff in protected groups and access to training and development opportunities.
5	**Reciprocal Mentoring (May 2026)** The launch of the Reciprocal Mentoring Programme is scheduled for May, with applications for mentors and mentees already closed. The aim is to pair network members and allies with Executive and senior leaders to enhance understanding of lived experiences. By increasing senior leaders' awareness of barriers that staff from the networks face in our workplace, the aim is for improved retention of high potential staff members through increased confidence and access to opportunities.
6	**Sexual Safety Charter** Continue to monitor the uptake of the mandatory Trust-wide eLearning on "Understanding Sexual Misconduct in the Workplace" to meet national commitments. Sexual misconduct disproportionately affects women, and therefore creating a safer culture can increase retention of women and enable them to progress to higher-banded positions.
7	**Menopause Support** Continue the delivery of menopause workshops providing education, support and signposting to adjustment and wellbeing resources. This ensures women are supported to stay well whilst at work, preventing early exit from the workforce due to menopause related issues. Retaining females at this point in their career ensures we are enabling more women to access more senior positions.
8	**Reasonable Adjustments** A Task and Finish group has been established with first meeting scheduled for March 2026, with aims to improve manager capability and streamline support pathways for staff seeking reasonable adjustments, aligned with policy expectations. Being able to access reasonable

	adjustments may be a key enabler, particularly for our disabled staff, in being able to remain and progress in our workforce.
9	**WRES and WDES action plan** Continue delivery of Trust Workforce Race Equality Standard and Workforce Disability Equality Standard action plans, with continued focus on embedding divisional ownership of action plans, focusing on measurable improvements in staff experience ensuring we are able to retain our workforce and develop internally into more senior positions.

Enclosures

N/A

FOI: Public

Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board

Date of Meeting	12th March 2026
Report title	2025 Staff Survey Results Summary
Sponsoring Director/Author	*Debbie Tunnell, Deputy Director for People & OD* *Josh Penston, Culture & Staff Experience Manager*

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

Executive Summary

The 2025 NHS Staff Survey results provide an important insight into the current experience of staff across the Trust. A total of 4,313 responses were received from 8,961 staff, representing a response rate of 50%. While this remains above the national average for acute trusts, it reflects a decline from 65% in 2024. The results present a mixed picture, with some areas of improvement, including elements of staff advocacy, alongside statistically significant declines in Staff Engagement and two People Promise themes. Benchmarking indicates the Trust continues to rank below many comparator organisations for engagement and morale.

The findings highlight that while staff remain strongly committed to delivering high-quality patient care, their overall experience of working in the Trust requires continued focus. Inequalities in experience persist for ethnic minority and disabled staff, particularly in relation to bullying and harassment, career progression, and feeling supported at work. These results reinforce the importance of sustained and targeted action to improve culture, engagement, and inclusion across the organisation.

The Trust has already begun sharing results across divisions to support local ownership and action planning, aligned with the Staff Experience Improvement Programme. Improvement activity will continue to be overseen by the People and OD Committee and Trust Leadership Team. There remains a clear organisational commitment to listening to staff feedback and taking meaningful action to improve staff experience, recognising this as essential to delivering high-quality patient care and organisational performance.

Previously considered by	People & OD Delivery Group (13th January 2026) Confidential Board (15th January 2026) People & OD Committee (17th February 2026)

Recommendations:

Public Board is asked to:

Note the results of the 2025 NHS Staff Survey, including the overall response rate of 50%, the decline in Staff Engagement and two People Promise themes, and the Trust's benchmarking position relative to comparator organisations.

Acknowledge the areas of strength, including continued staff commitment to patient care and improvements in selected advocacy measures.

Recognise the priority areas for improvement, particularly Staff Engagement, morale, equality of experience (WRES and WDES indicators), and themes where statistically significant declines have been identified.

Endorse the continuation of the Staff Experience Improvement Programme (SEIP) as the Trust's primary framework for improving staff experience, engagement, and organisational culture.

Support divisional accountability for improvement, ensuring that Divisions and services develop and deliver targeted local action plans aligned to Trust priorities and People Promise themes.

Support a strengthened focus on equality, diversity and inclusion, noting the disparities highlighted within the WRES and WDES results, and the requirement for targeted interventions to improve the experience of ethnic minority and disabled staff.

Note the governance arrangements, with oversight of improvement activity provided through the People and OD Committee and Trust Leadership Team, and request regular progress updates to the Board.

Support organisational efforts to improve future survey participation, recognising the importance of staff voice in shaping improvement and decision-making.

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. The Staff Survey is the primary means by which progress is assessed.

Implications on:	
Equality, Diversity and Inclusion	The annual Staff Survey enables us to monitor progress against the WRES and WDES indicators.
Health Inequalities	-
Finance and Resource	-
Regulation/Legal	-
CQC-Key line of enquiry	CQC Well-Led – staff experience, leadership, EDI, FTSU
Green Plan	-

Main Report

1. Purpose

The annual NHS Staff Survey results for 2025 were published nationally on 12th March 2026. The purpose of this report is to provide the Board with a high-level overview of the Trust's 2025 Staff Survey results, highlighting key outcomes, areas of strength, and priority areas for improvement.

Prior to national publication, the results were shared under embargo with key internal groups to inform strategic planning, organisational improvement activity, and operational decision-making. This report supports the Board in understanding current staff experience and the actions required to strengthen engagement and organisational culture.

2. Background

A total of 8,961 staff were invited to participate in the 2025 survey, with 4,313 responses received, representing a response rate of 50%. While this is above the national average for acute trusts (47%), it represents a decrease from the Trust's 2024 response rate of 65%.

In previous years, the Trust has offered incentive schemes to encourage participation. However, due to the significant financial pressures facing both the organisation and the wider NHS, a decision was taken not to offer incentives in 2025. This approach was communicated openly to staff, reinforcing that the most valuable outcome of the survey is the insight gained from staff feedback, which directly informs organisational improvement.

The survey consisted of 118 questions, the majority of which are comparable with previous years. However, a small number of questions were amended nationally in 2025 and are now classified as non-comparable. National guidance confirms these questions will be excluded from final benchmark calculations.

Independent analysis by NHS England has identified statistically significant declines in two of the seven People Promise themes and in the overall Staff Engagement score.

3. Results Summary

Overall, the Trust's results present a mixed picture, with some areas of improvement alongside a number of declining indicators.

Engagement and benchmarking

Nationally, there has been an overall deterioration in staff survey results in 2025. The Trust results show mixed performance but the 'break-away' from the poorest performance Trusts and our journey towards 'average' has continued across many of the questions. The Trust does, however, continue to perform below national averages across several People Promise and Staff Engagement metrics. Compared to IQVIA comparator organisations, the Trust ranks:

- 65th out of 71 acute and acute and community trusts for Staff Engagement
- 56th out of 71 for Staff Morale

Although there has been improvement in one Net Promoter Score measure, overall engagement remains an area requiring focused improvement.

