Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 14 May 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** • 12 March 2026	Assurance	Report	
5.	**Matters arising**			09.05
6.	**Questions from the public**			09.10
7.	**Staff Story: A briefing on the 'Improving Resident Doctors' Working lives' plan** *Mark Pietroni, Medical Director and Ailsa McKinlay, Chief Resident*			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) (as at March 2026** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Report	09.50
11.	**Perinatal Quality Oversight Report** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Report	10.00
12.	**Case for Change: Maternity Services Report** *Matt Holdaway, Chief Nurse & Director of Quality*	Assurance	Report	10.15
	GOVERNANCE			
13.	**Audit and Assurance Committee Report** *Shawn Smith, Non-Executive Director*	Assurance	Report	10.25
14.	**Integrated Governance Report – Legal, Regulatory and Policy Update** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.35
15.	**Risk Report (including Board Assurance Framework and review of risk appetite refresh)** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	10.50
16.	**Annual Provider Licence Requirements** *Kerry Rogers, Director of Integrated Governance*	Assurance	Report	11:00
	BREAK			
	PERFORMANCE & QUALITY			
17.	**Quality and Performance Committee Report**	Assurance	Report	11.15

	Sam Foster, Non-Executive Director			
18.	**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	11.25
19.	**Nursing Safer Staffing Annual Report** *Matt Holdaway, Chief Nurse*	Assurance	Report	11.45
	PEOPLE			
20.	**People and Organisational Development Committee Report** *Marie-Annick Gournet, Non-Executive Director*	Assurance	Report	11:55
	FINANCE			
21.	**Finance and Resources Committee Report** *John Noble, Non-Executive Director*	Assurance	Report	12:05
	STANDING ITEMS			
22.	**Any other business**			12.15
23.	**Governor observations**			
	Date and time of next meeting: Thursday 16th July 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 12 March 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
	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
	Raj Kakar-Clayton	Associate Non-Executive
	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
	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
	Ian Mean	Chair, Organ Donation Committee
	Trudie Neveu	Specialist Organ Donation Nurse
	Sarah Favell	Trust Secretary
	Deborah Tunnell	Deputy Director for People
	Fiona Hodder	Public Governor
Apologies	Andrew Chapnesss	Associate Non-Executive
	Marie-Annick Gournet	Non-Executive Director
Observers		
Governors	Mike Ellis, Emma Mawby, Kate Usmar	
Other	Francis Ryan, Unison representative	
Public	Three	

Ref	Item
1	**Chair's welcome and introduction**
	Deborah Evans, Chair, opened the meeting, welcoming all members of the public and governors in attendance. Acknowledging that Francis Ryan was in attendance, she thanked him for attending and noted the recent decision of the phlebotomists to cease industrial action and agree a referral of the job evaluation dispute to a national panel for determination. She expressed her pleasure that the industrial action would be ending and that she looked forward to welcoming phlebotomy colleagues back to work. It was noted that the meeting was the last meeting for John Cappock, Non-Executive Director and the Chair, on behalf of the Board and wider Trust, expressed her thanks for his commitment as a member of the board but also as Vice-Chair and Chair of Audit & Assurance Committee.

	The Chair expressed her disappointment that several papers were not as accessible to the public as they should be due to the usage of acronyms. She urged executive colleagues, responsible for the review of papers within their remit, to ensure that this was improved in future reports to the board.
2	**Apologies for absence**
	Apologies were received from Marie-Annick Gournet, Non-Executive Director and Andrew Champness, Non-Executive. It was confirmed that Andrew Champness' term as an Associate Non-Executive would cease at the end of March.
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 15th January 2026. **RESOLVED:** The Board APPROVED the minutes of the meeting held on 15th January 2026.
5	**Matters arising**
	There were no matters arising or actions to be reviewed.
6	**Questions from the public**
	There were no questions submitted.
7	**Patient Story**
	The Board was joined by Fiona Hodder, Public Governor, who spoke of her husband's and her experiences of hospital services as a recent in-patient. Fiona was a nurse by professional background. She described her husband's experiences since his initial admission late last year. She highlighted issues of concern regarding their experience in both the Acute Medical Unit and during an Emergency Department admission. These included cleanliness, inconsistent basic nursing practices, describing the focus of nursing and clinical staff as being on screens instead of listening to the patient to achieve an accurate diagnosis. She described a delay in receiving pain relief during the Emergency Department attendance. In contrast she was extremely positive about her husband's experience on Tivoli ward and with the urology service and virtual ward. She commented on the noise disruption on wards, particularly at night, with patients using phones and devices without headphones or thought for other patients in close proximity. She raised concerns about clinicians' regard to patient confidentiality, discussing clinical information regarding patients in the hearing of other patients. Both Mark Pietroni, Medical Director, and Matt Holdaway, Chief Nurse, thanked Fiona for her candour and positive comments but also apologised for aspects of her and her husband's experience. They spoke of the actions they would be taking to ensure the feedback would be acted on and the need to ensure the clinical vision of flow work was being embedded. Kevin McNamara, Chief Executive, spoke of the importance of 'closing the loop' on this important feedback, which was consistent with the themes identified in the recent national in-patient survey; noise, confidentiality, communication and fundamentals of care including cleaning standards. He tasked both the Medical Director and Chief Nurse with undertaking a piece of work to reflect on the feedback with the relevant teams and consider the 'so what' – what should be done to address the themes identified. **ACTION**

	Deborah Evans, Chair and other non-executive members of the board expressed their thanks to Fiona for taking the time to highlight her experiences, both positive and less so. Deborah Evans commented that this report, being brought by a public governor from a personal perspective, highlighted the valuable role of governors in raising issues relating to both patient experience and quality of care. The work to reshape the focus of governors towards these areas would continue at pace, recognising the statutory role of the governor would not continue in its current form.
8	**Chair's Report** *Deborah Evans, Chair*
	Deborah Evans, Chair, presented her report (taking the report as read) and highlighted the recent Iftar events within the Trust and acknowledged the anxiety that was felt by colleagues impacted by the events in the Middle East, both concerns about loved ones and concern for places of holy pilgrimage. She spoke of a recent visit to maternity services by Sir Geoffrey Clifton Brown, MP for North Cotswold and Chair, Public Accounts Committee where he was shown around by two of the service's matrons. She spoke of her pride at their professionalism and evident leadership during the visit. Finally, she confirmed that the Trust had been the subject of a CQC well-led inspection in early February and thanked colleagues, including the Corporate Governance team, for their engagement and professionalism both during and in preparation for the inspection. The report was not expected for some months, but she commented on the positive feedback received from the inspection team as to the cohesiveness and performance of the executive team. Looking to the start of the next financial year, the Chair commented on future objectives for board members and confirmed her focus would be on patient experience, health inequalities and the continued embedding of effective governance across the Trust. **RESOLVED:** The Board NOTED the report for information
9	**Chief Executive's Report** *Kevin McNamara, Chief Executive*
	Kevin McNamara, Chief Executive, presented his report to the Board, taking items as read but highlighting the two items in the report relating to maternity services; the interim Amos report and the recent decision to suspend the home births service. He commented that several of the themes identified in Baroness Amos' interim report resonated within the Trust and that he was encouraging all involved within the Trust to read the report carefully, considering its application to both maternity services and the Trust more widely. The final national report and individual Trust reports are expected in early summer, and he was clear that they must be met with openness and accountability as the Trust continues with its improvement journey. He identified that work was already being undertaken with a focus on understanding the volume and themes within complaints received from patients and families utilising the Trust's maternity services. Kevin McNamara acknowledged that the suspension of the home births services had been a contentious decision but was clear that it had not been an easily made decision. He

	acknowledged and apologised for the impact of the decision on the cohort of patients who had their choice of birth experience restricted, but he was clear that it was, at all times, a decision driven by staff concerns as to patient safety and it was vital that those concerns were listened to and acted upon. He confirmed that the judicial review proceedings had been paused by the claimants and the aim was to engage relevant stakeholders in the review as to what would need to be true for the Trust to be able to reopen the service safely. Turning to the phlebotomists' industrial action Kevin McNamara commented that his written report was out of date due to the fast-moving developments of the week. The result of the most recent ballot had been that the phlebotomists had voted to agree a referral of the job evaluation to the independent national panel. This was a proposal which had been originally made by the Trust in July 2025. Consequently, the industrial action would end, and phlebotomy colleagues would return to work in the next few days, with support and refresher training available. He thanked Francis Ryan, Unison representative, for his work to achieve this route to resolution and acknowledged the need for compromise by all parties, with the Trust waiving any overpayments made to staff taking industrial action. He confirmed that the Trust did not want to lose the patient service improvements that had been achieved and that there would be appropriate consultation with those staff regarding a potential new Band 3 role but that no changes to the phlebotomist's role would take place for a six-month period. There would also be support for the wider cohort of staff which had been impacted by the industrial action. Kevin McNamara acknowledged that emotions had run high during the industrial action but was clear that the focus must be on achieving reintegration and the continued improvement of patient services. Finally, Kevin commented on the CQC 'Well-led' inspection which took place in early February, confirming that the report was not expected for some months as there were several CQC reports outstanding currently. He was clear that the preparations for the inspection and the work of the wider Trust Leadership Team had reinforced a number of priorities for the Trust. These included the continued work to embed governance structures and best practice across the Trust, the embedding of the new Trust strategy and a review of the group structure with Gloucestershire Managed Services. He acknowledged that progress had been made and confirmed that Kerry Rogers, Director of Integrated Governance, would continue to lead the project. Will Cleary-Gray commented that the Chief Executive's report was helpfully structured around the four strategic aims (pillars) of the Trust with the focus being primarily on quality, patient experience and people but it would be good to include in future reports noteworthy matters relating to the 'Digital First' pillar as a lot of good work was being undertaken, which in turn would underpin the three other pillars. **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 Trust has self-assessed against all eight Care Quality Commission (CQC) conditions as 'fully met and sustainably embedded' • Good executive and board oversight with the service's governance structures working well. • The team is ahead of schedule in preparing for the national Maternal Early Warning Score and the NHSE Maternity Care Bundle elements. As part of the internal process leading to a request for the CQC to reinspect against the conditions in place the service would now request that the Integrated Care Board's oversight group formally confirm its assurance that it has reviewed the compliance evidence for each of the eight conditions and consider the conditions met and fully embedded. This would prompt the request to the Care Quality Commission for a re-inspection against the conditions in place. Vareta Bryan and Sam Foster, Non-executive directors, commented positively on the situation and acknowledged the openness and transparency experienced in conversations with the Service and the Clinical lead executive directors, both directly and at Quality and Performance Committee. **RESOLVED:** The Board NOTED the content of this report for assurance
11	**Perinatal Quality Oversight Report** *Matt Holdaway, Chief Nurse & Director of Quality*
	Matt Holdaway, Chief Nurse, confirmed that the report was a verbal update as the national framework required formal board updates on a quarterly basis, with the next full report being due at the board meeting in May 2026. An update was provided on the current maternity service leadership team vacancies with recent successful recruitment processes for both the Head/Associate Director of Midwifery and the Consultant Midwife posts. The teams had been very positive about the appointments made and discussions were ongoing to achieve early onboarding, if possible. Recruitment continued for the Director of Midwifery role, with the active support of the HR team. It was noted that the Maternity and Neonatal Voices Partnership lead had been involved in the recent senior recruitment exercises, and it was evident that the relationship was developing with her increased visibility on the wards. **RESOLVED:** The Board NOTED the verbal update received
12	**Audit and Assurance Committee Report** *John Noble, Non-Executive Director*
	John Noble, presented the report following the February meeting of the Committee, with much of the report being taken as read. He highlighted the work to align the Trust's risk management processes with the Trust's 2025-2030 Strategy and the discussions within committee as to assurance reporting on whistle-blowing processes with reports being provided to both Audit and Assurance Committee (regarding process and thematic findings) and the People and Organisational Development Committee. It was confirmed that digital had been a focus at the February Committee with a report from both the Internal Auditors and the Trust's team on cyber security, including penetration testing

	and multi-factor authentication. Overall, the assurance was positive with small areas of potential improvement in assurance identified. **RESOLVED:** The Board NOTED the report as a source of assurance.
13	**Modern Slavery Statement** *Kerry Rogers, Director of Integrated Governance*
	Kerry Rogers, Director of Integrated Governance, presented this report which set out the process followed for the annual review of the Trust's Modern Slavery Statement, a statutory requirement (Modern Slavery Act 2015). The recent review included updates to the procurement section to reflect the requirements of the NHS (Procurement, Slavery and Human Trafficking) Regulations 2025 and included updated provisions in respect of safeguarding training. The Statement was approved. Kerry Rogers advised that it was intended that the relevant Committees would seek assurance as to the effectiveness of the Trust's measures, primarily safeguarding training compliance (Quality and Performance Committee) and procurement audits (Finance and Resources Committee) during the year. This would be included in each committee's work plan. **RESOLVED:** 1. The Board APPROVED the Modern Slavery Statement and authorised publication of the statement on the Trust's website, signed by the Chief Executive Officer.
14	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*
	Sam Foster, Committee Chair, presented the report detailing the assurance received by the Committee at its meetings in January and February 2026. The January meeting had been the first of the new model 'deep dive' meetings when the focus, including a visit, had been on Trust maternity triage services. Overall, it had been a very effective meeting, providing an opportunity for the Committee to triangulate information against progress in respect of the conditions in place following Care Quality Commission s31 enforcement action. The work being undertaken in respect of the Committee's strategic risks was continuing at pace with strong support from the Corporate Governance team. It was noted that maternity services featured in both 'Alert' and 'Assure' which was evidence of both progress and the mixed picture within the service whilst several key midwifery roles remained vacant. The alert related to non-compliance with Maternity Incentive Scheme requirement, with a remedial action plan in place and the ongoing necessary suspension of the home birth service. The 'Assure' related to the completion of the Patient Safety Incident Investigations referenced within the perinatal and neonatal review, with duty of candour discharged and action plans in place. Other areas of strong assurance were mortality indicators within expected range, C difficile performance strong and an improve maternity governance position.

	In response to a request from Deborah Evans, Chair, for an update on the Central Sterile Services Unit issues impacting trauma and orthopaedic activity, it was confirmed that the issues relating to the unit were being monitored by the Decontamination Committee, chaired by the Director of Infection Prevention and Control. It was acknowledged by Matt Holdaway, Chief Nurse, that the issues did not solely relate to the Sterile Service Unit and consequently broader operational oversight arrangements were being put into place. The assurance route was confirmed as the Decontamination Committee which reported to the Infection Prevention & Control Committee, which in turn reports to the Quality and Performance Committee. **RESOLVED:** The Board NOTED the report for assurance, noting the matters escalated under 'Alert', particularly maternity safety compliance, operational performance risks and Central Sterile Unit non-conformances.
15	**Organ Donation Committee Annual Report** *Ian Mean, Chair, Organ Donation Committee and Trudie Neveu, Specialist Organ Donation Nurse*
	The Board heard from Ian Mean and Trudie Neveu about the work of the Organ Donation Committee, and particularly the donation figures for the Trust. During the year the Trust had referred 44 potential organ donors to the transplant team, facilitated 12 actual solid organ donors from 14 consented donors. This had resulted in 27 patients receiving a transplant. In addition, 188 corneas were received by the NHS Blood & Transplant Eye banks from donations by Trust patients. Following consistent engagement by the team all wards actively refer potential donors, with specialist nurses attending to each of those referrals. It was noted that, both locally and nationally, there had been a significant downward trend in organ donation consents, and this was thought to reflect diminishing public confidence in the NHS. Ian Mean emphasised the importance of sharing the positive story of organ donation, both within the Trust and the wider community. Ian Mean spoke of the excellent work of the specialist nurse team and the support of the Trust's communications team in getting that story out to the community and on the wards. He commended the work of the specialist nurses, who support families in the most difficult of times. The focus was increasingly on engaging with young people to share the positive message about organ donation with Deborah Evans, Chair, commenting on the potential role of the Young Influencers Group. Deborah Evans, Chair, expressed the thanks of the Board for both the presentation and for the vital work undertaken by the team and the Organ Donation Committee chaired by Ian Mean. **RESOLVED:** The Board COMMENDED the work of the Organ Donation Committee and noted the content of the Annual Report and supporting documentation.

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 January (with some commentary on the unvalidated data available for February and March). It was acknowledged that this was a peak demand period at a time when the bed base was reduced as a result of Tower reconfiguration work. There had been a resultant performance deterioration against standard which had been expected and was mitigated, with clear recovery plans in place. <u>Urgent and Emergency Care</u> Performance was challenging during January, as expected, but was positively managed with no requirement to declare a critical incident. Four-hour standard compliance fell from 64% to 60.3% with a corresponding deterioration of the Twelve-hour standard from 90% to 87.8 %. Paediatric attendances were reduced for the second month but the four-hour performance for paediatrics deteriorated again, from 78.3% to 76%. There were ongoing improvement projects in place with a focused 'sprint' during March. Ambulance handover times continue to maintain at approximately 22 minutes which was a significant achievement given the seasonal demand for services. <u>RTT (referral to treatment) (Standard 85%)</u> Performance deteriorated, primarily due to an increase of patients waiting over 18 weeks, though 45-week breaches fell from 724 to 692 with improvements across dermatology, orthopaedics and Upper Gastrointestinal. The Trust continued to perform strongly in comparison to other South-West region trusts, ending January with 21 reportable breaches. It was confirmed that limited funding had become available for a "sprint" exercise towards the end of the year, with a focus on shortening the time to first outpatient and diagnostic appointments. It was anticipated that the next financial year would start in an improved position. It was confirmed that it was the aim to have no more than eight patients waiting over 52 weeks by the end of March with an April target of zero. <u>Diagnostics</u> There was an overall improvement in performance (1.79%), with the waiting list reducing by 103 patients. Notable improvements for echocardiology, neurophysiology, gastroscopy and CT scan (Computed Tomography). It was noted that the Integrated Care Board has provided recurrent funding for endoscopy (40% of requested funding) which should help stabilise the service.