Staff advocacy and experience

Staff advocacy remains mixed:

- Approximately half of respondents would recommend the Trust as a place to work
- Around half would be happy with the standard of care if a friend or relative required treatment
- Nearly two-thirds of staff agree that patient care is the organisation's top priority

These findings highlight the continued commitment of staff to delivering patient care, while reinforcing the need to improve staff experience and engagement.

Equality of experience (WRES and WDES)

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators highlight ongoing inequalities in staff experience.

The WRES results show differences between ethnic minority staff and White staff in areas including:

- Experiences of bullying, harassment and discrimination
- Access to career progression opportunities
- Confidence in organisational processes

The WDES results similarly identify disparities between disabled and non-disabled staff, particularly in relation to:

- Workplace pressure
- Experiences of bullying and harassment
- Feeling supported to contribute to improvements

While some measures show stability or improvement, these findings reinforce the need for continued, targeted equality-focused action as part of the Staff Experience Improvement Programme (SEIP).

4. Organisational response and improvement activity

There is ongoing divisional engagement to support timely dissemination and local ownership of results. Divisions are aligning their priorities with the Staff Experience Improvement Programme, focusing on targeted actions to address areas of lower performance.

While progress has been made in recent years, the Trust must not be complacent. There remains a clear organisational commitment to improving staff experience and creating a positive, inclusive culture where staff feel valued, supported, and able to thrive.

The People and OD Committee and Trust Leadership Team will provide oversight and assurance of improvement activity over the coming year.

5. Next Steps

Further analysis and engagement

- Divisional and staff group level results were shared during January and February 2026 to support local interpretation and ownership
- Results have been presented to Divisional Boards, Service Line Tri's, managers, and senior leaders to enable meaningful discussion and validation of findings
- A detailed analysis of free-text comments will be undertaken once available to provide deeper insight into staff experience

Action planning

- Divisions and services will review their local results and develop targeted action plans aligned to Trust priorities and People Promise themes
- Areas of sustained strength will be identified to enable organisational learning and sharing of best practice
- Progress will be monitored through the established governance framework, including the People and OD Committee and Trust Leadership Team

Enclosures

NSS25 Results Summary – Public Board – March 2026 v0.TBC FINAL

FOI: The national embargo will be lifted at 09:30 on Thursday 12th March. Papers must be kept confidential and not shared outside of the organisation until this date and time.

Gloucestershire Hospitals NHS Foundation Trust

NHS Staff Survey 2025

High-level results report

Public Board

March 2026

caring | inclusive | compassionate | accountable

Introduction

This report summarises the findings from the core **NHS Staff Survey 2025** carried out by IQVIA. It does not include the Bank worker survey results which will be presented separately when available.

A total of **118** questions were asked in the 2025 survey, of these, **108** can be compared to 2024.

Results include every question where the organisation received at least 10 responses (the minimum required).

Full results are available to view on the NHS Staff Survey website.

Changes to 2025 reporting

On **Thursday 11th December**, the Survey Coordination Centre (SCC) informed contractors that questions **Q11b, Q15, and Q16c** in the 2025 NHS Staff Survey (and NSSB equivalents) will be treated as **non-comparable** due to wording changes introduced this year.

Key points:

- National reporting **does not include trend data** for these questions.
- People Promise scores and sub-scores exclude Q11b and Q15.
- WRES and WDES measures linked to Q15 will also exclude trend data.

Organisation details

Survey Coordination Centre NHS

Gloucestershire Hospitals NHS Foundation Trust

2025 NHS Staff Survey

Organisation details

Completed questionnaires	4313
2025 response rate	50%

This organisation is benchmarked against:

Acute and Acute & Community Trusts

Survey details

Survey mode	Mixed

2025 benchmarking group details

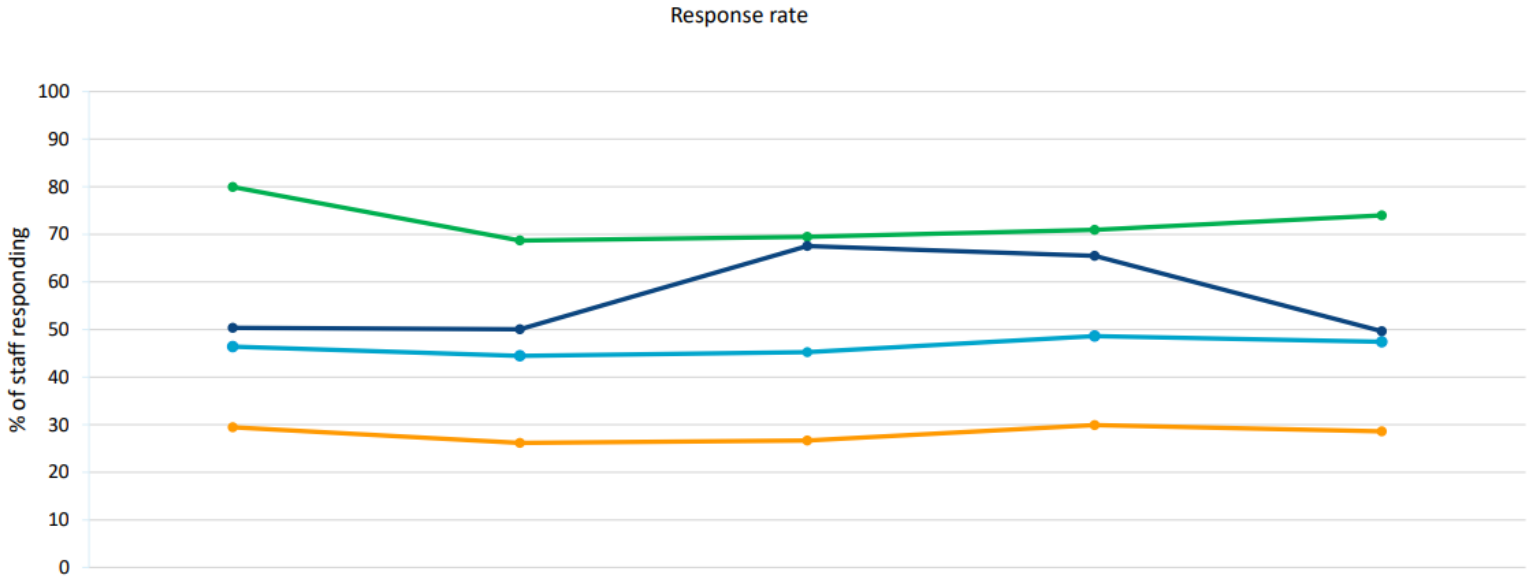
Organisations in group: 121

Median response rate: 47%

No. of completed questionnaires: 524528

Appendix A: Response rate

Survey Coordination Centre NHS

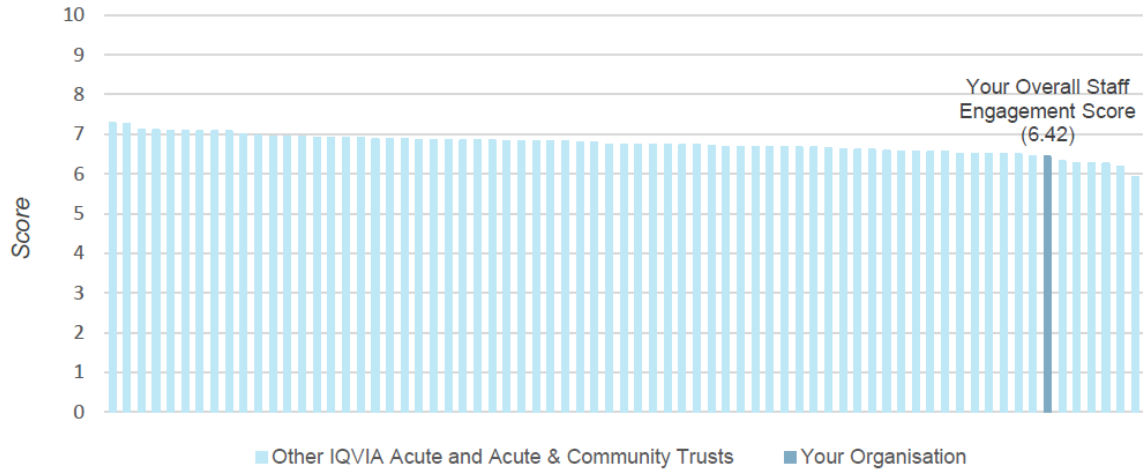


	2021	2022	2023	2024	2025
Your org	50.34%	50.06%	67.53%	65.47%	49.63%
Highest	79.95%	68.69%	69.45%	70.92%	73.97%
Average	46.38%	44.46%	45.23%	48.61%	47.42%
Lowest	29.47%	26.17%	26.65%	29.91%	28.60%
Responses	3897	4232	5475	5522	4313

Staff Engagement

Overall Staff Engagement across your Sector

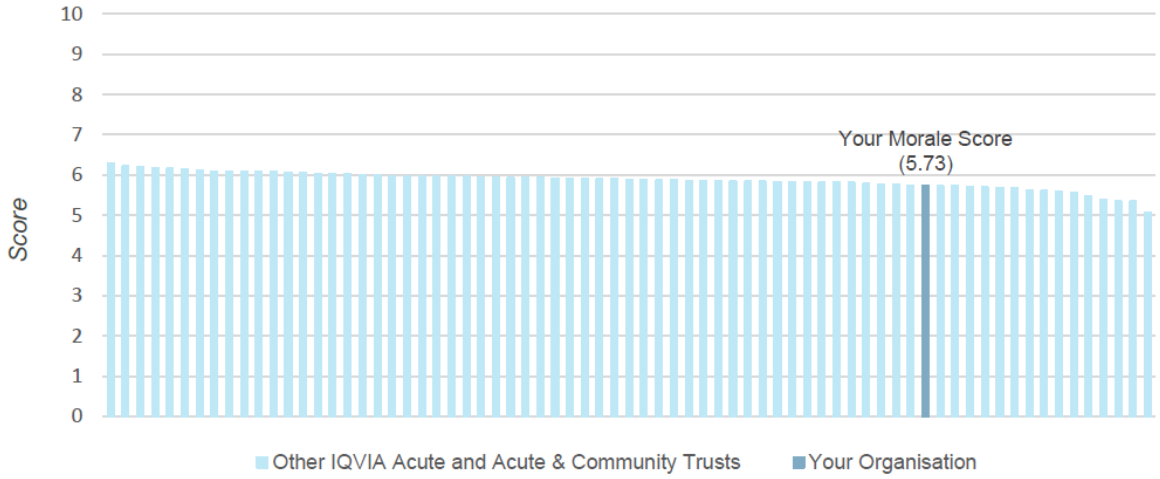
Presented in the chart below are the range of Overall Staff Engagement Scores across the Acute and Acute & Community sector, shown in ranking order. Your organisation's score is (6.42) and its position within the sector is marked dark blue. The lighter blue bars represent the scores of other organisations within your sector.



Morale

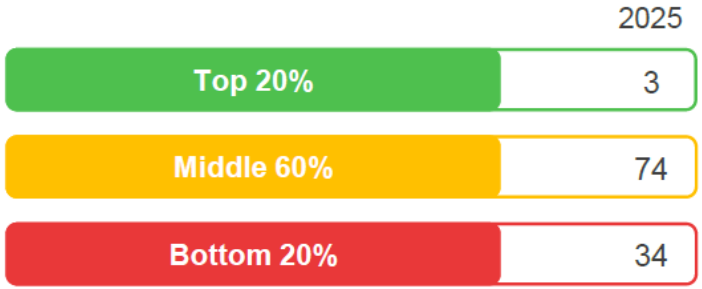
Morale across your Sector

Presented in the chart below are the range of Morale Scores across the Acute and Acute & Community sector, shown in ranking order. Your organisation's score is (5.73) and its position within the sector is marked dark blue. The lighter blue bars represent the scores of other organisations within your sector.



Benchmarking Percentiles

The table below summarises the distribution of core questions where your organisation scored amongst the top 20%, middle 60% and bottom 20% of the 71 organisations in your benchmarking sector (Acute and Acute & Community Trusts) that are contracted to IQVIA.