	It was noted that the sleep service continued to experience an increase in the number of breaches (32 in January), primarily because of a significant increase in referrals. This was being explored to better understand the rise in demand and ensure capacity for this low volume service. Al Sheward, Chief Operating Officer, confirmed that there would be a 'deep-dive' into the Winter response, which would be reported to board via Quality and Performance Committee. In summary he advised that the Trust managed the anticipated surges in demand well, with better management of flow internally and with better management of community access in conjunction with system partners. Challenges remained with weekend discharges in the management of discharge ready patients. John Noble, Non-Executive Director, commented on the focus within 'Planned Actions' on process whereas a focus on resources and timetable for recovery would be more useful. Shawn Smith, Non-Executive Director commented on the continued positive performance for ambulance handovers but also commented on the aspects of the patient story which related to the Emergency Department; the capacity and culture issues. Al Sheward confirmed that there was service level awareness of the areas requiring improvement with a quality improvement project improvement plan approved by the Chief Nurse/Chief Operating Officer/Medical Director two weeks ago. This would focus on the time to being seen by a clinician and management of patients who arrive on foot. There was also a quality improvement project looking at the ergonomics/design of the department's environment to improve patient flow and experience. The improvement in breast screening performance was also noted, with a 59% reduction in the backlog over 3 months. This had been achieved through a combination of data validation and increased capacity, through non-recurrent funding. In response to a question from Raj Kakar-Clayton, Non-Executive, regarding staff well-being during the winter pressures period, Al Sheward outlined the additional support provided. This included 'drop-in' calls for operational managers, which had led to speedier identification of issues and the provision of more effective escalation routes. Specific guidance on issues such as corridor care in the Emergency Department (not ward) had been provided which had given reassurance to the clinical teams as to the approach being taken. It was noted that the Trust had not permitted corridor care in ward areas since July 2024. Kevin McNamara commented that clinical services were concerned that corridor care in the Emergency Department was not sufficiently visible to Trust leadership, but this was not the case. It remained a focus for the senior leadership team with active measures being taken to ensure duration of corridor care episodes were kept to a minimum. Another area identified for focus was the relatively small cohort of patients who attend the Emergency Department with primarily mental health, not physical health, issues. Sam Foster, Non-Executive Director, expressed a wish to join an evening visit to the Emergency Department to better understand the pressures and capacity issues that led to the occasional provision of corridor care within the department. She proposed that an update on the issue be brought to the Quality and Performance Committee. **ACTION.**

She confirmed that the issue of mental health care provision was the subject of one of the planned Quality and Performance Committee 'deep-dive' sessions.

Al Sheward, Chief Operating Officer, was clear that any use of corridor care within the Emergency Department at Gloucestershire Royal Hospital was closely monitored at a senior level and that the team was not complacent as to its use. He advised that the average time spent receiving corridor care had reduced from 4 hours (January) to 2.5 hours in March with the aim to further reduce this substantially. The target was to eliminate corridor care within the Emergency department.

John Noble, non-executive director, commented on the useful discussions at a recent Quality and Performance Committee regarding rates of patients who 'did not attend' for elective care and the importance of accurate data to better understand themes and trends, particularly for paediatric patients from areas of significant social/economic deprivation. The Chair commented on the useful national survey report for services to children and parents which could inform outpatient booking strategy.

Quality and Safety Metrics

Matt Holdaway, Chief Nurse and Director of Quality, highlighted as 'Alert matters; a decrease in positive scores (Family and Friends survey) for the Emergency Department (77% decrease to 73%) but noting that overall performance remains static at 92.3% (January). He also flagged to the Board that whilst the Trust remains under trajectory for C. Difficile rates it was an area of focus for the Infection Prevention and Control team. Nationally, and across the South-West region, there had been an increased number of cases. A reduction plan, focused on cleanliness and timely testing, was in place and was being monitored by the Infection Control Committee.

The five patient falls resulting in harm were all being reviewed through the Patient Safety Incident Response Framework.

As 'Advise' matters he referred to an increased divisional focus on patient experience with an integrated review of relevant data being brought to an 'Experience of Care' meeting with a report to Quality and Performance Committee in due course.

It was confirmed that the Patient Advice and Liaison Service (PALS) were experiencing some workforce absence issues, but it was also recognised that this was a team which experienced a high volume of direct contacts with patients or families who had concerns and that work would be stressful. The team were fully supported by their leaders, who are proactive in their well-being support of team members, including actions to ensure rotation of duties within the team, both as a stress-management and personal development tool.

Sam Foster, non-executive director, commented that it would assist the board if the Trust could make better use of business intelligence to support work to identify key priority areas, perhaps a dashboard to assist in the identification of areas failing against key performance indicators which would prompt curiosity as to needed improvements. Lee Pester, Chief Digital Information Officer commented that this was a key area of development for the digital team and whilst there was a strong foundation in place additional resources were needed to make it completely effective.

Mark Pietroni, Medical Director, highlighted as an 'Advise' issue the continued challenges within the complaints and patient safety investigation teams. He acknowledged the significant workforce gaps impacting on performance, with a deterioration in response rates. He commented that it was the same staff cohort that were most impacted by the frequent regulatory inspections, removing them from their core business. This would be explored in the Complaints report to Quality and Performance Committee (April meeting) **ACTION**

Deborah Evans, Chair, commented on the quality of the data graphics in the complaints performance slide, noting that the use of a 60% scale could potentially mislead. **ACTION**

Kevin McNamara, Chief Executive, commented that this remained a focus for the senior leadership team and that the issues were broader than the identified staffing issues. This would be explored fully when the report was before Quality and Performance Committee.

Kaye Law-Fox, Associate Non-Executive, commented on the positive performance for C.Difficile infection rates, relating it to good cleaning and querying the focus on improving cleaning standards. Kevin McNamara challenged that cleaning standards are not where they need to be hence the need for an Improvement Summit in May, and that the focus had to be the patient experience and the visible standards of cleanliness within the Trust, following significant investment. He emphasised the need for this not to be a conversation about contracts and risk missing patient experience and overall quality. He indicated that this needed to be a focus in the relationship between the Trust and Gloucestershire Managed Services. The improvement summit would be led by Craig Bradley, Director of Infection Prevention and Control. Deborah Evans, Chair, commented that the focus must be on outcomes, which would then inform contractual arrangements.

Use of Resources/Finance metrics
Karen Johnson, Director of Finance, provided an update on financial performance as at Month 10, confirming that revenue was £0.1m favourable to the planned deficit with additional income from the Integrated Care Board enabling the Trust to be in a breakeven position. She indicated that Month 11 was expected to be consistent with this position. Areas of concern remain recurrent delivery of the financial savings programme with an in-year short fall of £5.9m, with a recurrent shortfall of £11m and capital spend remained behind plan.

In the next financial year the focus would also be on the transformation programme to achieve the required level of recurrent financial savings. The Trust's cash position was reasonable, but it was noted that cash balances were reducing and would face constraint if the financial savings programmes were not delivered. Deborah Evans, Chair, commended the work which had achieved effective control of nursing pay budgets.

People
Deborah Tunnell, Deputy 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. As part of that focus there would be divisional 'deep-dive' exercises into the causes/themes of sickness absence with mental health the primary reason for absence across the Trust. It was noted that the situation with healthcare workers who had recently moved from legacy contracts to Agenda for Change terms and conditions was being monitored as there had been a marked increase in sickness absence since that cohort of staff had become eligible for sick pay. Other actions taken to improve the

	management of sickness absence were that the role of the HR business partner had been removed from stage 1 of the sickness absence process, empowering local managers to own the process. This approach would be reflected in the Trust's new sickness management policy. The current appraisal rate compliance rate across the Trust was 82%, below the 90% target with managers expressing concerns regarding the process and documentation. This was being investigated with a report to brought to Trust Leadership Team meeting. In a response to a question from Vareta Bryan, Non-Executive Director, it was confirmed that the initial information from managers was that the appraisal system needed to be more flexible but that the HR team were going out to those areas with low compliance levels to better understand any barriers to compliance. Bank usage rates were seeing a month-on-month improvement with effective 'grip and control' processes of nursing and medical use of bank. It was noted that the Trust's 'bank only' staff were moving on to a 'pay by experience' contract as this was thought to more properly reflect the individuals' value to the Trust. This had been communicated to the affected staff with the focus of the response being on where they would be individually assessed instead of any reservations as to the principles behind the decision. This was a development that arose as an outcome of the bank workers grievance (November 2024), where one of the issues was the lack of recognition of the value of this cohort of staff. **RESOLVED**; The Board NOTED the contents of the Integrated Performance Report and associated metrics and remedial actions for assurance.
17	**Learning from deaths report** *Mark Pietroni, Medical Director and Director of Safety*
	Mark Pietroni, Medical Director, presented this report, providing assurance of the governance systems in place for the review of deaths, against the National Guidance on Learning from Deaths. The report covered the period April to June 2025 due to the requirement to rely on national data. It was confirmed the Trust did have other more contemporaneous mortality data available. It was also confirmed that the report had been reviewed and approved by the Quality and Performance Committee. Key items to note were the known correlation between excess Emergency Department waiting times (over 8 hours) and mortality. Whilst the risk remained an area of focus of both the department and clinical vision of flow programme, the data indicated that correct confidence limits had been achieved. It was important to note that the bereavement team continue to identify issues of communication between clinicians and families, in a small proportion of bereaved family feedback. **RESOLVED:** 1. The Board NOTED the report for assurance.
18	**People and Organisational Development Committee Report** *Deborah Tunnell, Deputy Director for People & Organisational Development*
	This report was presented by Deborah Tunnell, in the absence of Marie-Annick Gournet. Within the alert section the risks continued to be: • the achievement of the required workforce reduction and transformation agenda,

	• vacancies in the senior maternity services workforce; and • culture issues including workforce inequalities. Other emerging risks included the impact of changes to immigration rules which may affect staff on both primary and dependent visas. Risk assessments are being undertaken to assess the impact of the changes, both on existing staff and recruitment sources. Other areas of focus are the implementation of guidance after the Supreme Court decision (biological sex) and the desire to achieve a balance between the rights and protections of different staff and patient groups. Sam Foster, Non-Executive Director, commented that there was significant assurance around the speaking up agenda and increased profile of the sexual safety charter. She commented that it would be useful if the work on sexual safety could be included in the Freedom to Speak Up Guardian's reports to Board. **ACTION** **RESOLVED:** The Board NOTED the report for assurance.
19	**Gender Pay Gap Report** *Deborah Tunnell, Deputy Director for People & Organisational Development*
	In accordance with the Equality Act 2010 the Trust, as an employer of over 250 employees, was obliged to publish on an annual basis relevant data regarding the pay disparity on the basis of gender. Whilst not mandatory, the Trust also undertakes the analysis based on ethnicity and disability. The gender pay gap has increased to a 26.5% mean and 17.8% median gap (favouring men). It was noted that, when medical staffing were removed from the calculation the differential substantially reduced, showing near equal mean pay and a median gap in favour of women. It was acknowledged that the medical workforce disparity was largely historic because of clinical excellence awards which were predominantly awarded to senior consultants (male). Local Clinical Excellence Awards have now stopped, and national awards would gradually reduce in impact, as the individuals leave the workforce. The data disclosed a small mean (1.2%) and median (3.4%) pay gap differential in favour of 'ethnic minority' staff, likely due to the composition of the medical workforce. Deborah Tunnell, Deputy Director for People, highlighted the significant differential in pay for Trust staff identifying as disabled with a mean disability pay gap of 13.1% and median disability pay gap of 12.6% in favour of non-disabled staff. Analysis indicated that disabled staff were unrepresented in senior leadership roles and were more likely to be employed in lower banded and/or part-time roles. The data would be utilised by the People and Organisational Development team to focus on improvement plans to create a more inclusive and supportive environment for disabled colleagues with several targeted and Trust-wider initiatives. Deborah Evans, Chair, referred to the recommendations and actions in section 25 of the report and proposed that those are remitted to the People and Organisational Development Committee for review and agreement of SMART objectives. **ACTION**

	Sally Moyle, Non-Executive Director, asked if there was any benchmarking material available for other Trusts and it was agreed that Deborah Tunnell would investigate what information was available. **RESOLVED:** The Board: 1. ENDORSED the report for publication by 31 March 2026 2. NOTED the action plan to deliver improvements which would be remitted to the People and Organisational Development Committee for identification of smart objectives for the Trust.
20	**Staff Survey Report** *Deborah Tunnell, Deputy Director for People and Organisational Development*
	Deborah Evans noted that the staff survey report had only been released from national embargo that morning and therefore members of the public, and indeed the board, would not have had adequate opportunity to consider the survey data. It was agreed that this item would be postponed to the next board meeting (May).
21	**Finance and Resource Committee Report** *John Cappock, Non-Executive Director*
	Before presenting this report John Cappock took the opportunity, at his last board meeting, to thank his board colleagues for his time as a non-executive director. Deborah Evans, on behalf of the Board, reiterated the thanks of the board for John's commitment during his term of office. John Cappock, Non-Executive Director, presented the report relating to the committee meetings in January and February 2026, confirming that the Alert matters remain financial sustainability programme and the capital/estates programme delivery. The remainder of the reports were taken as read. **RESOLVED:** The Board NOTED the report for assurance.
22	**2026/27 Budget Setting Report**
	This report was presented by Karen Johnson, Director of Finance, as an update on the budget setting process to ensure it was fully aligned with the recent Medium-term planning submission made on 12 February 2026. It was confirmed that the Trust had submitted a breakeven financial plan for 2026/27. It was noted that the plan included significant non recurrent measures which meat the underlying deficit was approximately £64.3m. It was confirmed that the report had been previously considered by the Trust board on 9th February and by the Finance and Resource Committee on 24th February 2026. It was confirmed that there was one change to the report before the board as the meeting with the Divisions to agree financial sustainability programme targets had now taken place with an increased target of 4% agreed across all divisions. Kevin McNamara, Chief Executive, commented that the budget and delivery plans would be a focus at the strategy day for the Trust Leadership Team scheduled for May and that there would be value in non-executive colleagues attending those discussions regarding the transformation work. **RESOLVED:** The Board APPROVED the financial plan, and associated budget, for 2026/27.
23	**Any other business**

	There was no other business before the Board.
24	**Governor observations**
	Mike Ellis, Deputy Lead Governor, provided observations on behalf of the attending governor observers commenting in particular on the evolution of the governor role and the current national uncertainty. He expressed his gratitude to Fiona Hodder for her presentation as to the experience of her husband as a patient and noted the commitment of both the Medical Director and Chief Nurse to reflect on the feedback with clinical colleagues. He commented positively on the improvements within urology and the news that the phlebotomists were returning to work.

Close: 12:30
Date and time of next meeting: 14th May 2026, 09:00, Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

ACTIONS/DECISIONS

Item	Action	Lead / Due Date	Update
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	July 2026 board
26/Jan Item 16 & 26/Mar Item 16	A report providing assurance on the management of complaints (long-term delayed responses) to QPC. To include details of workload/capacity of team	Medical Director	April 2026 QPC
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
26/Mar Item 7	Medical Director/Chief Nurse to review patient story with relevant Services to agree any improvement actions	Medical Director/Chief Nurse	May 2026 Board
26/Mar Item 16	Update to QPC on use of corridor care within Emergency Department (GRH)	Chief Operating Officer/Chief Nurse	By May 2026 QPC
26/Mar Item 16	Future complaints data infographics within IPR to be accurate in terms of scale/percentage	Medical Director	May 2026
26/Mar	Freedom to Speak Up Guardian Annual Report to include section on sexual charter work within the Trust	Freedom to Speak Up Guardian	July 2026

Chairs Report to May Board

1. **Purpose**

   This is my report on my activities as Chair since the March 2026 Board.

2. **The role of governors**

   This Trust has enjoyed a good relationship with our governors over several years and we very much value their input. The changes to the NHS landscape associated with the NHS Ten Year Plan include the cessation of NHS Trust governors. The abolition of the governor function could happen in this financial year.

   The newly formed NHS Alliance is working with NHS Trusts to consider the implications of the changes and have produced a document about possibilities for the future.

   https://thenhsalliance.org/resources/beyond-councils-of-governors-rethinking-public-accountability/

   In this Trust we have been engaging with our Council of Governors over several months on repurposing their roles towards patient and colleague experience so that we don't lose their contributions. This is reflected across much of the country.

   Over the next few months, we will also pay attention to managing the transition, for example by ensuring quoracy to support important decisions such as Non-Executive Director appointments or ensuring that we have the required number of staff governors.

   Dame Gill Morgan, the newly appointed Southwest Regional Chair is convening a meeting of Trust chairs so that we can explore the transitional issues collectively.

3. **The changing role of Integrated Care Boards and the Regional Tier**

   The last week in March saw the final meeting of the Gloucestershire Integrated Care Board in its previous form. It has now started holding meetings in common with Bristol, North Somerset and South Gloucestershire Integrated Care Board both at committee and Board level.

   One of the consequences of this is that the Trust Chairs for Gloucestershire Health and Care and GHFT who were "partner members" will no longer attend and participate in ICB Board meetings or Board development sessions. As our Chief Executive was a full Board member, these were useful in creating an inclusive dialogue across stakeholders and in providing opportunities to understand health, social care and public health issues across the County. A Non-Executive Director network has also been discontinued.

   However, we now have the new role of Regional Chair which is already proving useful. Chair and Chief Executive networking conferences have also been reinstated.

4. My visits

Since the last Board meeting in March have included:

- A visit to the chaplaincy at Cheltenham which included an inclusive concertation with our chaplains. I followed up with a meeting with our Hindu chaplains to understand their religious needs in our Trust.
- An evening visit to Gloucestershire Royal Emergency Department with a specific focus on how we care from frail older people.
- The deep dive visit to surgery under the aegis of the Quality and Performance Committee, an innovation in our governance which seems promising.
- A visit from Cameron Thomas MP which was stimulated by a letter of thanks from a constituent who had head and neck surgery with us. Cameron particularly appreciated his discussion with the Multi-Disciplinary Team.
- A visit to Medicine with the medical Tri (chief of service, deputy director of quality, nursing, and manager) which focussed on the Gloucestershire Royal Tower block wards. It was evident that the Medical Division are making sustained progress in service delivery, standard setting and creating a more supportive environment for colleagues.
- Quality Academy Graduation - this was as interesting as ever with frontline clinicians from a variety of departments presenting their quality improvement projects including an evaluation of combining flu jabs with colleague health checks and a project on improving mothers experience of support following early pregnancy loss.
- Phlebotomy – I have had conversations with phlebotomy colleagues on a number of occasions when passing the Edward Jenner department at Gloucestershire Royal. Both colleagues who took industrial action and a colleague who did not have said that with the support of Julie Highfield, our Head of Psychology, reintegrating as a team and within the Trust has been constructive.