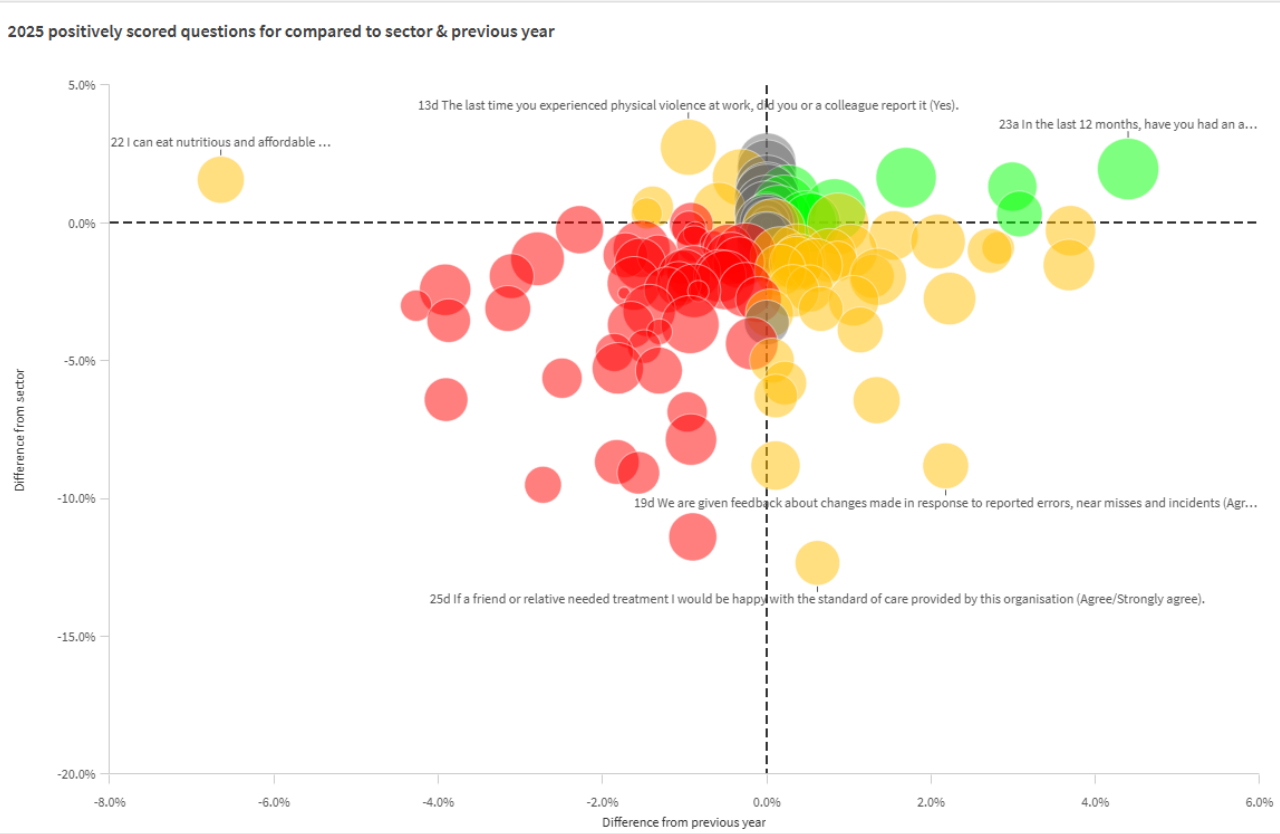


High scores getting worse

6 (6.06%)

High scores getting better

10 (10.10%)



Low scores getting worse

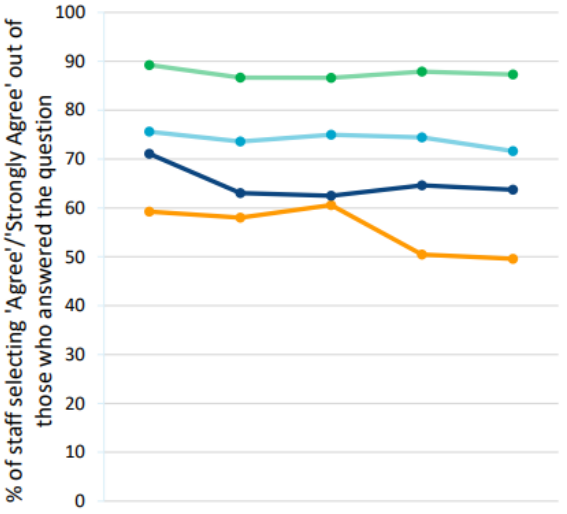
50 (50.51%)

Low scores getting better

33 (33.33%)

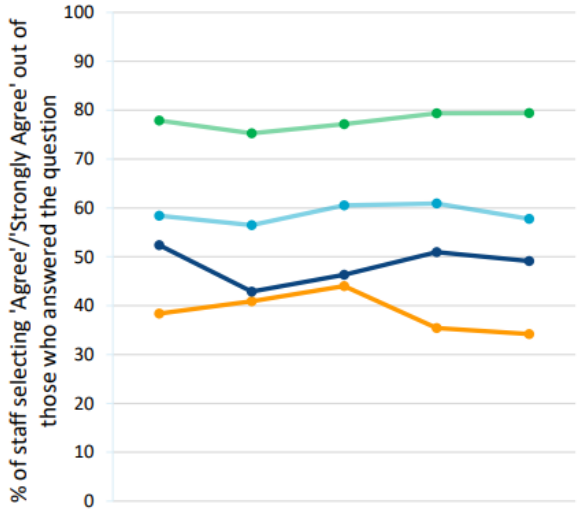
Net Promoter Questions

Q25a Care of patients / service users is my organisation's top priority.



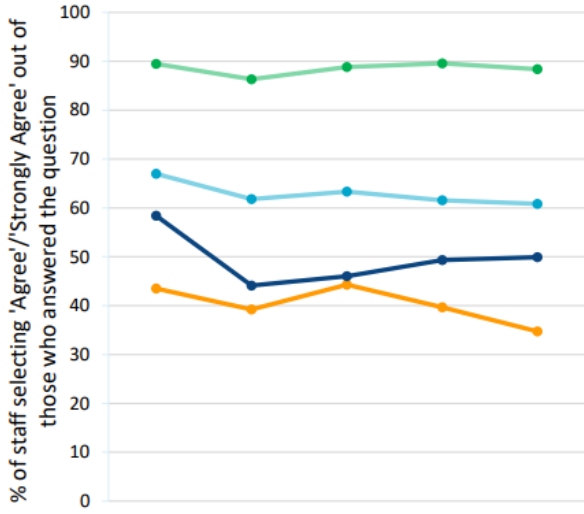
	2021	2022	2023	2024	2025
Your org	71.07%	63.02%	62.48%	64.62%	63.71%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	3873	4208	5442	5510	4288

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	52.40%	42.88%	46.33%	50.94%	49.11%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	3869	4207	5441	5506	4283

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



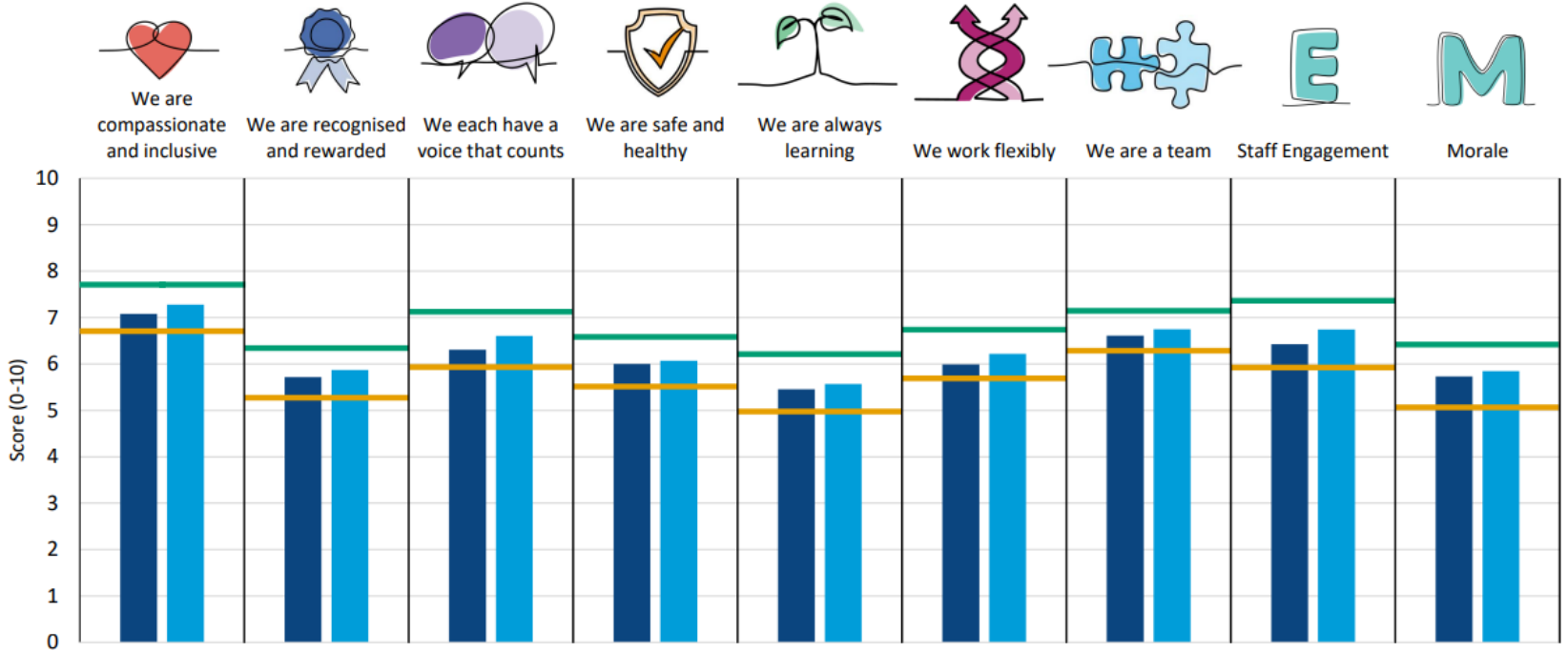
	2021	2022	2023	2024	2025
Your org	58.39%	44.12%	46.03%	49.35%	49.92%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	3866	4205	5442	5505	4285

People Promise

People Promise elements and themes: Overview

Survey Coordination Centre NHS

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.08	5.72	6.30	6.00	5.45	5.99	6.61	6.43	5.73
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	4299	4295	4246	4260	4173	4266	4289	4294	4299

Significance testing 2024 vs 2025

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.10	5511	7.08	4299	Not significant
We are recognised and rewarded	5.76	5510	5.72	4295	Not significant
We each have a voice that counts	6.38	5487	6.30	4246	Significantly lower
We are safe and healthy	6.08	5487	6.00	4260	Significantly lower
We are always learning	5.44	5263	5.45	4173	Not significant
We work flexibly	5.99	5493	5.99	4266	Not significant
We are a team	6.59	5502	6.61	4289	Not significant
Themes					
Staff Engagement	6.53	5518	6.43	4294	Significantly lower
Morale	5.78	5519	5.73	4299	Not significant

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

Next steps

High-level timeline

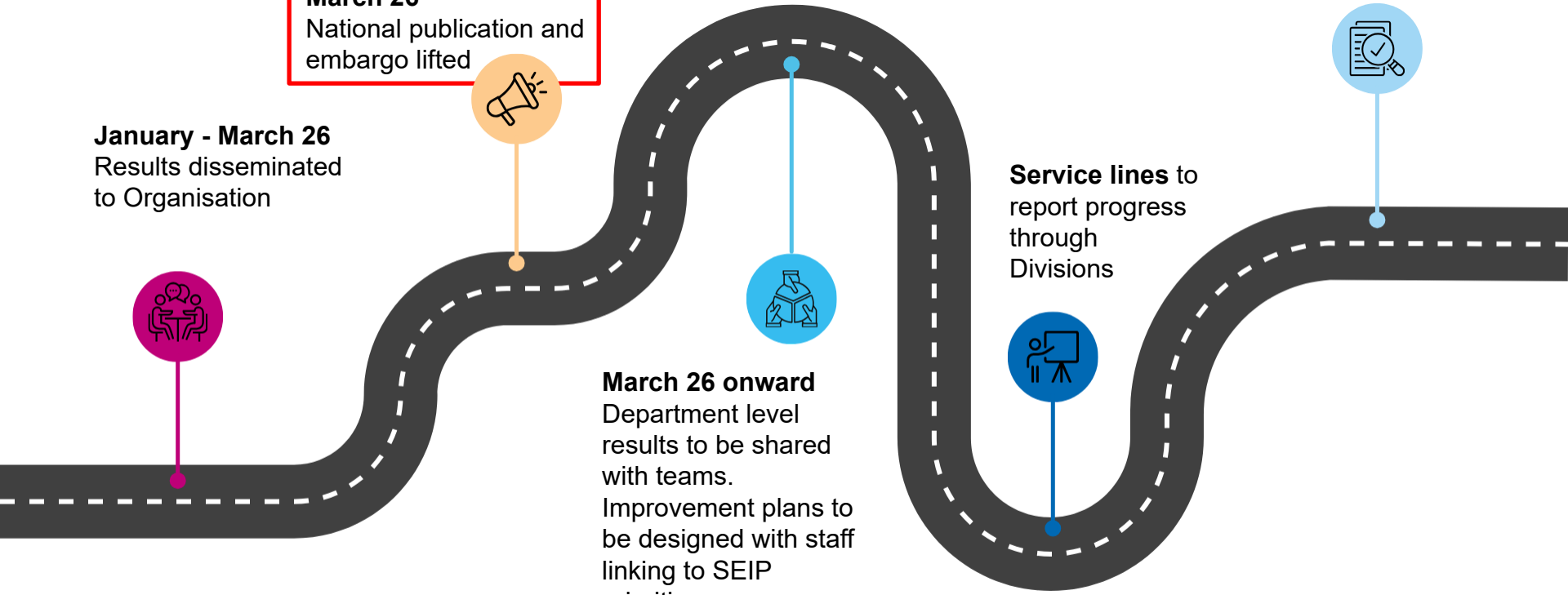
March 26
National publication and embargo lifted