5. Meetings

Some highlights from the many meetings I attend included:

- Research and Innovation Panel – I spent a day with colleagues listening to and assessing small grants bids. We have innovative and motivated colleagues whose proposals covered endoscopy HCA training, digital solutions in respiratory and in infection control, greener pain relief, outreach kidney care, and many others.
- Southwest Region Chairs and Chief Executives conference; where we were roundly thanked for our sustained work on improving waiting times, urgent and emergency care flow and throughput and financial sustainability.

- Our Chief Executive gave a presentation about our work on stopping corridor care on our wards and improving flow which was very well received.
- Non-Executive Director appraisals. I have spent much of the last two months undertaking appraisals for our non-executives, who are commit themselves to supporting and challenging us to become the best we can be for local people. In acknowledge in their contribution I also want to thank everyone, and especially our governors who strengthened the value of the exercise by giving thoughtful feedback.

Chief Executive Report to Board – May 2026

1 Patient Experience

1.1 Maternity services in Gloucestershire

In November 2025, the Trust suspended the home birth service for at least six months, following safety concerns raised by our staff.

Over the past six months, we have been working on plans to safely reinstate the service across the county and to reopen the midwifery led Cheltenham Birth Centre – the latter of which has been closed since 2022.

The more recent decision on Home Births and the decision on Aveta were taken in response to safety concerns and, for Home Births in particular, we recognise that the suspension of the service has meant a loss of choice and certainty for families who had planned and hoped to give birth at home for which we are sorry.

The work we have been doing to re-establish these services forms part of the wider Community Maternity Transformation Programme which aims to develop a new model for how we can meet the changing needs of women, babies and families across Gloucestershire – needs which have been carefully considered by the ICB in its recent Maternity Health Needs Assessment and Case for Change.

Our goal is to provide the degree of choice in the county that there was pre-2022 but to do so in a way that is safe and sustainable. This means we cannot view individual elements of the maternity service in isolation, and part of the Community Maternity Transformation Programme is to look at different ways to deliver this goal.

As these proposals are developed, following recent engagement with maternity colleagues in Stroud, some media coverage has been generated that suggests that Stroud Birth Unit will close under these proposals. It is important to put on record that that Stroud Maternity Hospital is not closing and there are no plans to close it. The Birth Unit remains open and will continue to be an option for midwifery-led care day and night under these proposals should they be taken forward.

The changes we are seeing in terms of demand for maternity care are not unique to Gloucestershire and are replicated across the country.

As a Trust, we have a responsibility to consider how maternity services are provided for all of Gloucestershire and any proposals are being shaped by the recent Health Needs Assessment of the changing needs of women across Gloucestershire shows how demand for services and the nature of that demand have changed significantly over recent years so that we take an evidence based approach.

A critical part of our work is ensuring we have robust, sustainable staffing for our community maternity services so we can offer a full range of services across the whole of the county. Our maternity services must meet the needs of all our diverse communities, address health inequalities and support safe, personalised choice wherever possible across the whole of Gloucestershire.

There has also been positive progress in strengthening leadership within our maternity services, with the recruitment of a new Director of Midwifery, Deputy Director of Midwifery and Consultant Midwife, who take up post starting this month and on into the summer, and welcoming three new obstetricians.

1.2 Gloucestershire Cancer Centre

The Trust has reached a significant milestone in the development of the new Gloucestershire Cancer Centre at Cheltenham General Hospital, with the planning application being submitted at the end of March 2026.

This marks the completion of the early design phase and enables the programme to progress into the next stage of delivery. The new centre is intended to modernise facilities that are now more than 25 years old and respond to rising demand and changing patient needs across Gloucestershire and the wider region.

The proposed centre will provide a more welcoming, patient-centred environment, including modern clinical and treatment spaces, improved access to digital consultations, a dedicated support centre for patients and families, and better access to wrap-around support services. Plans also include peaceful therapeutic gardens designed to support wellbeing and recovery. Together, these improvements are intended to enhance patient experience and support better outcomes for people affected by cancer.

The project is being delivered in close partnership with Cheltenham and Gloucester Hospitals Charity through the Big Space Cancer Appeal. Thanks to the generosity of donors across Gloucestershire, £9.7 million of the £17.5 million fundraising target has already been raised, providing a strong foundation for the next phase of development. Reaching the planning stage allows the Trust to move forward with appointing a contractor and progressing detailed design work, including room layouts, interior design and the overall look and feel of the building.

Engagement with patients, staff and partners continues to play a central role in shaping the new centre. More than one thousand patients, carers and members of the public have already contributed feedback, ensuring plans reflect what matters most to those who will use the service. This approach supports the Trust's commitment to inclusive design and to delivering a modern cancer centre that meets both current and future needs.

1.3 Greener hand surgery transforms care for patients

The Trust has introduced a new "GreenHand" pathway for patients undergoing carpal tunnel surgery, demonstrating how care can be delivered more quickly while also reducing environmental impact. The pathway, with support from NHS Net Zero funding, redesigns the traditional patient journey, which often involved multiple outpatient appointments, diagnostic tests, theatre-based surgery and in-person follow-up visits.

Under the new model, suitable patients complete a digital questionnaire and are then invited to a one-stop clinic led by a senior clinician. At a single appointment, patients can be assessed and, where appropriate, receive their surgery on the same day under local anaesthetic in a dedicated procedure room rather than a traditional operating theatre.
The pathway also delivers significant sustainability benefits. Operating theatres are among the most energy-intensive clinical environments, using three to six times more energy than other hospital spaces.

Based on current activity, applying the GreenHand pathway to around 972 patients each year could save over 63,000kg of carbon emissions, equivalent to the annual electricity use of more than 100 homes.

2 People, Culture and Leadership

2.1 Resident Doctors and BMA Industrial Action

The British Medical Association held further industrial action in England between 7 to 13 April 2026, which was the 15th time industrial action has taken place since March 2023. As part of the Trust's contingency planning, we reviewed all services to ensure that any disruption was kept to a minimum and that patients could continue to access care normally.

It is possible that further periods of industrial action will continue this year and we will continue to see disruption impacting patients. The British Medical Association has also notified all Trusts that they are extending the ballot for action to all consultants and specialty, associate specialist and specialist doctors (SAS doctors) and balloting will run from 11 May 2026 until 6 July 2026.

3 Quality, Safety and Delivery

3.1 UNICEF Baby Friendly Initiative

The Trust's Neonatal Unit has achieved a Certificate of Commitment from the UK Committee for UNICEF Baby Friendly Initiative, marking the first stage in gaining full Baby Friendly accreditation. This recognition reflects the Unit's sustained commitment to improving infant feeding support and the wider care experience for mothers and babies.

The Certificate acknowledges the work underway to increase breastfeeding rates and ensure all mothers receive evidence-based, compassionate support. Breastfeeding provides significant long-term benefits, protecting babies against serious illness in infancy and reducing the risks of cardiovascular disease, asthma, diabetes and obesity in later life. It also lowers the risk of certain cancers for mothers and supports positive mental health for both mother and baby.

3.2 System Memorandum of Understanding to support transformation

Gloucestershire Hospitals NHS Foundation Trust has agreed a Memorandum of Understanding (MoU) with NHS Gloucestershire ICB, Gloucestershire Health and Care and the GP collaborative to deliver on the transformation priorities set out in the 5 Year Population Health and Strategic Commissioning Plan.

The areas of focus for the partnership are improving support for older people living with frailty, transforming care for people with multiple long-term conditions and expanding community mental health and crisis care for people of all ages.

The MoU reflects the ICB's shift towards strategic commissioning and a provider-led model of transformation, in which the ICB sets commissioning intentions based on population health needs and providers collaborate to redesign care in ways that best meet the needs of local communities. The partnership will also support delivery of the Neighbourhood Health Framework published by the Department of Health and Social Care and NHS England in March.

3.3 NHS England planning and priorities for 2026/27

On 1 April NHS England wrote to ICBs and trusts to recognise the progress made during 2025/26, particularly in stabilising finances, changing the way the NHS operates and improving performance in areas such as waiting times and urgent and emergency care.

An important improvement has been positive change in public confidence in the NHS after two difficult years, which has included financial recovery, industrial action and winter pressures but clearly there is more to do. Looking ahead, NHS England confirms that system plans for 2026/27 are workable and form part of a multi-year planning approach.

Systems are now being asked to strengthen their longer-term plans by setting out, in clearer and more practical terms, how commissioners and providers will work together over the next three years.

This includes how neighbourhood-based care will be developed, whether changes to financial flows or payment systems would help delivery, and what further national support may be needed to remove barriers to local change.

To support the next phase of improvement, NHS England has highlighted eight priority areas where it believes the biggest gains can be made this year and beyond:

- Transforming outpatient care, with less reliance on traditional clinic models and more use of advice and guidance, and fewer unnecessary follow-up appointments.
- Reducing hospital bed days for people at highest risk, with neighbourhood teams playing a central role in proactive and preventative care.
- Reforming urgent care scheduling and access, so patients can more easily book the right urgent care appointment and avoid unnecessary attendance at emergency departments.
- Improving productivity through technology, including wider use of tools such as ambient voice technology, better theatre utilisation, improved discharge flow, and digital support for waiting list management and prescribing.
- Expanding the role of the NHS App as a clearer digital front door for patients, supporting triage, navigation and access to services.
- Reforming payment systems so that financial incentives better support the service changes systems are trying to deliver, including in urgent and emergency care.
- Putting quality back at the centre of delivery, including a new national quality strategy, updated service frameworks and new approaches to reducing unwarranted variation in care.
- Strengthening leadership and workforce capability, including the launch of a new NHS Leadership College and a renewed focus on developing and supporting staff.

4 Digital

4.1 Digital Strategy and roadmap

Digital First is a key enabler of the Trust's wider transformation priorities, reshaping outpatient care, making better use of the estate, improving productivity, and empowering patients in their care. The current focus is on getting the basics right first by stabilising systems, improving data quality and strengthening infrastructure. This creates the conditions for better real-time information, more predictive insight and more proactive care.

The Digital Roadmap 2026–31 is in the final stages of development; it defines the Trust's Digital First ambition and how this will be delivered over time. It is built around three strategic pillars: moving from analogue to digital processes, enabling seamless and knowledge-driven care, and providing a resilient and accessible digital service. The roadmap aligns with the Trust Strategy and the NHS 10-Year Plan and is supported by clear delivery phases, benefits measures and implementation considerations across the five-year period.

Two major reviews of our current state have been commissioned and completed, a strategic review of our current digital systems, their architecture and efficacy in supporting Trust operations and care, and a refreshed assessment by the Healthcare Information and Management Systems Society (HIMSS), an international way of measuring how digital a hospital is managed. These assessment show that small tweaks will not be enough to meet out ambitions. The current digital environment remains constrained by fragmented systems, inconsistent use of standard processes and ageing infrastructure. To improve safety, patient flow and productivity, we need a more joined-up and electronic patient record, consistent ways of recording information with and across pathways, and ongoing focus on system usability, staff training, and reliability.

Phase 1 of the plan, covering 2026–27, focuses on stabilisation and tactical optimisation of systems. This also includes setting clear direction on the future Electronic Patient Record (EPR) through business case processes, improving infrastructure resilience via a movement of our data centres to hybrid cloud, and strengthening implementation and adoption governance. During this phase, there

will be disciplined prioritisation to stop or defer non-essential digital activity where capacity is limited, alongside targeted system-level partnerships to accelerate delivery while maintaining clear Trust accountability for outcomes. The Digital Strategy and roadmap will come to Board late summer.

4.2 Stryker Medical cyber-attack

A major US medical technology supplier to the NHS, Stryker, has been affected by a global cyber-attack. The incident disrupted Stryker's internal IT systems, affecting order processing, manufacturing and shipping.

The disruption has had a knock-on impact on NHS supply chains, particularly for a small number of products including some defibrillator components and oral swabs. NHS Supply Chain has implemented control demand management for affected items to prioritise availability where stocks are limited, and is working closely with Stryker, NHS England and DHSC to manage the situation nationally.

The issue relates to supplier systems, not NHS IT, and there is no indication of risk to patient data or the safety of equipment already in use. While some short-term supply disruption may continue, mitigations are in place and the situation is being actively managed at a national level. It once again highlights the cyber security risk for all parts of the NHS eco system.

4.3 Sunrise Upgrade

The Sunrise Electronic Patient Record was successfully upgraded overnight on 21 and 22 April 2026. Despite the scale and complexity of a Trust-wide upgrade, the change went very well overall.

The overnight downtime exceeded the planned 12-hour window by approximately two hours due to an electronic prescribing issue identified during testing. This was resolved safely, and the system went live as close to original plan.

On the morning of 22 April, clinical and operational teams worked at pace to clear the backlog of paper records generated during downtime.

Some temporary system slowness was observed post go-live, attributed to Citrix load management as user demand increased. This was closely monitored, with supplier support on site. Reassuringly, all other reported issues remained at priority 3 or below, providing further assurance on system stability.

What has been particularly outstanding throughout this upgrade has been the exceptional teamwork across digital, operational, and clinical teams. Colleagues worked collaboratively, calmly, and with a shared focus on patient safety, which was instrumental in delivering a successful outcome. This collective effort is a real credit to those involved and demonstrates the Trust's growing maturity in managing complex digital change.

The Trust now has its major clinical system on the latest technology which will also provide opportunities around ambient voice adoption embedded into EPR, as well as increased reliability and an improved cyber position.

4.4 Electronic Patient Record Paediatric Discharging and the General Surgery

At the end of February 2026, Paediatric Discharging and the Digital Operation Note for General Surgery went live within the Sunrise clinical wrap. Paediatric Discharging addresses a long-standing risk associated with timely and consistent discharge information for children, particularly those discharged following surgery. Early performance data shows a significant improvement, with the proportion of paediatric discharge summaries reaching GPs within 24 hours increasing from around 60% to 98%, and most now transmitted within four hours. This strengthens continuity of care and reduces clinical risk following discharge.

The introduction of the Digital Operation Note in General Surgery extends an established electronic standard already used in six other surgical specialties. Given the scale and activity of General Surgery, this represents an important step in improving standardisation, accessibility of operative information and clinical governance.

5 Regulatory

5.1 CQC rates Dialysis Services at Gloucestershire Royal Hospital as 'Good'

The Care Quality Commission (CQC) has rated Dialysis Services at Gloucestershire Royal Hospital as 'Good', following an inspection carried out in July 2025.

The dialysis service is provided by Diaverum Facilities Management Limited, working in partnership with Gloucestershire Hospitals NHS Foundation Trust.

The full CQC report is available on the CQC website. Dialysis Services

In terms of the inspection reports still due to be shared with the Trust by the CQC following previous inspections, we continue to wait for the Maternity inspection from September 2025, the Urgent and Emergency Care and Medicine inspections from December 2025 and the more recent Well Led inspection from February 2026.

5.2 National Oversight Framework March 2026 results

In the latest NHS England National Oversight Framework update for Quarter 3 (October – December 2025) the Trust has moved down the national league table from 17th to 38th out of 134 acute trusts. We have also been placed in Segment 3 and reflects a temporary change to the financial position at the end of Month 9 in December 2025.

The change in ranking and segmentation is primarily driven by the financial impact arising from Residential Doctors' Industrial Action in October and December 2025, which resulted in additional costs, including temporary staffing, during this period.

As a result, an automatic national financial override was applied to the Trust's Quarter 3 position, which affected our segmentation, despite continued strong performance across many of our operational and quality measures. The Trust delivered a 'break even' financial position at the end of the 2025/26 financial year (subject to audit) and it is anticipated to be reversed in the Quarter 4 update.

5.3 National Provider Capability ratings

The Provider Capability Ratings are a new NHS England assessment that sit alongside the National Oversight Framework and focus specifically on how effectively provider boards and executive teams lead, govern and improve their organisations. They are intended to give a consistent view of leadership capability, complementing performance and quality measures rather than replacing them.

Ratings are informed by a structured self-assessment against the six domains of the Insightful Provider Board, followed by regional review and national moderation. Each trust is given an overall rating of Green, Amber/Green, Amber/Red or Red, reflecting NHS England's view of current leadership capability and capacity.

Gloucestershire Hospitals NHS Foundation Trust has been rated Amber/Green for Quarter 3 of 2025-2026. Ratings will be reviewed quarterly, with the underpinning assessment refreshed annually to reflect changes in leadership and organisational maturity.

5.4 South West Region appointments

Gill Morgan been appointed as the Regional Chair for Southwest in what is a new role for the NHS following the NHS England reorganisation. The Regional Chair is a new, non-executive leadership role introduced as part of NHS England's shift to a more regionally empowered operating model under the 10-Year Health Plan.

The Regional Chair is intended to provide visible, independent non-executive leadership at regional level undertaking a governance and assurance role, rather than an operational one, and to act as a bridge between national priorities and local delivery.

The Chair and I attended a regional CEO and Chairs meeting in Bristol to hear from the national NHS England CEO and Chair, as well as Gill Morgan on future expectations and priorities. At the event we were asked to present our work on ambulance handovers and corridor care as part of a regional exemplar showing positive progress in patient care.

Kevin McNamara
Chief Executive

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Report title	CQC Section 31 Conditions Report (April 2026)
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	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.

ALERT

1.2. The Trust was issued with eight CQC Section 31 conditions in May 2024 relating to maternity services at Gloucestershire Royal Hospital, reflecting serious concerns regarding intrapartum safety, clinical risk assessment, escalation, workforce arrangements and governance. These conditions required immediate action, sustained improvement and monthly assurance reporting to the CQC and Trust Board. The regulatory risk associated with these conditions has been actively managed and remains a critical area of Board oversight.

ADVISE

1.3. Following comprehensive delivery of improvement programmes, the Trust has self-assessed all **eight CQC Section 31 conditions as fully met and sustainably embedded**. This assessment is supported by robust evidence.

1.4. Key national oversight and assurance mechanisms remain in place, including CQC inspection activity (September 2025), NHS England Maternity and Neonatal Improvement Team (MNIST) support, Integrated Care Board

enhanced oversight, and participation in the Independent National Maternity Investigation.

1.5. The Trust plans to submit condition removal documentation to the CQC once the latest inspection report is received. It has been 7 months since the inspection.

1.6. ASSURE

1.7. The Board can be assured that:

- Effective systems are now embedded for managing postpartum haemorrhage, fetal monitoring, MEOWS escalation, VTE risk assessment and agency workforce induction.
- Improvements are underpinned by strong clinical leadership, clear governance routes, PSIRF-aligned learning processes, and routine assurance through forums and committees.
- Performance is monitored through high-compliance audit data, real-time digital dashboards and exception reporting.
- Regulatory reporting requirements under Conditions 7 and 8 have been fully complied with, with all monthly submissions delivered on time and reviewed through Trust governance structures.

APPLAUD

1.8. The Board is asked to recognise and commend the sustained commitment and collaborative effort of maternity clinical teams, divisional leadership and corporate support functions in delivering a complex and long-term improvement programme under intense scrutiny. The maturity of governance arrangements, transparency with regulators, and demonstrable culture of learning and improvement represent a significant step forward in the Trust's maternity safety journey and provide a strong platform for continued improvement.

1.9. In conclusion, the Trust is well positioned to seek formal removal of the CQC S31 conditions and to maintain ongoing assurance of safe effective and compassionate maternity care.

Previously considered by	*New report*

Recommendations:

The Trust Board are asked to:

1. Note the progress set out in this report and the Trust's assessment that all eight CQC Section 31 conditions have been met, supported by evidence of delivery, governance and oversight, and note the key current issues highlighted including: (i) the outstanding CQC draft inspection report (September 2025) which is required to enable submission of the formal condition-removal request; (ii) a single-month dip in the hourly peer review ("fresh eyes") metric; (iii) implementation of the national MEWS (go-live 5 May 2026) with interim assurance arrangements; and (iv) system-wide improvement actions for pre-booking thromboprophylaxis/VTE standards (primary care/community pathway).
2. Be assured that the recent variance in hourly peer review ("fresh eyes") for fetal monitoring (75% against a target of 85%, small sample) has been identified through routine monitoring, reviewed at the Intrapartum Forum and is subject to tracked improvement actions; further assurance will be provided through next month's data, with escalation through the Perinatal Oversight and Assurance Meeting if thresholds are not met or variance is sustained.
3. Note that enhanced external oversight remains in place (including ICB Enhanced Oversight Group, NHS England MNIST support and participation in the Independent National Maternity Investigation) and agree that any material change in regulatory position, risk profile or delivery trajectory will be escalated to the Board via established reporting routes.
4. Support the Trust's intention to consider submission of a formal request to the Care Quality Commission for removal of the Section 31 conditions, subject to receipt and consideration of the final CQC inspection report.
5. Agree that ongoing oversight of maternity safety, regulatory compliance and the associated strategic risk (SR1) will continue through established Trust governance and assurance mechanisms.
6. Support continued engagement with the Care Quality Commission regarding the Trust's compliance with the Section 31 conditions, including consideration of next steps once the final inspection report is received.

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?
SR1 - Inability to deliver safe and effective services against regulatory and statutory requirements

Implications on:	
Equality, Diversity and Inclusion	The actions taken to meet the CQC Section 31 conditions support more equitable and consistent maternity care by reducing variation in clinical practice, strengthening escalation and improving safety for all women and birthing people. Ongoing governance and learning arrangements will continue to support inclusive, patient-centred care across diverse populations.
Health Inequalities	This report provides assurance to the Trust Board and the CQC that all eight CQC Section 31 conditions relating to maternity services have been fully met and sustainably embedded, with robust governance and oversight arrangements in place to maintain safe, effective and equitable care.
Finance and Resource	The actions taken to meet the CQC Section 31 conditions have been delivered within existing resources, with ongoing requirements absorbed into business-as-usual workforce, governance and improvement arrangements.
Regulation/Legal	This report provides assurance on the Trust's ongoing compliance with the CQC Section 31 conditions and informs the Trust's next steps in regulatory engagement, including consideration of a formal request for condition removal once the final CQC inspection report is received.
CQC-Key line of enquiry	Well led, safe, caring, effective, responsive
Green Plan	There are no significant direct implications for the Trust's Green Plan, with improvement activity focused on strengthening clinical practice and governance within existing systems and pathways.

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.

3. Background

3.1. 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, can access the maternity electronic records system and Trust policies, as well as enter and exit the unit without delay**.

4. Current situation

4.1. Care Quality Commission

4.2. Maternity core service inspection September 2025

4.3. CQC have inspected the maternity services at Stroud and Gloucestershire Royal Sites. This was a full comprehensive inspection with a team of 7 inspectors. The draft report is expected but has not yet been received.

4.4. CQC has advised the Trust to await receipt of the draft inspection report (September 2025) before submitting a formal request for removal of the Section 31 conditions; the draft report remains outstanding and CQC has apologised for the delay.

4.5. Self-assessment against S31

4.6. We have self-assessed and consider that we have met all eight conditions. The Trust will submit the condition removal forms to CQC in line with the approach set out in section 4.4.

4.7. Table: Summary of position against CQC conditions

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

4.8. External oversight for maternity services

4.9. ICB led Enhanced Oversight Group (EOG) for Maternity Services

4.10. This meeting was held on 13 April 2026 and the focus for the meeting was to receive assurance that programmes of improvement work continues to demonstrate compliance with the conditions.

4.11. NHS England Maternity and Neonatal Improvement Support Team (MNIST)

4.12. The NHS England team continue to provide support to the Trust with Maternity and Neonatal Improvement Advisors working with us on specific programmes of work. The Team meet with the executives on a monthly basis and the last meeting was 22 April 2026.

4.13. Independent National Maternity Investigation (Amos)

4.14. On 15 September 2025, it was announced that the Trust was part of a national rapid investigation of maternity and newborn care across England.

4.15. The next steps are that a final report will be published in Summer 2026, which will include one set of national recommendations to improve safety and experience of maternity and neonatal care.

5. Conditions with reasons and evidence for removal

Condition 1
The registered provider 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).

5.1. Summary

5.2. In summary, the Trust has **removed the immediate risk to service users** by implementing a comprehensive and effective system for the continual risk assessment and management of post-partum haemorrhage (PPH) and major obstetric haemorrhage (MOH). This system is based on nationally aligned, evidence-based practice and ensures early identification of risk, timely escalation and coordinated multidisciplinary response.

5.3. The risk of recurrence has been **mitigated through standardised and reliable controls**, including consistent use of quantified blood loss, structured risk stratification at key points of care, clear escalation triggers for MOH, and accessible clinical guidance. These controls are embedded into routine practice and supported by training, simulation and induction arrangements for all staff groups, including agency and newly appointed staff.

5.4. Sustained compliance and effectiveness are demonstrated through **routine audit, trend monitoring and exception reporting**, with high levels of performance maintained over time rather than at a single point.

5.5. Oversight is provided through established governance structures, with first-line assurance at the Intrapartum Forum and escalation through the Perinatal Oversight and Assurance Meeting, providing clear line-of-sight to executive and Board-level oversight. Any deviation from expected standards triggers prompt review and corrective supportive action.

5.6. Learning from PPH and MOH events is embedded through **PSIRF-aligned multidisciplinary review**, ensuring contributory factors are identified, learning is shared, and improvements are translated into changes in practice. This closed-loop learning system provides assurance that the controls in place remain effective and responsive to emerging risk.

5.7. Taken together, the Trust can demonstrate that the **risk identified in Condition 1 has been addressed, is actively monitored**, providing confidence that improvements are sustainable and that safe, effective care is consistently delivered.

5.8. Reasons and evidence for PPH condition removal

5.9. To ensure our maternity service is prepared for postpartum haemorrhage (PPH) and major obstetric haemorrhage (MOH), we have embedded a system that moves away from "reaction" and toward "prediction and preparation."

5.10. Governance and clinical leadership

5.11. Clinical leaders

5.12. Our clinical leaders are crucial for overseeing continuous improvement as they establish a culture of evidence-based care, remove barriers for staff engagement and foster innovation by trusting and supporting clinical teams.

5.13. Our PPH Team Leads are:

- Consultant Obstetrician and Labour Ward Lead - Dr Victoria Cordell,
- Labour Ward Matron - Rachael Harris,
- Obstetric Anaesthetic Lead - Dr Joanna Collins, and
- Education and Training Lead - Clemmie Skilton.

5.14. Governance

5.15. Oversight of the effectiveness of the system is at the Intrapartum Forum. Escalating any issues to the Perinatal Oversight and Assurance Meeting using the 4 As format (alert, advise, assure and applaud).

5.16. Standardised management policy

5.17. Providing safe, quality, compassionate care is important to the Maternity Service.

5.18. 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.

5.19. The guideline is currently being reviewed and updated to ensure that it remains contemporaneous with current practise and the new NHSE Maternal Care Bundle.

5.20. Visual aids within the policy

5.21. The policy contains a flowchart that details step-by-step management.

5.22. Active management of the third stage

5.23. Within the policy there is guidance for staff for the routine use of uterotonics and timely cord clamping.

5.24. Major obstetric haemorrhage initiation (MOH) for blood loss >1500ml

5.25. There is a specific, streamlined "trigger" to activate a multidisciplinary response (2222 – Major Obstetric Haemorrhage), including immediate access to O-negative blood and "haemorrhage packs (pack A and pack B)."

5.26. Quantified Blood Loss (QBL)

5.27. We have moved away from "estimated" blood loss (which is notoriously inaccurate) to weighing swabs and using calibrated collection drapes. This ensures MOH is identified much earlier.

5.28. "Reduce checklist"

5.29. Early recognition is 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.

5.30. The Reduce Checklist (stepwise management) continues to be used in practice and completion rates averaged 85% in the last 3 months (target 85-90%).

5.31. Risk assessment compliance

5.32. Team PPH have oversight of compliance with systems for risk assessment and report to the Intrapartum Forum. The Team will now audit compliance with risk assessment process within the thematic reviews carried out for the implementation of the NHSE Maternal Care Bundle.

5.33. Outcome metrics

5.34. Using benchmarking data for PPH is essential to reduce preventable maternal morbidity and mortality by identifying gaps in care, ensuring timely interventions, and driving the consistent implementation of best practices.

5.35. Internationally PPH remains a leading cause of maternal death, with studies showing that comprehensive, interdisciplinary response to PPH—supported by benchmarking—improves patient outcomes, such as reduced severe morbidity, fewer blood transfusions, and lower rates of unplanned hysterectomy.

5.36. CQUIM+

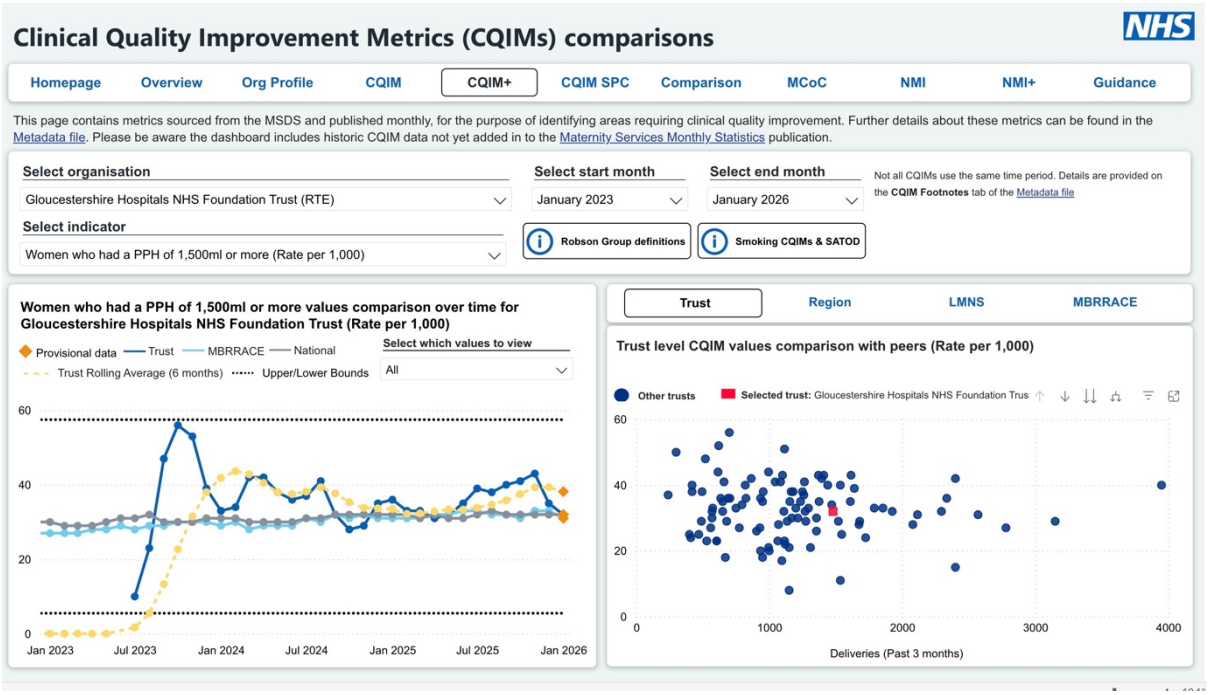
5.37. The latest National Data was published, and this demonstrates that our PPH rate for the CQIM metric is at national average (NB: The national data and the Trust data are aggregated slightly differently).

5.38. Table: Monthly data and 6 monthly rolling average

CQIMs Data	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
National	31	32	32	32	32	32	32	32	32
Trust data and 6 month rolling average	32	35	39	38	40	41	43	35	32
	33.33	33.33	33.83	34.67	35.83	37.5	39.33	39.33	38.17

5.39. The graph below demonstrates that the Trust's CQUIM outcome measure for postpartum haemorrhage is broadly in line with the national position (latest available national benchmark, Jan 2026), providing external benchmarking assurance alongside the Trust's internal monthly/rolling-average data.

5.40. Graph: Maternity National Database CQUIM data January 2026 (this is the latest data)



5.41. Staff training

5.42. Mandatory training

5.43. Training for PPH management is part of the Maternity Core Competency Framework (v2) and it is expected that 90% of each relevant maternity unit staff group has attended an "in house" MDT training day which includes a minimum of four maternity emergencies with all scenarios covered within a 3 year period (and priorities) based on locally identified training needs. For the last 2 years, we have included PPH scenarios in our training programme.

5.44. Trolley teaching

5.45. In addition to the mandatory specialty training the PPH Team carried out trolley teaching with teams as they introduced new documentation.

5.46. Culture of continuous improvement

5.47. Care bundle implementation

5.48. 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).

"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"

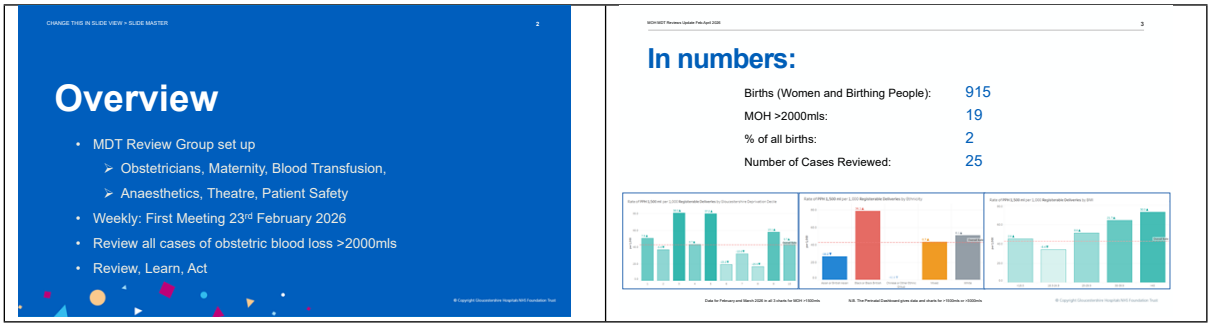
5.49. Patient Safety Incident Framework (PSIRF)

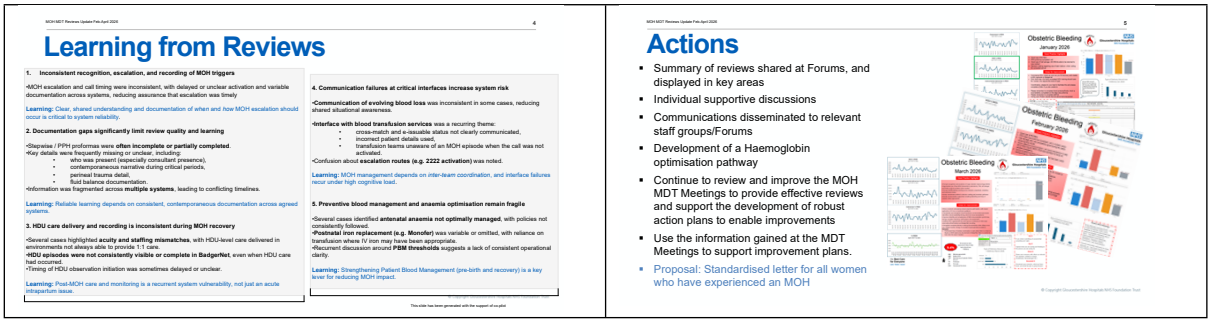
5.50. Weekly multidisciplinary **Major Obstetric Haemorrhage (MOH)** review meetings are held every Monday (09:00–10:00) to review all cases with blood loss >2L; these reviews are now undertaken in a dedicated forum with attendance from the Reduce Team and the Perinatal Governance Team, applying **PSIRF** methodology and **SEIPS** analysis to strengthen learning by taking a systems-based approach to identifying contributory factors (including human factors, tasks, environment and teamworking) and translating these into proportionate, tracked improvement actions.

5.51. Learning from these reviews is consolidated into a monthly infographic and shared with staff; in addition, the team has strengthened the data collection proforma to include completion of the **Maternal Early Warning Score (MEWS)** and **PPH risk assessment**.