January - March 26
Results disseminated to Organisation

March 26 onward
Department level results to be shared with teams. Improvement plans to be designed with staff linking to SEIP priorities

Service lines to report progress through Divisions

Divisions to report on their progress into Executive review meetings




Thank you
Let's do this together
STAFF SURVEY 2025
Post Op Bay B
Thank You
Bay 1

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on Thursday 12 March 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: John Cappock Executive Directors: Karen Johnson, Director of Finance Al Sheward, Chief Operating Officer Lee Pester, Chief Digital Information Officer
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 Finance and Resources Committee held on 27 January 2026. 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 9, the Financial Sustainability programme continued to show signs of stress evidenced by £11.5M year shortfall against recurrent savings – a full year underdelivery risk of c£7.2m was highlighted. 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.
- **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 previously been agreed to support Gloucestershire Managed Service and the Procurement team in accelerating the programme, as well as further

schemes being added. The Committee was advised that advancing of schemes from 2026/27 were likely to mitigate against in year slippage towards year end

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

- **Costing –** The Committee received a helpful report on the costing strategy which is a key enabler of the FSP. The intel being produced is driving better informed decision making. Rated amber as there is more to do to capitalise on this work
- **Financial systems update –** Committee received an update on the various challenges associated with getting the proposed new system to an acceptable position and in a position to implement. Some fundamental impediments remain and it is very unlikely that proposed April 26 implementation will be achieved and it would be prudent to defer. Clearly a lessons learned exercise will be required particularly in light of the Trust being a first adopter of this system in a health environment.
- **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.
- **Inter-systems contract extension –** Extension is necessary precursor to reviewing the electronic patient record strategy moving forward. Extension period will be required to prepare the way for this.
- **Digital infrastructure resilience update –** The Committee received an update on the various challenges faced in light of ageing physical and digital environment

ASSURE: inform the board where positive assurance has been received

- **Integrated digital report –** The Committee received a helpful report from the Chief Digital Information Officer. This included an update on 27 projects which have been cohered into 5 programmes and which had seen significant progress in recent months around management and mitigation. It was also positive to see the significant improvement in first contact resolution of problems.
- **Digital strategy –** The Committee received a progress report on the draft of the new digital strategy which was clear, digestible and appropriately ambitious.
- **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

- **Inter systems contract extension –** The Committee APPROVED a three year extension to the existing contract with Inter systems

- **Bed management contract –** The Committee DEFERRED APPROVAL of a £14.8M (within budget) 16 year contract to Drive DeVilbiss Sidhil Ltd pending additional information to be provided by the COO

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.

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on Thursday 12 March 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Finance and Resources Committee held on 24 February 2026
Board member lead(s)		Committee Chair: John Noble Executive Directors: Karen Johnson, Director of Finance Al Sheward, Chief Operating Officer Lee Pester, Chief Digital Information Officer
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 Finance and Resources Committee held on 24 February 2026. 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 10, a full year under delivery risk of c£7.1m was highlighted. This was an improvement of £0.1m on prior month, but that the level of recurrent under-delivery remains a concern going into 2026/27.
- **Capital and Estates Programme Delivery** - At the end of Month 10, the Trust had goods delivered, works done or services received totalling £20.1m, against a planned spend of £39m, equating to a variance of £18.9m behind plan. This is a significant risk. Review work carried out in January forecast an underspend of £2.9m. Mitigations were in place, and the Trust had since agreed to return £700k of funding to NHSE.

- **GMS Alert, Advise and Assure** Fire safety compliance and enforcement risk were highlighted.

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

- **Gloucestershire Cancer Institute project update -** The Committee noted the identification of substantial enabling works that were materially under-scoped at Outline Business Case stage and now sat on the programme's critical path. A material increase in forecast total programme capital costs driven by inflation, design development and market conditions was noted. This carries significant reputational risk.
- **Financial Performance Report -** The M10 position was a £0.35m surplus, which was £0.1m favourable to plan. This included the support from the Integrated Care Board and non- recurrent measures and income. Without these, the Year-to-Date position would be £14.6m adverse to plan.
- **Financial Risk Register -** Risk 948: the risk of operating an unsupported legacy system for a prolonged period due to delays in the implementation of the new finance and procurement system, had been increased.
- **Contract Management Group Exception Report -** Incidents, increased activity demands and staff sickness had contributed to continued failures in a few Key Performance Indicators. Gloucestershire Managed Services were reviewing their resilience plans.
- **2026/27 Budget Setting update -** The Committee were updated on the budget setting process undertaken within the Trust; this was fully aligned with the Medium-Term Plan submission. A breakeven financial plan for 2026/27 was submitted; this included significant non-recurrent measures which meant that the underlying deficit was £64.3m.
- **Estates Strategy Programme** - The Committee was updated on the work taking place on the Estates Strategy Programme. This is complex and challenging work. It was proposed that the Board look at Estates work at a Board Development Day. A masterplan was being developed to provide an understanding of the Trust's assets, data, and compliance and work was taking place around procurement and suppliers. The Estates Rationalisation Group had now been set up and the Committee received an update on the programme reset and governance alignment to the Estates Alliance Subcommittee.

ASSURE: inform the board where positive assurance has been received

- **Medium Term Planning** - The Trust's approach to medium term planning, and the national planning requirements was set out. The plan had been submitted on 12th February 2026 and feedback was awaited.

APPROVALS: decisions made by the Committee

- **Bed Management Contract –** The Committee APPROVED OPTION 2: PURCHASE EQUIPMENT. This option would require revenue investment of £6.3m over 16 years in addition to current spend which could be spread over 4 years from Year 1 to Year 4 with

a rolling replacement required Year 10 to Year 13. *This assumed that the Trust purchases standard bed frames and continues to hire bariatric and hi/lo frames.*

- **Gloucestershire Cancer Institute project update**
  The Committee APPROVED increased CDEL commitment for the Gloucestershire Cancer Institute programme, subject to Full Business Case conclusion. The Committee noted that the Full Business Case required Capital Delivery Group approval as timings had not aligned.
  The Committee APPROVED the proposed mitigation of contracting with a built-in pause to enable further fund-raising if needed and/or alignment with the CDEL 4-year plan.
- **Altera Sunrise EPR Contract Extension -** The Committee APPROVED the extension of the Altera Sunrise EPR contract for three years from 1st April 2026, under the terms permitted in the current agreement.
- The VIRTUAL APPROVAL of the **Prescott Ward Refurbishment** was noted.
- The VIRTUAL APPROVAL of **Mobile Clinical IT CART Replacement** was noted.
- **2026/27 Budget Setting update -** The Committee APPROVED the financial plan for 2026/27.