5.52. A summary of reviews completed to date, including volumes, key learning themes and associated improvement actions, is set out below.

5.53. The action tracker is reviewed at each meeting to confirm progress, agree any further actions and maintain oversight to completion.





5.54. Handovers and Safety Huddles

5.55. Explicitly naming "high-risk" patients during shift changes so the whole team (including anaesthetics and haematology) are aware.

5.56. Patient experience

5.57. Debrief service

5.58. The service offers debriefs for women who have been impacted by their birth experience.

5.59. Maternity and Neonatal Voices Partnership

5.60. 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.

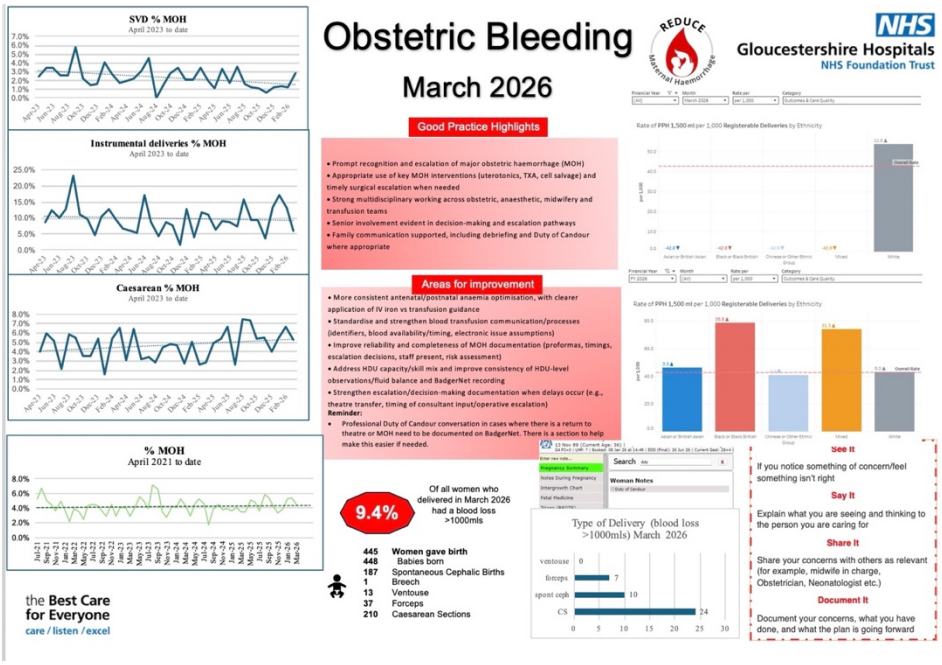
5.61. Summary of the data reported to the Intrapartum Forum March 2026 and then shared with staff

5.62. Slide summary – Obstetric Bleeding (March 2026)

- **Activity (context for assurance):** 445 women gave birth (448 babies) in March 2026; birth modes included 187 spontaneous cephalic births, 210 caesarean sections, 13 ventouse and 37 forceps (plus 1 breech).
- **Bleeding rate (monitoring metric):** 9.4% of women who delivered had an estimated blood loss >1000 ml; this is monitored through routine obstetric bleeding surveillance and reviewed through the established MOH/PPH governance arrangements.
- **Assurance from case review (good practice observed):** Reviews demonstrated timely recognition and escalation of major obstetric haemorrhage, appropriate use of key interventions (uterotonics, tranexamic acid, cell salvage) with prompt surgical escalation where required, effective multidisciplinary working (obstetric, anaesthetic, midwifery and transfusion), appropriate senior decision-making and family communication, including debrief and Duty of Candour where indicated.
- **Assurance actions / controls to strengthen (work in progress):** Improvement actions are in place to strengthen reliability in: antenatal/postnatal anaemia optimisation (clearer application of intravenous iron vs transfusion guidance); transfusion communication and process controls (patient identifiers, blood availability/timing and use of electronic issue); completeness of MOH documentation (proformas, timings, escalation decisions, staff present and risk assessment); HDU capacity/skill mix and consistency of HDU-level observations, fluid balance and BadgerNet recording; and clear documentation of escalation/decision-making where delays occur (e.g., theatre transfer and timing of consultant review/operative escalation). Progress is monitored through the MOH review forum and action tracking.
- **Documentation assurance:** Professional Duty of Candour conversations are recorded on BadgerNet where major obstetric haemorrhage or return to theatre occurs, supporting auditability and assurance of patient communication.

- **Safety culture / escalation:** “See it, Say it, Share it, Document it” continues to reinforce prompt escalation, shared situational awareness and clear recording of decisions and actions.

Picture: Monthly overview Obstetric Bleeding March 2026



Condition 2
The registered provider must ensure maternity staff at Gloucestershire Royal Hospital complete hourly peer reviews (also known as 'fresh eyes') during intrapartum care in line with national guidance.

5.63. Summary

5.64. In summary, the Trust has embedded an effective approach to intrapartum fetal monitoring, combining defined peer support arrangements, clear escalation pathways and clinical oversight aligned to current national guidance. While hourly peer review ("fresh eyes") is no longer a mandated national audit requirement under **Saving Babies' Lives Care Bundle Version 3**, the Trust retains peer review as a locally agreed safety control to support reliable decision-making and mitigate intrapartum risk.

5.65. Board assurance is provided through a combination of: (i) a standardised intrapartum fetal monitoring policy and competency-based training; (ii) routine audit and dashboard monitoring (including peer review compliance and escalation); and (iii) clearly defined governance routes, with review at the Intrapartum Forum and escalation through the Perinatal Oversight and Assurance Meeting where thresholds are not met or where there is sustained variance.

5.66. Where audit identifies variation (for example, in peer review completion), this is reviewed promptly through first-line intrapartum governance, with proportionate improvement actions implemented and tracked; learning is progressed via **PSIRF-aligned** processes to support closed-loop improvement and sustained reliability.

5.67. Overall, these arrangements demonstrate that the controls underpinning Condition 2 are embedded, proportionate and sustainable, with timely identification of variance and appropriate escalation available where required.

5.68. Taken together, the Trust can demonstrate sustained compliance with the key components of Condition 2, supported by triangulated evidence (policy and training, audit/dashboards and governance review), providing assurance that safe intrapartum fetal monitoring is consistently delivered.

5.69. Reasons and evidence for condition removal

5.70. Following national guidance updates (including the **Maternity Incentive Scheme (MIS) Year 7**, confirmed April 2025), hourly peer review ("fresh eyes") has been removed as a mandated national audit indicator within **Saving Babies' Lives Care Bundle Version 3 (SBLCBv3)**. The Trust has reflected this change by focusing Board assurance on the effectiveness of fetal monitoring controls (competency, interpretation and escalation) and on locally agreed monitoring of peer review as a safety support.

5.71. This approach supports proportionate assurance by prioritising measures most closely linked to safe care and outcomes, while reducing reliance on high-frequency documentation as a proxy for safety.

5.72. Accordingly, while peer review remains recognised as good practice, it is treated as a **local safety control** rather than a nationally mandated metric; the rationale is set out below:

- To maintain deliverability, national bodies reduced the number of mandated process measures; services reported that hourly documentation was difficult to sustain alongside direct clinical care.
- Greater assurance is obtained by focusing on a smaller set of high-value standards (risk assessment, interpretation, timely escalation and outcomes), rather than high volumes of process audit activity.

- SBLCBv3 aligns more closely with **NICE** and **RCOG Green-top guidance**, which emphasise robust risk assessment and escalation pathways; locally, the Trust continues to measure peer review completion as a supportive control where CTG monitoring is in use.
- SBLCBv3 supports locally agreed improvement priorities with system partners (including the Integrated Care Board), enabling proportionate local monitoring, defined escalation thresholds and targeted improvement action where performance varies.

5.73. Table: Comparison of requirements

Version [2, 3, 6, 8]	Peer Review Requirement	Status
SBLCB v2	At least **hourly** review of fetal well-being using a Buddy system.	**Mandatory**
SBLCB v3	Encouraged as a **best practice principle** but not a mandated national metric.	**Optional/Local**

5.74. Governance and clinical leadership

5.75. Clinical leaders

5.76. Our clinical leaders are crucial for overseeing continuous improvement as they establish a culture of evidence based care, remove barriers for staff engagement and foster innovation by trusting and supporting clinical teams.

5.77. Our Fetal Monitoring Team Leads are:

- Consultant Obstetrician - Dr Rebecca Evans Jones
- Fetal Monitoring Lead - Antonia Berki
- Education and Training Lead - Clemmie Skilton.

5.78. Governance

5.79. Oversight of the effectiveness of the system for fetal monitoring is the Intrapartum Forum. Escalating any issues to the Perinatal Oversight and Assurance Meeting using the 4 As format (alert, advise, assure and applaud).

5.80. Standardised management policy

5.81. The staff have a fetal monitoring policy to guide practice M1068 Intrapartum Fetal Monitoring (review date April 2027) and the requirements for peer review are laid out in the policy.

5.82. Audit data

5.83. Performance against the hourly peer review ('fresh eyes') metric reduced to 75% this month (from 100% in the previous month) for a single reporting period (small sample); this variance has been reviewed through the Intrapartum Forum, actions have been implemented to restore compliance, and the next month's data will provide assurance on improvement.

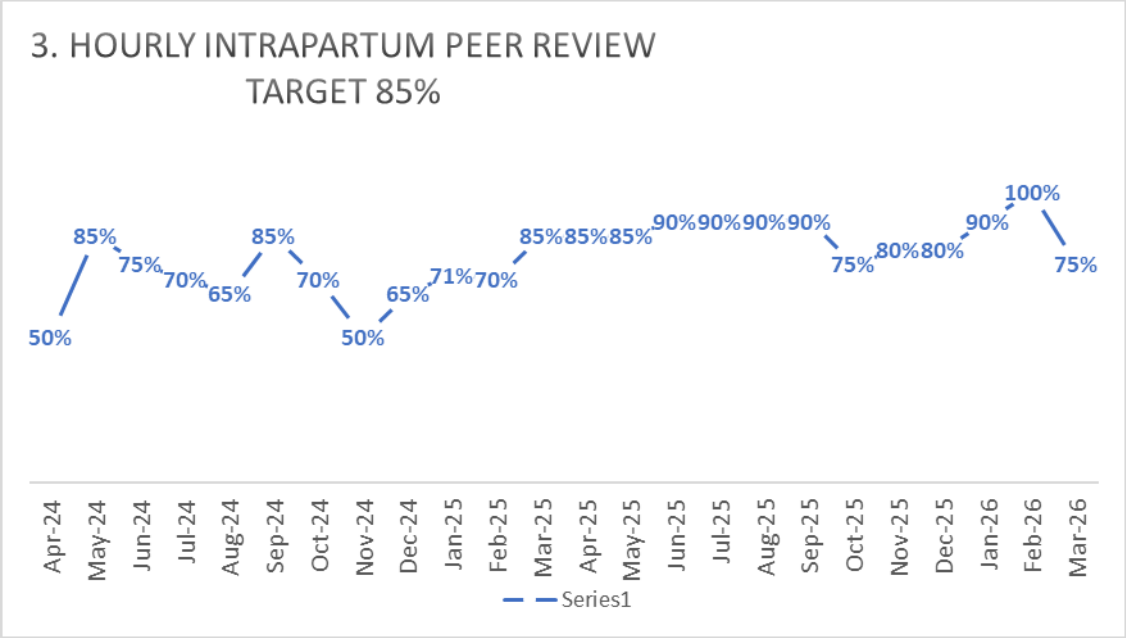
5.84. This demonstrates the governance system is working because it shows a complete local control cycle operating as designed:

- Detection: the decline in the "fresh eyes" metric was identified promptly through routine monitoring/exception reporting.

- Local oversight: it was reviewed at the Intrapartum Forum (the correct first-line governance forum for intrapartum safety).
- Action at the right level: corrective actions were agreed and put in place within operational governance, without delay.
- Escalation only if needed: the pathway to escalate to Perinatal Oversight/Executive/Board remains available, but is used proportionately—i.e., only if the issue is sustained, significant, or not responding to actions.
- Feedback loop: next month's data provides the check that actions have been effective ("closed loop" assurance).

5.85. We are just discussing and gaining consensus to determine whether hourly peer reviews are the best way to maintain safety in our unit as we can still choose to monitor it locally even though it is now not mandated nationally.

5.86. Graph: Hourly peer reviews 90% (target 85%)

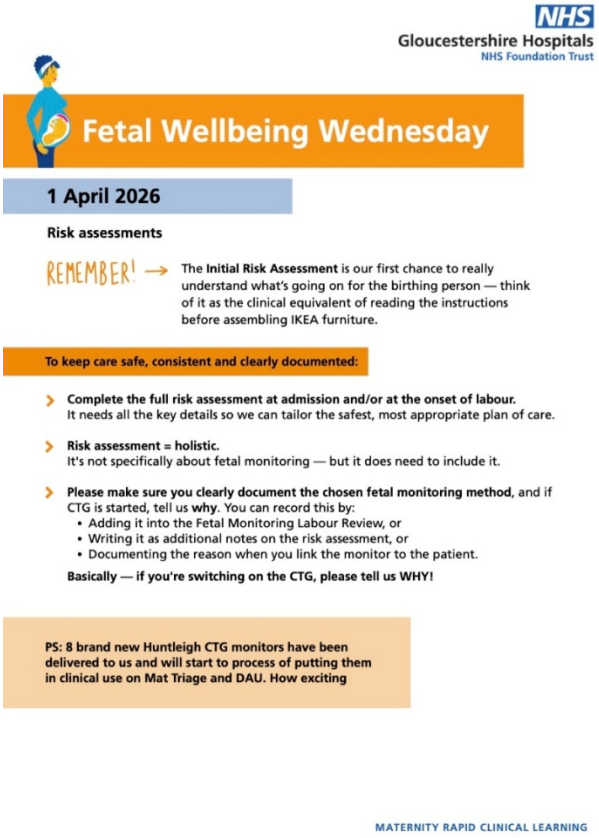


5.87. Culture of continuous improvement

5.88. The fetal monitoring improvement team continue to work on the implementation of Saving Babies Lives Element 4 continuing to ensure that there is competency in interpreting electronic fetal heart monitoring in the intrapartum period.

5.89. Each Wednesday a "Fetal Wellbeing Wednesday" update is sent to staff and below is an example.

5.90. Picture: Example weekly "Fetal Wellbeing Wednesday" communications to staff



5.91. Progress Report to the Intrapartum Forum – CTG audit standards (what is measured)

Audit standards (what is being measured):

CTG audit reporting is now aligned to clearly defined standards, including:

(1) Appropriate monitoring method selected (CTG vs intermittent auscultation) based on documented risk assessment;

(2) CTG interpretation documented using the agreed classification;

(3) Timely escalation where CTG concerns are identified, evidenced by documented review/escalation within the expected timeframe; and

(4) Second review ("fresh eyes") undertaken and recorded where CTG monitoring is in use (local standard, target 85%).

Condition 3
The registered provider must 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.

5.92. Summary

5.93. In summary, the Trust has implemented a reliable system to support accurate fetal monitoring interpretation and timely escalation, aligned to **Saving Babies' Lives Care Bundle Version 3**, **NICE** and the **NHS Resolution Maternity Incentive Scheme**.

5.94. Key controls include structured intrapartum risk assessment, competency-based training (CTG interpretation and intermittent auscultation), defined escalation pathways and peer/senior clinical support; these apply across all staff groups, including permanent, bank and agency staff.

5.95. Board assurance is provided through triangulated evidence of sustained compliance: routine audit and dashboard monitoring (including MIS Year 7 standards), exception reporting, and structured governance review via the Intrapartum Forum with escalation through the Perinatal Oversight and Assurance Meeting where required; PSIRF-aligned review supports identification of themes and delivery of tracked, closed-loop improvement actions.

5.96. Taken together, the Trust can demonstrate that fetal monitoring arrangements are embedded and sustainable, with clear oversight, escalation and learning processes in place to maintain safe and effective intrapartum care.

5.97. Reasons and evidence for condition removal

5.98. Saving babies lives version 3 implementation

5.99. The Trust's approach to fetal monitoring is aligned to **NHS England Saving Babies' Lives Care Bundle (Version 3) – Element 4**, and provides evidence that the intent of the CQC condition is met (appropriate monitoring method, accurate interpretation and timely escalation); supporting evidence is summarised below.

5.100. SBLCBv3 Element 4 – assurance standards and supporting evidence:

- **Competency and training:** a competency-based programme is in place for CTG interpretation and intermittent auscultation, with compliance evidenced through training records and oversight of mandatory update rates across staff groups (including bank/agency where relevant).
- **Peer review ("fresh eyes"):** structured second review is maintained as a local safety control (target 85%), with performance monitored through audit/dashboards and reviewed at the Intrapartum Forum, with escalation where variance is sustained or thresholds are not met.
- **Effective monitoring (right method, right time):** intrapartum risk assessment is documented and used to determine the appropriate monitoring modality (CTG vs IA), with compliance evidenced through audit against defined standards and exception reporting where deviations occur.
- **Escalation and senior review:** escalation pathways are clearly defined within the intrapartum fetal monitoring guideline and are audited through documentation of interpretation, escalation and response; governance review ensures that any themes or delays are identified and addressed.

- **Audit, review and learning:** ongoing assurance is provided through routine audit and dashboard monitoring, alongside PSIRF-aligned review of relevant incidents and themes (including intrapartum compromise), with actions tracked to completion and re-measurement used to evidence closed-loop improvement.

5.101. Collectively, this evidence demonstrates that the Trust has an embedded and sustainable system for effective fetal monitoring, with proportionate monitoring and escalation in place.

5.102. NHS Resolution – Maternity Incentive Scheme Safety Action 6

5.103. We have declared compliance to NHS Resolution that we have met the standards for safety standard 4, element 4 in our latest submission for the Maternity Incentive Scheme in March 2026.

5.104. Our compliance demonstrates that staff can interpret fetal heart rate (FHR) traces accurately, understand the clinical context, and escalate concerns promptly in line with NICE guidelines.

5.105. Governance and clinical leadership

5.106. Clinical leaders

5.107. Our clinical leaders are crucial for overseeing continuous improvement as they support our clinical teams.

5.108. Our Fetal Monitoring Team Leads are:

- Consultant Obstetrician - Dr Rebecca Evans Jones
- Lead Midwife Fetal Wellbeing- Antonia Berki (0.8 WTE)
- Education and Training Lead - Clemmie Skilton.

5.109. Governance

5.110. Oversight of fetal monitoring happens at the Intrapartum Forum. Escalating any issues to the Perinatal Oversight and Assurance Meeting using the 4 As format (alert, advise, assure and applaud) and on to the Executive Led Perinatal Delivery Group.

5.111. Standardised management policy

5.112. There is a fetal monitoring policy to guide practice M1068 Intrapartum Fetal Monitoring (review date April 2027) and this is currently being updated in line with the updates to the NICE guidance. The updated intrapartum fetal monitoring guideline provides a key governance control to standardise practice and support safer decision making.

5.113. Audit data (Saving Babies Lives Version 3 - element 4 effective fetal monitoring)

5.114. Element 4 promotes effective fetal monitoring during labour through ensuring all staff responsible for fetal monitoring are competent in the techniques they use in relation to the clinical situation, use the buddy system, and escalate accordingly when concerns arise or risks develop. This includes staff that are brought in to support a busy service from other clinical areas, as well as locum, agency of bank staff.

5.115. Maternity Incentive Scheme Compliance Year 7

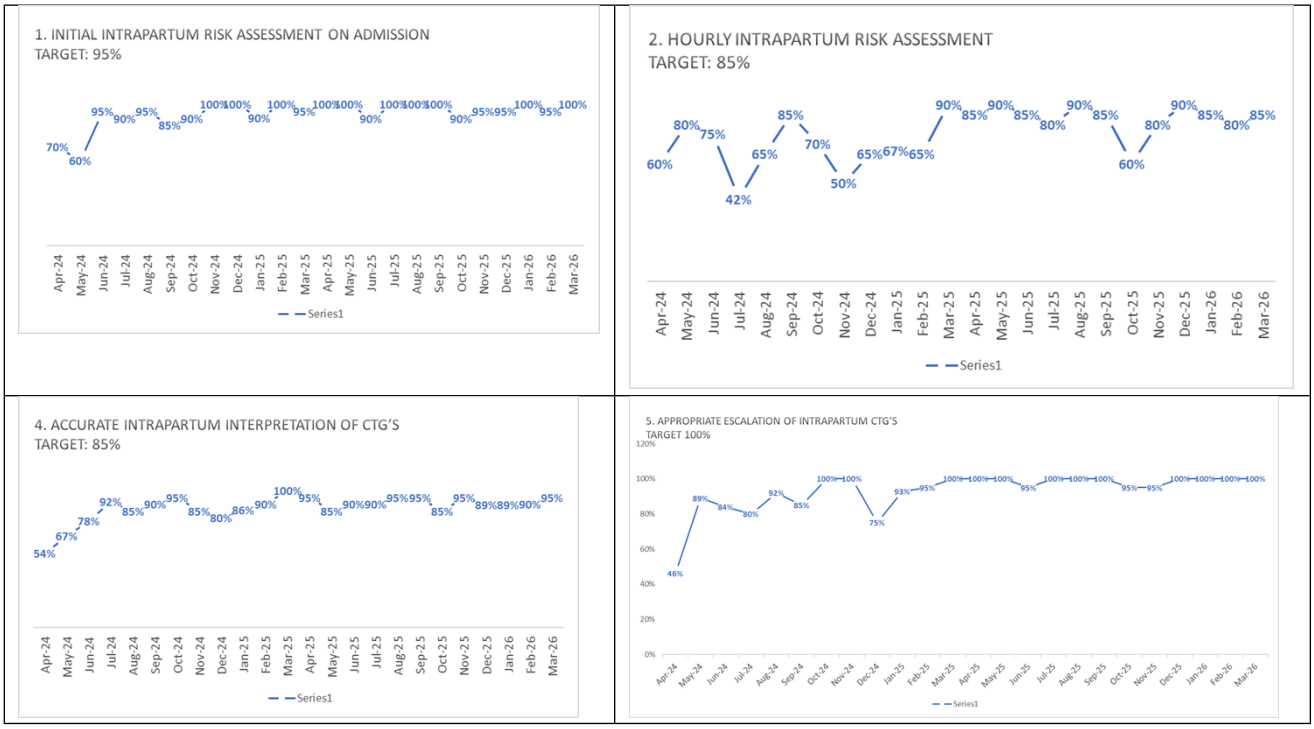
5.116. We have met or exceeded our own locally agreed targets continuously throughout the year with all SBL interventions. An exception report has not been produced for women who have had an incorrect risk assessment for the method of fetal monitoring required (intervention 4.2), because our fetal monitoring audit has not identified any non-compliance with this metric.

5.117. The Trust has appointed a new Lead Midwife for Fetal Wellbeing, Antonia Berki, within this MIS reporting window, who commenced the role in June 2025 at 0.8WTE. We also have

a Lead Consultant for Fetal Wellbeing, Dr Rebecca Evans-Jones. Both roles have been specifically confirmed to the LMNS through the Perinatal Delivery Group meeting in November 2025. The Trust has also met the target of 90% for all staff receiving annual training on CTG interpretation and intermittent auscultation (process indicator 4a), with 93.3% of all midwives, consultant obstetricians and registrars attending training within the required MIS window.

5.118. Our data demonstrates that we now have a reliable system of peer review (see previous condition).

5.119. Graphs – snapshot audit 10 cases



5.120. PSIRF - Patient Safety Themes presented to the Intrapartum Forum March 2026

5.121. <u>Perinatal compromise Datix thematic review (June- 23 February 2026)</u>

5.122. The Intrapartum Forum received a thematic review presentation of 134 cases that have been reviewed. The outcomes for these cases were that the baby had either low Apgar's scores, low cord gases or the babies required neonatal resuscitation).

5.123. This thematic review will be progressed in line with **PSIRF** learning and improvement processes, using a structured approach to identify contributory factors, agree proportionate actions (for example, targeted safety huddle communications, refresher training/simulation, updates to local guidance and checklists/proformas, and dashboard/exception-reporting triggers), and evidence closed-loop learning through governance oversight.

Condition 4
The registered provider must 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.

5.125. Summary

5.126. In summary, the Trust has **removed the immediate risk to service users** by implementing an effective and reliable system for the completion, review and escalation of maternity early obstetric warning scores (MEOWS) across intrapartum and postnatal care. This ensures timely recognition and escalation of maternal deterioration in line with Trust guidance and national standards.

5.127. The risk of recurrence has been **mitigated through standardised controls**, including clear escalation thresholds, defined response times, competency-based staff training and routine monitoring of compliance. Performance is reviewed through structured audit and digital dashboards, with a particular focus on “act on amber” and red escalation compliance, enabling early identification and management of any variation in practice.

5.128. Sustained effectiveness is demonstrated through **ongoing audit, trend monitoring and exception reporting**, with oversight provided through established governance arrangements, including the Postnatal Forum and escalation to the Perinatal Oversight and Assurance Meeting. This provides clear line-of-sight to executive and Board-level oversight and supports timely corrective/ supportive action where required.

5.129. The Trust is **actively managing the transition to the national Maternal Early Warning Score (MEWS)** system, with an agreed implementation plan, staff training in place and temporary adjustments to audit arrangements to ensure focus on safe implementation. This transition further strengthens sustainability and alignment with national guidance.

5.130. Taken together, the Trust can demonstrate that the **risk identified in Condition 4 has been addressed, is actively monitored**, providing confidence that systems for recognising and escalating maternal deterioration are embedded and sustainable.

5.131. Reasons and evidence for condition removal

5.132. We can provide evidence across audit compliance, staff training, clinical governance, and patient outcomes.

5.133. Governance and clinical leadership

5.134. Our clinical leaders are crucial for overseeing continuous improvement as they support our clinical teams.

5.135. Our Deteriorating Patient Team Leads are:

- Consultant Obstetrician - Dr Sharan Athwal and Dr Helena Van De Nelson
- Matron - Kat Pickering
- Ward Manager – Claire Watson-Pople
- Education and Training Lead - Clemmie Skilton.

5.136. Standardised management policy

5.137. We have a system implemented and described in MOEWS clinical guidelines (Severely Ill Obstetric Patient M2010). There is also a Maternity Early Warning Scores Standard Operating Procedure.

5.138. Audit data

5.139. New audits to commence once new Maternal Early Warning Score implemented which is proposed for 5 May 2026.

5.140. Plan

5.141. The plan is to implement new national MEWs on 5 May 2026 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.

5.142. Next steps

5.143. The new national maternal early warning score (MEWS) system is being implemented now on 5 May 2026.

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

5.145. Training for the new system is available to staff.

5.146. The Leads have requested to the Postnatal Forum to pause audits until new MEWs have been implemented so that resources can be focused on implementation.

5.147. The Maternity Service is a NHSE pilot site for Maternity Martha's Rule implementation and continue to promote this initiative.

5.148. The service will continue to monitor MEWs completion via the Triage dashboard until the new MEWS dashboard is launched.

NEW INTRANET PAGE

On this page

Maternity Early Warning Score (MEWS) Chart

The MEWS table

PIER Framework

ESR e-learning

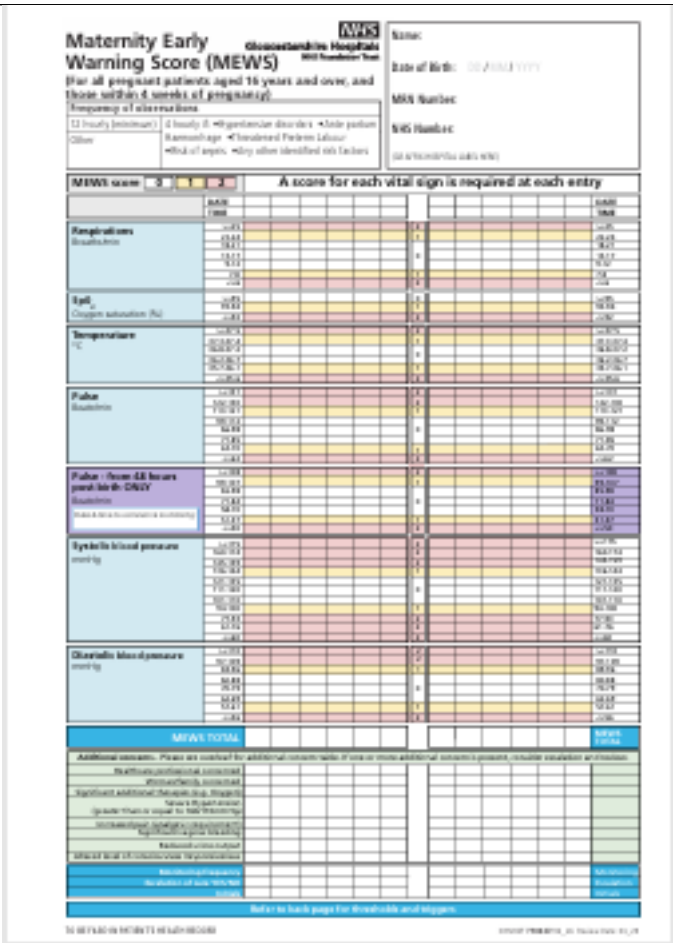
Further Reading and Resources

The national MEWS tool has been developed with key stakeholders and designed with insights from population data and consensus building with healthcare professionals.
The tool has been designed to ensure that identification of deterioration is based on pure physiology using a total score. This total score is combined with subjective assessments (additional concerns) which support the escalation process.

The MEWS tool is intended to guide clinical judgements and not replace it. Health professionals should ensure accurate taking and recording of a full set of vital signs to support a graduated and timely escalation process.

Maternity Early Warning Score (MEWS) Chart

National MEWS Chart



Maternity Early Warning Score (MEWS)

Gloucestershire Hospitals NHS Foundation Trust

(For all pregnant patients aged 16 years and over, and those within 4 weeks of pregnancy)

Name:

Date of Birth:

MRN Number:

NHS Number:

Frequency of observations

12 hourly (minimum)

Other

4 hourly if: •Hypertensive disorders •Ante partum Haemorrhage •Threatened Preterm Labour •Risk of sepsis •Any other identified risk factors

MEWS score 0 1 2

A score for each vital sign is required at each entry

Respirations

Breaths/min

SpO2

Oxygen saturation (%)

Temperature

°C

Pulse

Beats/min

Pulse - from 48 hours post birth ONLY

Beats/min

Systolic blood pressure

mmHg

Diastolic blood pressure

mmHg

MEWS TOTAL

Additional concerns. Please see overleaf for additional concern table if one or more additional concerns present, escalate escalation as necessary

Healthcare professional concerned

Woman/family concerned

Significant additional therapies (e.g. Oxygen)

Severe Hypertension (greater than or equal to 160/110mmHg)

Increased pain (re- or analgesic requirement)

Significant vaginal bleeding

Reduced urine output

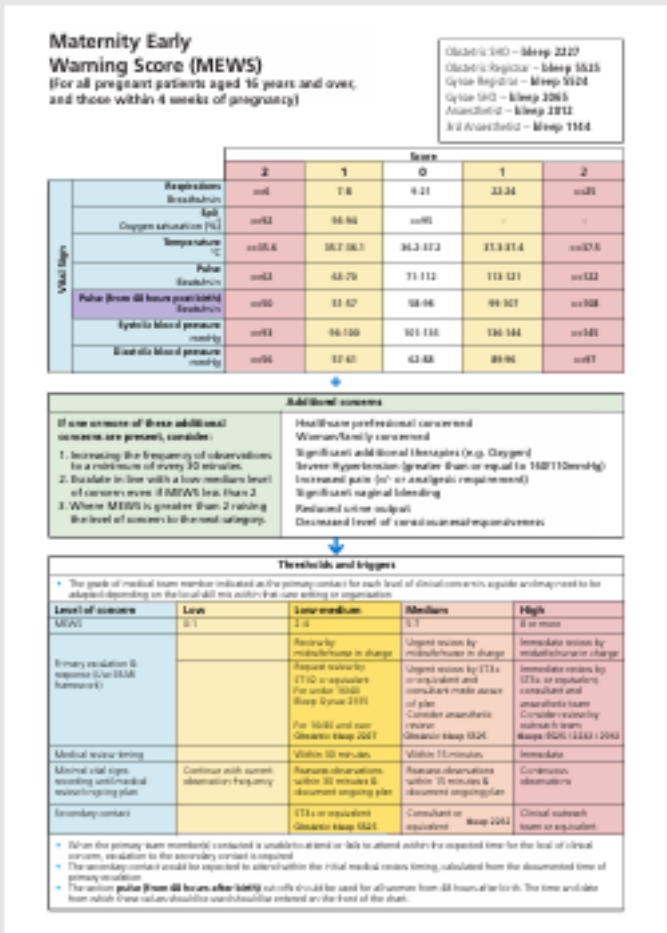
Decreased level of consciousness/responsiveness

Escalation frequency

Escalation of care to/by

Initials

Refer to back page for thresholds and triggers



Maternity Early Warning Score (MEWS)

(For all pregnant patients aged 16 years and over, and those within 4 weeks of pregnancy)

Obstetric SHO – bleep 2227

Obstetric Registrar – bleep 1525

Gynae Registrar – bleep 1524

Gynae SHO – bleep 2265

Anaesthetist – bleep 2812

3rd Anaesthetist – bleep 1104

		Score				
		3	2	1	0	1	2
Vital Signs	Respirations Breaths/min	≤8	9-11	12-20	21-24	≥25
	SpO2 Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.0	35.1-36.0	36.1-37.5	37.6-37.9	≥38.0
	Pulse Beats/min	≤40	41-50	51-110	111-129	≥130
	Pulse (from 48 hours post birth) Beats/min	≤50	51-60	61-90	91-109	≥110
	Systolic blood pressure mmHg	≤90	91-100	101-160	161-179	≥180
	Diastolic blood pressure mmHg	≤50	51-60	61-90	91-99	≥100

Additional concerns

If one or more of these additional concerns are present, consider:

1. Increasing the frequency of observations to a minimum of every 30 minutes.
2. Escalate in line with a low medium level of concern even if MEWS less than 3
3. Where MEWS is greater than 3 raising the level of concern to the next category.

Healthcare professional concerned
Woman/family concerned
Significant additional therapies (e.g. Oxygen)
Severe Hypertension (greater than or equal to 160/110mmHg)
Increased pain (re- or analgesic requirement)
Significant vaginal bleeding
Reduced urine output
Decreased level of consciousness/responsiveness

Thresholds and triggers

- The grade of medical team member indicated as the primary contact for each level of clinical concern is guide and may need to be adapted depending on the local skill mix within that care setting or organisation
- When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required
- The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation
- The section **pulse (from 48 hours after birth)** cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.

Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-3	4-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife/nurse in charge	Urgent review by midwife/nurse in charge	Immediate review by midwife/nurse in charge
		Request review by CT(G) or equivalent For under 16bill Bleep Gynae 2101 For 16bill and over Obstetric bleep 2227	Urgent review by CT(G) or equivalent and consultant made aware of plan Consider anaesthetic review Obstetric bleep 1525	Immediate review by CT(G) or equivalent, consultant and anaesthetic team Consider maternity outreach team Bleep 15251 / 2063
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		CT(G) or equivalent Obstetric bleep 1525	Consultant or equivalent Bleep 2063	Clinical outreach team or equivalent

The MEWS chart provides a score for each of the vital signs: Respirations, SpO2, Temperature, Pulse, Systolic Blood Pressure, Diastolic Blood Pressure, providing a numerical MEWS frequency. This chart should be used for all pregnant patients in all wards and departments, and those who have been pregnant in the last 28 days.

The early warning score is recorded on the electronic patient records (EPR) and transcribed onto paper MEWS charts to provide a score and identify triggers for escalation.

The MEWS table

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	<=6	7-8	9-21	22-24	>=25
	SpO_2 Oxygen saturation (%)	<=92	93-94	>=95	-	-
	Temperature °C	<=35.6	35.7-36.1	36.2-37.2	37.3-37.4	>=37.5
	Pulse Beats/min	<=62	63-70	71-112	113-121	>=122
	Pulse (from 48 hours post birth) Beats/min	<=50	51-57	58-98	99-107	>=108
	Systolic blood pressure mmHg	<=93	94-100	101-135	136-144	>=145
	Diastolic blood pressure mmHg	<=56	57-61	62-88	89-96	>=97

Please note the addition of Pulse (from 48 hours post birth) beats/min, adjusting the MEWS score for this critical time.