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	SR8, SR04

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.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Date of Meeting	12th March 2026
Report title	2026/27 Budget Setting Report
Sponsoring Director/Author	Karen Johnson

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

Executive Summary

This paper provides an update on the budget setting process undertaken within the Trust and is fully aligned with the recent MTP submission made on 12th February 2026.

The Trust has submitted a breakeven financial plan for 2026/27 which is compliant with NHS England requirements. The plan includes significant non recurrent measures which means that the underlying deficit is £64.3m.

Previously considered by	Trust Board 10th February 2026 Director of Finance 12th February 2026 Finance & Resources Committee 24th February 2026

Recommendations:

The Board are asked to approve the financial plan, and associated budget, for 2026/27.

Strategic Aims (tick as appropriate)

Patient experience and voice	
People, culture and leadership	
Quality, safety and delivery	✓
Digital first	

Impact on any Strategic Risks?

Implications on:	
Equality, Diversity and Inclusion	*Not assessed*
Health Inequalities	*Not assessed*
Finance and Resource	This report provides an update on the 2026/27 financial plan and the associated budget position.
Regulation/Legal	This report provides an update that the Trust is planning to deliver the NHSE requirement to breakeven.
CQC-Key line of enquiry	The report aligns to multiple CQC key lines of enquiry by demonstrating that the Trust is planning to deliver against planned targets and is managing the associated risk and mitigations.
Green Plan	*Not assessed*

Main Report

2026/27 Budget Setting Sign Off

1. Summary

The 2026/27 budget setting process has been running alongside the medium term plan (MTP) since October 2025 and has been informed by the outputs of the business planning process. This paper provides an update on the process undertaken so far within the Trust and is fully aligned with the recent MTP submission made on 12th February 2026. Should any subsequent changes be made to contractual values the implications of these will be reflected, for example the impact of the pay award and changes to the cost uplift factor.

The Trust has submitted a breakeven financial plan for 2026/27 which is compliant with NHS

England requirements. The plan includes significant non recurrent measures which means that the underlying deficit is £64.3m.

Table 1: Summary of 2026/27 financial plan

Trust Summary All £'000s	2025/26 Exit Posn	2026/27 Rec.	 NR.	 Total
Income	(772,465)	(810,233)	(44,833)	(855,066)
Pay	503,109	508,756	(5,556)	503,200
Non Pay	370,707	365,740	(13,874)	351,866
Deficit / (surplus)	101,351	64,263	(64,263)	0
BAU FSP included in deficit / (surplus) position		(27,820)	(5,980)	(33,800)
Transformational FSP included in deficit / (surplus position)		(9,453)	(9,093)	(18,546)
Total FSP opportunities required per annum		(37,273)	(15,073)	(52,346)
Total FSP as % of turnover				6.1%

The plan includes a financial sustainability target of £52.3m which is 6.1% of turnover. It also includes budget for cost pressures of £5m.

Budget sign off will take place at divisional level on 3rd March 2026, followed up with budget holder sign off prior to 31st March 2026.

2. Budget Setting Principles

The principles used to set the 2026/27 budget were shared at the start of the process. The principles are:

- All budget changes will be transparent.
- A division/corporate area must review benefits and underspends in the 2025/26 position as well as identifying cost pressures. These must be formally reviewed and supported to manage run rate changes. Any underspends must be a first call to support any cost pressures.
- The Budget Setting Process will run alongside the Financial Sustainability Process and Business Planning Process.
- The Budget Setting Process includes Executive review of the proposed budget and cost pressures.
- Funded establishment will not be increased without review of existing vacancies across the Trust.

3. Movement of plan during February 2026

The Board was presented with a draft financial plan of £5.4m deficit on 10th February. Prior to submission on 12th February, the financial sustainability programme was increased by £5.4m, to £52.3m. This improved the position to breakeven. The movement to get to the breakeven plan are shown in table 2. The 2026/27 budgets will be built from this agreed position and will be fully aligned to the medium term financial plan which has been built at cost centre level.

Table 2: Movement from December submission to February submission

All £'000s	26/27
Deficit / (surplus) reported to Board 10/2/26	5,446
FSP	(5,446)
Deficit / (surplus) as per 12/2/26	0

4. 2026/27 plan

The 2026/27 plan submitted is breakeven. This includes non recurrent measures including £44.5m Gloucestershire ICB income. The overall value won't change budget the split between recurrent and non recurrent is subject to change as the contract has not been signed off yet. Once these measures cease, the recurrent underlying deficit position for 2026/27 is £64.3m. This is driven largely by undelivered recurrent FSP in prior years.

The budget includes £52.3m efficiencies (FSP) which is 6.1% of turnover. This target is split £37.3m recurrent and £15m non recurrent.

Table 3: 2026/27 budget

All £'000's	Recurrent	Non Recurrent	26/27 Total
2025/26 exit deficit position	101,351	0	101,351
Commissioning income - rebasing	(23,094)	5,662	(17,432)
Net growth funding impact	(500)		(500)
Technical costs	3,000		3,000
Inflation	19,490		19,490
FSP	(37,273)	(15,072)	(52,345)
GICB non recurrent income		(38,019)	(38,019)
Depreciation non recurrent income		(6,512)	(6,512)
Part funding for posts	1,000		1,000
Other non recurrent income		(500)	(500)
Carry forward impact		(5,700)	(5,700)
Net depreciation allocation change		(2,000)	(2,000)
Net depreciation	0	(2,315)	(2,315)
Other changes	289	193	482
2025/26 exit deficit position	64,263	(64,263)	0

5. Cost Pressures

As part of the business planning and budget setting processes divisions and corporate areas submitted their cost pressures. These been reviewed by deputy executives, executives and chiefs of service with significant challenge provided to explore all opportunities for mitigations. The recently agreed Principles for Prioritisation of Cost Pressures have been applied as part of the review. Table 5 below shows the steps taken in the review process.

Following the review, the 26/27 financial plan has been set at £5m budget for cost pressures. Appendix 1 provides supporting detail of the funded pressures.