Thresholds and triggers for escalation:

Thresholds and triggers

- The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation

Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife/nurse in charge	Urgent review by midwife/nurse in charge	Immediate review by midwife/nurse in charge
		Request review by ST1/2 or equivalent For under 16/40 Bleep Gynae 2555 For 16/40 and over Obstetric bleep 2227	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review Obstetric bleep 5525	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team bleeps 5525 / 2232 / 2012
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent Obstetric bleep 5525	Consultant or equivalent bleep 2232	Clinical outreach team or equivalent

- When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required
- The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation
- The section **pulse (from 48 hours after birth)** cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.

Additional Concerns

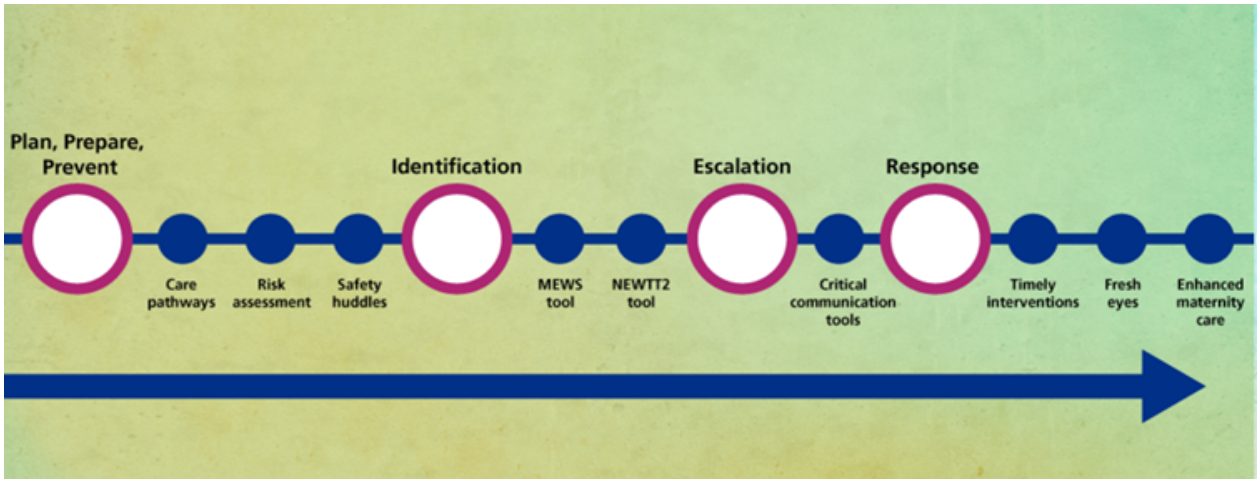
Additional concerns	
If one or more of these additional concerns are present, consider: 1. Increasing the frequency of observations to a minimum of every 30 minutes 2. Escalate in line with a low-medium level of concern even if MEWS less than 2 3. Where MEWS is greater than 2 raising the level of concern to the next category.	Healthcare professional concerned Woman/family concerned Significant additional therapies (e.g. Oxygen) Severe Hypertension (greater than or equal to 160/110mmHg) Increased pain (+/- or analgesic requirement) Significant vaginal bleeding Reduced urine output Decreased level of consciousness/responsiveness

If any of these additional concerns are present, along with an elevated MEWS score, it's important to consider increasing the level of concern. If no physiological abnormality is present, but any of these additional concerns are present, then escalation should still occur.
These features have not been quantified deliberately as the degree of concern if likely to be context specific and these features are a guide to multi-professional staff.
Significant additional therapies is included within the additional concerns to ensure the therapy is highlighted. These may include oxygen, magnesium sulphate, intravenous antibiotics and uterotonics.

Please note:

- Severe hypertension (greater than or equal to 160/110 mmHg) will be added to the additional concerns
- A score of 4 with additional concern of severe hypertension raises the level of concern to the next thresholds and triggers category to a medium
- This therefore elicits a response to escalation within 15 minutes

PIER Framework



ESR e-learning

ESR e-learning: 318 Maternal and Neonatal Deterioration

Further Reading and Resources

NHS England have created 2 podcasts which explain the design of the new national MEWS:

Condition 5

The registered provider must implement an effective system for ensuring staff at Gloucestershire Royal Hospital complete venous thromboembolism (VTE) risk assessments.

5.149. Summary

5.150. In summary, the Trust has **removed the immediate risk to service users** by implementing an effective and reliable system to ensure the completion and review of venous thromboembolism (VTE) risk assessments across the maternity pathway. This system is aligned with **NICE and RCOG guidance** and ensures that VTE risk is identified promptly and managed appropriately at key points of care.

5.151. The risk of recurrence has been **mitigated through standardised and embedded controls**, including mandatory VTE risk assessment within the electronic patient record, clear clinical guidance, and defined responsibilities for reassessment when a woman's clinical condition changes. These controls prevent omission of risk assessment and support consistent clinical decision-making across antenatal, intrapartum and postnatal care.

5.152. Sustained compliance is demonstrated through **routine audit and production board monitoring**, with performance consistently meeting or exceeding national expectations. Oversight is provided through established maternity and Trust-wide governance arrangements, including the Maternity VTE Leads attending the Trust wide VTE Group, ensuring clear line-of-sight to executive and Board-level assurance.

5.153. Patient information and discharge education further support risk reduction beyond the inpatient setting.

5.154. Taken together, the Trust can demonstrate that the **risk identified in Condition 5 has been addressed, is actively monitored**, providing confidence that arrangements for VTE risk assessment are embedded, effective and sustainable.

5.155. Reasons and evidence for condition removal

5.156. To demonstrate that we have an effective system for ensuring complete venous thromboembolism (VTE) risk assessments, we have implemented a combination of robust governance, digital integration, consistent staff training, and rigorous auditing, aiming for the national standard of 95% compliance.

5.157. Governance and clinical leadership

5.158. <u>Maternity</u>

5.159. Our maternity clinical leaders are crucial for overseeing continuous improvement as they support our clinical teams.

5.160. Our Maternity VTE Leads are:

- Consultant Obstetrician - Dr Amanda Airey
- Matron - Kat Pickering
- Ward Manager – Claire Watson-Pople

5.161. <u>Trust wide VTE prevention</u>

5.162. We have a dedicated Trust wide VTE Prevention Improvement Group led by the Medical Director responsible for reviewing data and supporting the improvement work.

5.163. Standardised management policy

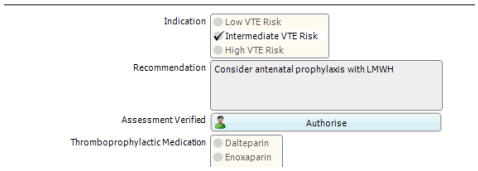
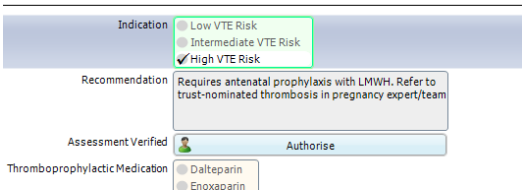
5.164. We have a system implemented and described in Guideline M2014 VTE Disorders Diagnosis and Treatment – thromboprophylaxis during pregnancy labour and after delivery. The guideline is aligned with NICE guidance (NG89) and RCOG guidance (Green Top 37a and 37b).

5.165. Digital systems

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

5.167. The VTE risk assessment is embedded within the antenatal booking pathway and the postnatal admission pathway, functioning as a mandatory step that prevents skipping the assessments.

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

AN Intermediate VTE risk assessment	AN High risk
	

5.168. Reassessment Documentation

5.169. We are working on our pathways to ensure that VTE risk is re-evaluated when the patient's condition changes, or during consultant reviews, not just on admission.

5.170. Audit - risk assessments

5.171. Now our new Obstetric Lead has been identified we are aiming to refresh the audit programme.

5.172. Audits are now to be completed quarterly as the last “on admission” audit demonstrated 100% compliance (February 2026). Quarterly audits have been agreed and the next audit is now due May 2026.

5.173. 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 May 2026	Target
Manual audits	100 %	90%	92%	100 %	96%	97%	100 %	100%		95%

Thromboprophylaxis

5.174. Spot check audits, for both antenatal and postnatal women, continue to demonstrate 95-100% compliance and will be checked in May 2026. It is mandated that these fields are completed and so compliance has remained consistently high.

5.175. Patient Information

5.176. Discharge Education

5.177. We are continuing to improve documentation that patients have received written information (e.g., trust leaflet/ letter) on VTE risks, symptoms of DVT/PE, and the importance of prophylaxis upon discharge.

5.178. **Patient Safety Incident Framework response**

5.179. Investigation of Events

5.180. We are encouraging that all cases of hospital-associated thrombosis are reported as "safety incidents", with a plan to carry out detailed, PSIRF style multidisciplinary review to identify why the system of assessment or prophylaxis failed.

5.181. **Next steps**

5.182. Audits for compliance with risk assessment completion will now be completed quarterly next due May 2026.

5.183. On 6 January 2026, a new Maternal Care Bundle was released by NHS England and element 1 is a programme of work to improve and reduce VTE.

5.184. The Perinatal Governance Team have started the gap analysis against the Care Bundle VTE recommendations and will develop an action plan to ensure that all elements are introduced with a target date of March 2027. We are waiting for the national tool to be published but have completed a first audit against the MCB standards.

5.185. Maternal Care Bundle Baseline Audit – prebooking thromboprophylaxis

5.186. The first audit has been completed which reviewed local implementation of NHS England's Maternal Care Bundle (Element 1: Venous Thromboembolism). Importantly, this standard is primarily delivered **before women reach the maternity service**, at the **first maternity service contact** (often in primary care/community) and prior to the antenatal booking appointment, requiring timely VTE risk identification and commencement of low molecular weight heparin (LMWH) for women identified as high risk (audit standard: 100% commenced by booking). In a Trust snapshot of 15 women identified as high risk at booking, 9/15 (60%) had LMWH started before booking, 2/15 (13%) had not started despite meeting criteria, and 4/15 (27%) had variable or unclear pathways (commonly where initiation was delayed pending obstetric review or where risk status was later revised).

5.187. The findings provide clear learning about where the pathway is working well and where reliability can be strengthened.

5.188. Strengths included early initiation at first booking contact in several cases, seamless continuation for women booking in already on LMWH, and prompt escalation for late bookers once identified. Opportunities for improvement centred on (1) reducing avoidable delays for women with clear risk factors (including previous VTE), (2) supporting consistent decision-making across **primary care/community and maternity** aligned to the national tool (so initiation does not depend on awaiting specialist confirmation when criteria are met), and (3) improving documentation so clinical reasoning and any risk re-categorisation are transparent and auditable.

5.189. The service is using these learning points to strengthen a **whole-pathway ("system") approach** with partners, standardising early-pregnancy processes across primary care/community and maternity services: reinforcing community-led initiation and a 72-hour safety-net for high-risk cases, refreshing multidisciplinary training and communications for referrers, embedding the national questionnaire across all referral/self-referral routes, introducing a structured BadgerNet template to improve documentation and auditability, reviewing cases where risk was downgraded to share learning, and providing ongoing

oversight via the Maternity Clinical Effectiveness Group, with re-audit planned within six months.

Condition 6
The registered provider must implement an effective system for ensuring agency midwifery staff at Gloucestershire Royal Hospital 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.

Summary

5.191. In summary, the Trust has removed the immediate risk to service users by implementing an effective and reliable system to ensure agency midwifery staff are appropriately inducted, supported and able to work safely within the maternity unit. This system ensures that agency staff have timely access to the clinical environment, electronic patient records and essential Trust policies, enabling them to deliver safe care from the start of each shift.

5.192. The risk of recurrence has been mitigated through standardised and embedded controls, including a structured induction process, clear local guidance for temporary staff, defined access arrangements and oversight of agency workforce deployment. These controls are applied consistently and ensure that agency staff are supported, supervised and integrated into clinical teams, reducing reliance on informal workarounds.

5.193. Sustained effectiveness is demonstrated through routine monitoring of agency usage, induction compliance and workforce assurance, with oversight provided through established maternity governance arrangements, including the Workforce Meeting and escalation to the Maternity Oversight and Assurance Committee. This provides clear line-of-sight to executive and Board-level oversight, with any identified issues escalated and addressed promptly.

5.194. The Trust's approach ensures that agency workforce arrangements are safe, proportionate and sustainable, supporting continuity of care during periods of workforce pressure while maintaining clear accountability and governance.

5.195. Taken together, the Trust can demonstrate that the risk identified in Condition 6 has been addressed, is actively monitored, providing confidence that agency staff induction and access arrangements are embedded and effective.

Governance

5.196. The service continues to monitor bank and agency usage monthly.

5.197. 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).

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

Condition 7
Within 21 days of this notice and monthly thereafter, the registered provider must provide a detailed action plan that includes the following:

a. A detailed plan of how it will ensure service users at Gloucestershire Royal Hospital have effective post-partum haemorrhage risk assessments and PPH proformas are used effectively to manage obstetric emergencies and reduce the severity of blood loss. The plan must identify how it will achieve this in the short to medium term, including any immediate actions taken.
b. A detailed plan of how it will ensure service users at Gloucestershire Royal Hospital have effective fetal monitoring in line with national guidance.
c. Summary report of the actions taken to address the immediate risk to service users at the Gloucestershire Royal Hospital, this should include detailed evidence of how you will achieve and monitor this.
d. The action plan must include assigned responsibilities, timelines for completion and measurable actions.

5.199. In summary, the Trust has **fully met the requirements of Condition 7** by submitting a comprehensive quality improvement plan within the required timeframe and providing **consistent monthly assurance reporting** to the CQC and Trust Board. These reports have demonstrated clear progress against each condition, with defined actions, accountable leads, delivery timelines and measurable outcomes.

5.200. The enhanced reporting arrangements required under Condition 7 provided **effective regulatory and Board assurance during a period of elevated risk**, enabling close oversight of improvement delivery and timely identification and management of any issues. Reports were routinely reviewed through established Trust governance structures, including Trust Board and its committees, with **no unresolved actions or escalations** arising from this reporting process.

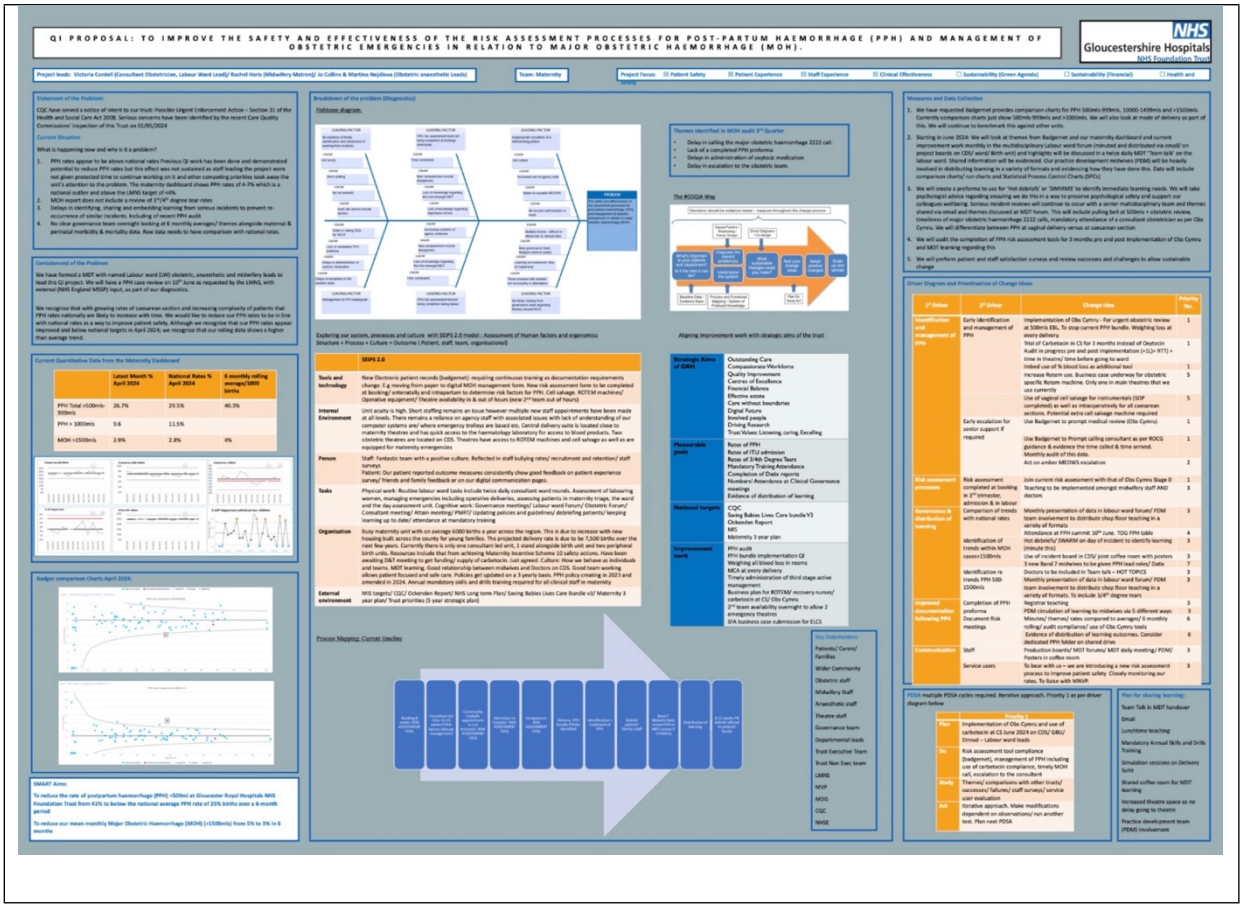
5.201. As improvements across Conditions 1–6 have matured and become embedded, the risks originally mitigated through time-limited action plans are now **managed through business-as-usual governance, audit and PSIRF-aligned learning arrangements**. Oversight has appropriately transitioned from enhanced regulatory reporting to established maternity and Trust-wide assurance mechanisms, reflecting improved stability and reduced regulatory risk.