Table 4: 26/27 cost pressure budget

All £'000s	Dec submission	Exec & Deputy review	CoS review	Remove Corporate & GMS	Apply 20% reduction to digital	26/27 Plan
	£000	£000	£000	£000	£000	£000
Divisional (clinical)	11,231	-2,245	-5,497			3,489
Corporate	1,031			-1,031		0
Digital	3,319	-1,260			-412	1,647
GMS	3,190	-1,190		-2,000		0
Reductions to be identified	0					-136
Total cost pressures	**18,771**	**-4,695**	**-5,497**	**-3,031**	**-412**	**5,000**

As part of budget sign off, divisions and corporate areas have been asked to provide assurance that mitigations are in place for those cost pressures that have not been funded to ensure they do not materialise in 2026/27. Divisions are aware that it is essential that these pressures are fully mitigated or stopped before 1st April 2026. Overspends relating to these pressures will not be considered as an accepted adverse deviation to plan. This will be monitored during 26/27.

6. Risks to the 2026/27 budget plan

There are risks to the 2026/27 budget plan that have been identified throughout the budget setting process and are outlined in the table below. These include risks of increased costs due to inflation and cost pressures. The largest risk is on delivery of Financial Sustainability.

Risks will be monitored throughout the year through Financial Improvement Boards for each division and regular Executive Review meetings. The accountability framework will enable additional support to be provided to those areas facing financial challenge.

Table 5 Risks to 2026/27 Plan

Risks to 2026/27 Plan	Value	Likelihood	Estimated weighted impact on SoCI
Upside			
Pay award is funded	5,418	100%	5,418
Critical care capacity pressure is funded by commissioners	300	75%	225
Endoscopy pressure due to DMO1 target is funded by commissioners	2,000	75%	1,500
Total upside	**7,718**		**7,143**
Downside			
Level of FSP delivery given historical performance	7,400	50%	3,700
Pay award: GHFT does not usually receive the full value due to efficiency factor	5,418	100%	5,418
Non pay - Additional 1% inflationary pressure	3,182	50%	1,591
Unfunded cost pressures not mitigated	2,500	50%	1,250
Critical care capacity pressure is funded by commissioners	300	75%	225
Endoscopy pressure due to DMO1 target is funded by commissioners	2,000	75%	1,500
Total downside	**20,800**		**13,684**
Net	**13,082**		**6,541**

7. Budget sign off

Budget sign off will be the formal agreement from divisional leads and budget holders who have been fully engaged in the 2026/27 budget setting process which began in the autumn when budget holders were asked to review their recurrent budgets. Since then, there have been a number of cost pressure reviews and budget discussions involving divisional leads and executives.

Budget sign off will take place at divisional level on 3rd March 2026, followed up with budget holder sign off prior to 31st March 2026.

Summarised below are the high level budgetary envelopes which operational and corporate teams will be delegated to operate within.

Table 6 Divisional and Corporate Financial Envelopes (indicative)

2026/27 Budget	D&S £000	Medicine £000	Surgery £000	W&C £000	Corporate £000	Central & Income £000	Total £000
Recurrent Budget 2025/26							
Income	(9,473)	(5,587)	(6,587)	(4,887)	(21,746)	(715,796)	(764,075)
Non Pay	74,078	56,489	47,410	19,594	128,129	4,422	330,122
Pay	103,025	130,664	143,937	55,533	61,873	8,654	503,685
Recurrent Budget 2025/26 M11	167,631	181,566	184,760	70,240	168,255	(702,720)	69,732
Budget adjustments for 2026/27							
FSP outturn shortfall from 2025/26	4,379	3,878	5,851	2,560	317	(6,881)	10,104
Cost Pressures	1,838	956	605	90	1,647	(166)	4,970
Recurrent maternity budget				1,000	0	0	1,000
Non-recurrent maternity budget				1,300	0	0	1,300
Central Adjustments					(2,637)	(84,469)	(87,106)
							0
Budget*	**173,848**	**186,400**	**191,216**	**75,190**	**167,582**	**(794,236)**	**(0)**
*divisional and corporate budgets are before FSP, inflation and pass through changes							

8. Next steps

The 2026/27 plan has been submitted and will be reviewed by NHS England during February. There remain a number of actions to be completed to ensure delivery of the plan. These include:

- Approve 2026/27 budgets at divisional and corporate levels
- Clarity on transformation FSP schemes, supported by delivery plans
- Pushing further on divisional FSP plans to achieve as close to 100% identification as possible, and de-risking schemes already identified, supported by Improvement and Delivery Directorate
- Identification of mitigations for cost pressures that have not been supported
- Budget sign off at director level and budget holder level.

9. Recommendations

The Committee is asked to approve the financial plan for 2026/27.

Appendix 1 – 26/27 cost pressures

Division	Reference	Speciality	Description of Cost Pressure	£000
D&S	2627_029	Pathology	Pathology non pay (across all areas at current costs)	346
D&S	2627_033	Pathology	Histopathology report outsourcing	412
D&S	2627_040	Radiology	ED outsourcing - if activity continues at current level.	390
D&S	2627_042	Radiology	Agency - Sonography	128
D&S	2627_043	Radiology	GHC recharges	246
D&S	2627_044	Division wide	GHC SLT/podiatry and GHC paed OT/PT	120
D&S	2627_041	Radiology	Consultant Radiologists on-call	62
D&S	2627_037	Radiology	ED transfer team - bank (24/7)	32
D&S	2627_039	Radiology	Radiology Block contract (activity overall)	104
D&S Total				**1,838**
Medicine	2627_053	Acute med	SDEC Nursing Overspend	128
Medicine	2627_056	Division-wide	Non-Pay - Cardiology	520
Medicine	2627_064	Division-wide	Non-Pay - Clinical Supplies - Emergency Department	240
Medicine	2627_065	Division-wide	Other Pay - Virtual Wards	68
Medicine Total				**956**
Surgery	2627_088	Theatres	GRH Recovery funding shortfall	240
Surgery	2627_082	Division-wide	Supplies costs unfunded inflationary pressures	190
Surgery	2627_083	T&O	Orthotics products cost pressure	48
Surgery	2627_084	Urology	Continence products cost pressure	84
Surgery	2627_093	Theatres	Urology Aquablation GICB activity growth from 45 to 64 cases per year included in business case	42
Surgery Total				**605**
W&C	2627_007	Gynae	Gynaecology Nursing Overspend	90
W&C Total				**90**
TOTAL DIVISIONS				**3,489**
Digital	2627_100		Infoflex 26-27	720
Digital	2627_101		EMIS 26-27	49
Digital	2627_102		Intersystems (License Costs & Theatres) (Clinical Systems)	340
Digital	2627_103		CDC & CRIS Kiosk Support (Clinical Systems)	44
Digital	2627_107		Tableau	238
Digital	2627_111		iGEL License/support (Computing - CGH HQ)	240
Digital	2627_115		HSCN firewall license (IT Contracts Shared Service)	17
Total digital				**1,647**
Reductions to be identified				(136)
TOTAL COST PRESSURES				**5,000**

Enclosures:

None

FOI: Partly Confidential