5.202. Taken together, the Trust can demonstrate that the **purpose of Condition 7 has been fulfilled**, that ongoing risks are effectively controlled through routine governance, and that continued compliance is **sustainable without the need for enhanced regulatory reporting**.

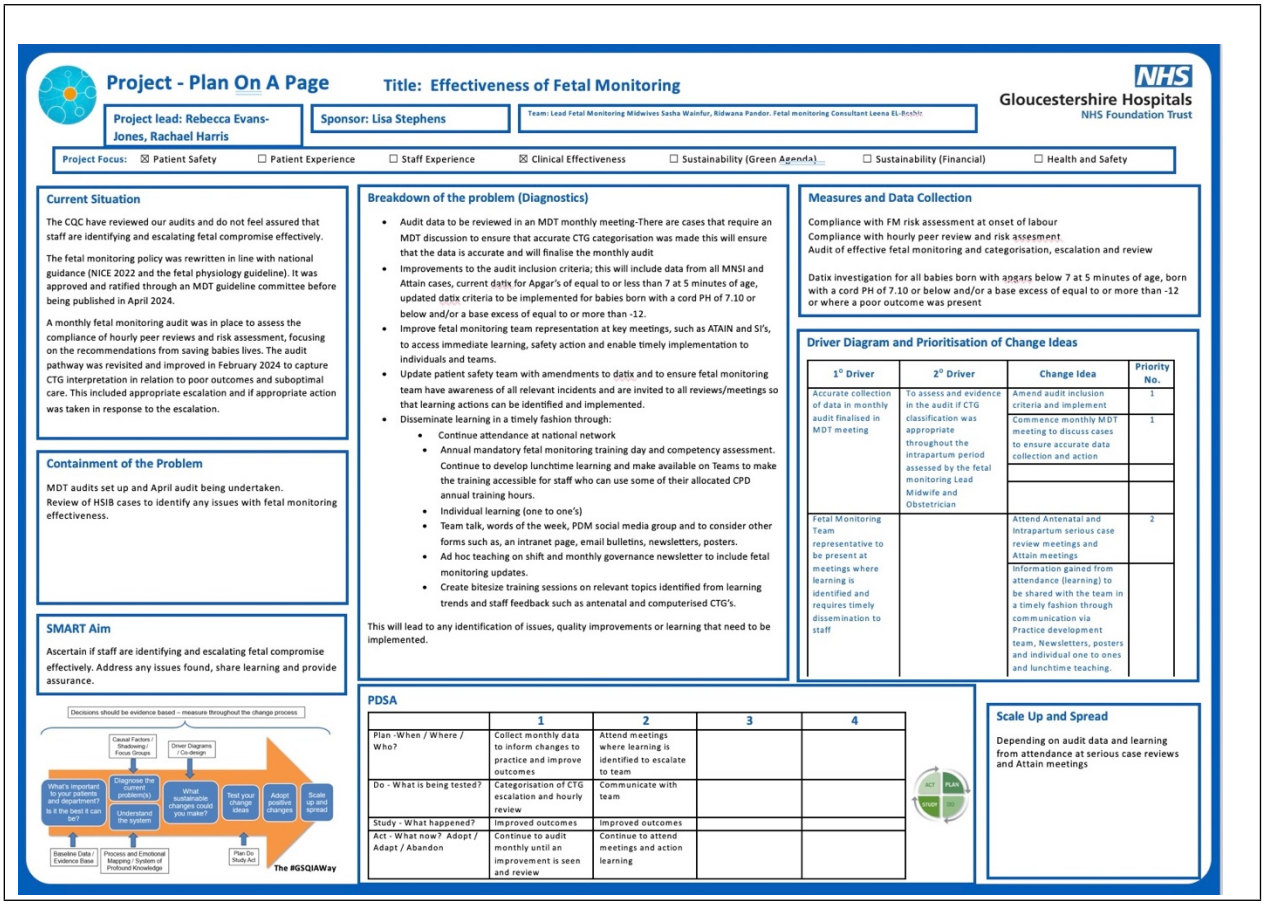
5.203. A quality improvement plan was submitted within 21 days of this notice, in May 2024, and the Clinical Leads have been using QI methodology to improve maternity services.

5.204. Picture: Condition 7a Quality Improvement plan for PPH submitted to CQC

Quality Improvement Plan for Postpartum Haemorrhage 22 May 2024



5.205. Picture: Condition 7b Quality Improvement plan for Fetal Monitoring submitted to CQC



Project - Plan On A Page

Title: Effectiveness of Fetal Monitoring

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Project lead: Rebecca Evans-Jones, Rachael Harris

Sponsor: Lisa Stephens

Team: Lead Fetal Monitoring Midwives Sasha Wainfur, Ridwana Pandor. Fetal monitoring Consultant Leena EL-Beshir

Project Focus: ☒ Patient Safety ☐ Patient Experience ☐ Staff Experience ☒ Clinical Effectiveness ☐ Sustainability (Green Agenda) ☐ Sustainability (Financial) ☐ Health and Safety

Current Situation

The CQC have reviewed our audits and do not feel assured that staff are identifying and escalating fetal compromise effectively.

The fetal monitoring policy was rewritten in line with national guidance (NICE 2022 and the fetal physiology guideline). It was approved and ratified through an MDT guideline committee before being published in April 2024.

A monthly fetal monitoring audit was in place to assess the compliance of hourly peer reviews and risk assessment, focusing on the recommendations from saving babies lives. The audit pathway was revisited and improved in February 2024 to capture CTG interpretation in relation to poor outcomes and suboptimal care. This included appropriate escalation and if appropriate action was taken in response to the escalation.

Containment of the Problem

MDT audits set up and April audit being undertaken.
Review of HSIB cases to identify any issues with fetal monitoring effectiveness.

SMART Aim

Ascertain if staff are identifying and escalating fetal compromise effectively. Address any issues found, share learning and provide assurance.

Breakdown of the problem (Diagnostics)

- Audit data to be reviewed in an MDT monthly meeting-There are cases that require an MDT discussion to ensure that accurate CTG categorisation was made this will ensure that the data is accurate and will finalise the monthly audit
- Improvements to the audit inclusion criteria; this will include data from all MNSI and Attain cases, current datix for Apgar's of equal to or less than 7 at 5 minutes of age, updated datix criteria to be implemented for babies born with a cord PH of 7.10 or below and/or a base excess of equal to or more than -12.
- Improve fetal monitoring team representation at key meetings, such as ATAIN and SI's, to access immediate learning, safety action and enable timely implementation to individuals and teams.
- Update patient safety team with amendments to datix and to ensure fetal monitoring team have awareness of all relevant incidents and are invited to all reviews/meetings so that learning actions can be identified and implemented.
- Disseminate learning in a timely fashion through:
  - Continue attendance at national network
  - Annual mandatory fetal monitoring training day and competency assessment. Continue to develop lunchtime learning and make available on Teams to make the training accessible for staff who can use some of their allocated CPD annual training hours.
  - Individual learning (one to one's)
  - Team talk, words of the week, PDM social media group and to consider other forms such as, an intranet page, email bulletins, newsletters, posters.
  - Ad hoc teaching on shift and monthly governance newsletter to include fetal monitoring updates.
  - Create bitesize training sessions on relevant topics identified from learning trends and staff feedback such as antenatal and computerised CTG's.

This will lead to any identification of issues, quality improvements or learning that need to be implemented.

Measures and Data Collection

Compliance with FM risk assessment at onset of labour
Compliance with hourly peer review and risk assessment
Audit of effective fetal monitoring and categorisation, escalation and review

Datix investigation for all babies born with apgars below 7 at 5 minutes of age, born with a cord PH of 7.10 or below and/or a base excess of equal to or more than -12 or where a poor outcome was present

Driver Diagram and Prioritisation of Change Ideas

1° Driver	2° Driver	Change Idea	Priority No.
Accurate collection of data in monthly audit finalised in MDT meeting	To assess and evidence in the audit if CTG classification was appropriate throughout the intrapartum period assessed by the fetal monitoring Lead Midwife and Obstetrician	Amend audit inclusion criteria and implement	1
		Commence monthly MDT meeting to discuss cases to ensure accurate data collection and action	1
Fetal Monitoring Team representative to be present at meetings where learning is identified and requires timely dissemination to staff		Attend Antenatal and Intrapartum serious case review meetings and Attain meetings	2
		Information gained from attendance (learning) to be shared with the team in a timely fashion through communication via Practice development team, Newsletters, posters and individual one to ones and lunchtime teaching.	

PDSA

	1	2	3	4
Plan -When / Where / Who?	Collect monthly data to inform changes to practice and improve outcomes	Attend meetings where learning is identified to escalate to team		
Do - What is being tested?	Categorisation of CTG escalation and hourly review	Communicate with team		
Study - What happened?	Improved outcomes	Improved outcomes		
Act - What now? Adopt / Adapt / Abandon	Continue to audit monthly until an improvement is seen and review	Continue to attend meetings and action learning		

Scale Up and Spread

Depending on audit data and learning from attendance at serious case reviews and Attain meetings

Condition 8
Within 21 days of this notice and monthly thereafter, the registered provider must provide to the CQC the following:
a. An updated action plan with clear details of progress on all conditions contained within this notice.
b. All reports written to provide assurance to the senior leadership team and/or Trust board to demonstrate compliance with the conditions.
c. The Trust maternity dashboard.

5.206. In summary, the Trust has **fully met the requirements of Condition 8** by providing **timely, comprehensive and consistent monthly submissions** to the CQC, including updated action plans, Board-level assurance reports and the maternity dashboard. These submissions have demonstrated clear progress against each condition and provided transparent evidence of how risks were being monitored and managed.

5.207. The reporting required under Condition 8 has provided **effective regulatory and senior leadership assurance**, enabling the CQC and the Trust Board to maintain clear oversight of maternity safety, improvement delivery and compliance throughout the period of enhanced regulatory scrutiny. Reports were routinely reviewed through established Trust governance arrangements, including Trust Board, Quality and Performance Committee and executive-led maternity forums, with **no outstanding concerns or unresolved actions** arising from this reporting.

5.208. As improvements across Conditions 1–6 have become embedded and sustained, the enhanced reporting arrangements required under Condition 8 have **fulfilled their purpose**. Assurance has appropriately transitioned to routine business-as-usual governance, supported by integrated dashboards, audit, PSIRF-aligned learning and established escalation routes, reflecting improved stability and reduced regulatory risk.

5.209. Taken together, the Trust can demonstrate that the **requirements of Condition 8 have been met in full**, that ongoing risks are effectively managed through established governance arrangements, and that continued compliance is **sustainable without the need for enhanced regulatory reporting**.

5.210. Table: 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

Dates due	Update
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	– complete
31 March 2026	– complete
30 April 2026	This report
29 May 2026	Next Report

5.211. Maternity services dashboard

5.212. **We have** defined how information will be reported to the board, management, and other stakeholders and have updated our Perinatal Dashboard which complements the Perinatal Oversight Report.

5.213. Trust Board

5.214. The last Trust Board meeting was 12 March 2026, and the Board members reviewed the last February 2026 report and the next meeting is 14 May 2026.

(Link to the papers)

5.215. Quality and Performance Committee (sub board)

5.216. The Quality and Performance Committee reviewed the last S31 Report on 23 April 2026 and will next review progress 30 April 2026.

5.217. Perinatal (Maternity) Delivery Group (Executive led)

5.218. On 8 April 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).

6 Conclusion

In conclusion, the Trust may take assurance that robust ward-to-board governance arrangements are firmly embedded to maintain effective oversight of maternity safety and ongoing compliance with the CQC Section 31 conditions. Assurance is further strengthened through established local monitoring systems (including routine audit, dashboards and exception reporting), with clear escalation routes and an embedded, constructive culture of check and challenge through the Intrapartum Forum, Perinatal Oversight and Assurance Meeting and onward reporting to the Executive Team and Trust Board as required.

Key governance benefits

- Clear ward-to-board line of sight, supporting timely decision-making and executive/Board accountability.
- Early identification of variance through routine audit, dashboards and exception reporting, enabling proportionate action at the right level.
- Defined escalation routes through agreed forums, ensuring issues are progressed promptly when thresholds are not met or variance is sustained.

- Triangulated assurance (policy/standards, training/competency and performance data) to evidence sustainability beyond single-point compliance.
- Strengthened learning culture, with PSIRF-aligned review and closed-loop improvement actions tracked to completion.
- Improved transparency and assurance to regulators and system partners through consistent reporting and governance oversight.

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Enclosures

Current maternity dashboard (appendix A)

FOI: *Public*

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Report title	Perinatal Quality Oversight Report - March 2026 (version 4)
Sponsoring Director/Authors	Matt Holdaway, Chief Nurse and Director of Quality Sarah Ashwood, Perinatal Quality and Governance Lead Suzie Cro, Director of Quality Governance

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

Executive Summary

Executive Summary – Four As (Alert, Advise, Assure, Applaud)

Alert (matters requiring Trust Board attention)

- **Workforce and training:** Integrated Care Board decision required on funding for safety-critical posts (including four whole time equivalent consultant obstetrician posts (which have now been agreed)) and continued oversight of Newborn Life Support Training recovery until competence assurance is restored.
- **Maternity triage estates:** option appraisal and risk assessment for safe decanting in development; assurance required on interim risk controls during delivery.
- **Service suspensions:** temporary homebirth suspension (public/media interest) and other suspensions; action plan in place to restore services safely, with any impact on outcomes and experience monitored through governance.
- **External review dependencies and experience:** overdue external Perinatal Mortality Review Tool reviews and experience backlogs (including complaints) remain a risk to timely learning and assurance; actions are tracked and escalated by exception. There are now 3 reviews that require completion for care provided by external Trusts.

Advise (areas for Trust Board discussion and ongoing monitoring)

- **Improvement plan governance:** continue oversight of prioritisation, ownership, due dates and escalation for red-rated actions.
- **Service model and equity programme:** monitor progress of community transformation and the Health Needs Assessment case for change through Integrated Care Board, Trust Board and scrutiny routes.
- **Safety intelligence and action closure:** ongoing oversight of dashboard trends and the learning pipeline (patient safety investigations and learning responses, Maternity and Newborn Safety Investigations recommendations, Perinatal Mortality Review Tool timeliness) to evidence action and impact.

Assure (board-level assurance from this report)

- Governance and escalation routes are in place (including delegated committees, the Perinatal Oversight and Assurance Meeting and mandated support), supporting visibility of key risks, exceptions and decisions.
- Learning processes are operating across Patient Safety Incident Response Framework responses, Patient Safety Incident Investigations, the Perinatal Mortality Review Tool and the Maternity and Newborn Safety Investigations programme, with family engagement and duty of candour processes described and actions tracked through governance.
- Workforce and training assurance is being managed through the updated training needs analysis and recovery actions (including urgent Newborn Life Support reset training), with identified capacity gaps escalated.
- Service-user voice, equity and delivery assurance are beginning to be embedded through co-production with the Maternity and Newborn Voices Partnership, action tracking and escalation routes across priority workstreams (including triage, care bundles and culture improvement).

Applaud (progress and achievements)

- Governance has strengthened and external oversight is established, with a stable regulatory position and evidence held that Care Quality Commission Section 31 conditions have been met (pending September 2025 CQC inspection report).
- Maternity triage improvement has progressed, with over 80% of actions complete or in progress and recent recovery and stabilisation in triage performance while estates solutions are developed.
- Saving Babies Lives Care Bundle version 3.2 (compliance to ICB set standards) has been declared for Year 7 Maternity Incentive Scheme, with fetal monitoring reported as fully implemented and preterm birth audit activity completed and reviewed through governance.
- Learning and family engagement processes are active, with investigations and learning responses progressed, families informed and duty of candour undertaken; all Trust-led Perinatal Mortality Review Tool cases remain within timeframe.
- Culture and service-user voice have strengthened, with a perinatal culture programme under way and the Maternity and Neonatal Voices Partnership embedded across workstreams to support co-produced improvements.

Previously considered by	Quality and Performance Committee (updated post meeting to version 4 – this version) Perinatal Delivery Group (updated post meeting to version 3) Perinatal Oversight and Assurance Meeting (updated after meeting to version 2).

Recommendations:

- Note the Perinatal Quality Oversight Report assurance position, including the key risks and exceptions escalated in this report.
- Note the Integrated Care Board decision on funding for safety-critical workforce posts (including four whole time equivalent consultant obstetrician posts).
- Request continued Board-level oversight of the Newborn Life Support Training recovery plan until competence assurance is restored, with progress monitored through the Perinatal Quality Oversight Meeting governance and reported by exception.

- Request assurance on the maternity triage estates and decant programme (including interim risk controls) and continued oversight of delivery through the established governance route.
- Note the current service suspensions (including the county-wide homebirth pathway) and request ongoing oversight of the restoration plan and any impact on access, experience and outcomes.
- Note the reliance on external Trust-led Perinatal Mortality Review Tool reviews and experience backlogs as a risk to timely learning and assurance, and request continued escalation and tracking by exception until resolved.

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?
SR01 - Inability to deliver safe and effective services against regulatory and statutory requirements SR01 is impacted due to ongoing workforce and training compliance gaps, MIS Yr 7 non-compliance and service suspensions which may compromise delivery of safe and effective care against regulatory/statutory requirements, with controls through PQOM reporting and escalation, mandated support/MNiST oversight, PSIRF learning responses and monitored recovery action plans.

Implications on:	
Equality, Diversity and Inclusion	This report reinforces the need to design and deliver perinatal services that are accessible and culturally appropriate for all women and families—identifying and reducing inequities (e.g., by ethnicity, language need, and deprivation) so outcomes and experiences are fair and safe for everyone.

Health Inequalities	This report highlights that perinatal outcomes vary by deprivation and ethnicity, so services and improvement actions must target and monitor these gaps to reduce unequal outcomes for women and babies.
Finance and Resource	Delivery of the improvement programme may require additional funded capacity (e.g., substantive staffing, backfill for training and QI leadership time) and, as Maternity Incentive Scheme (MIS) actions were not met, could increase financial exposure through higher indemnity costs and reduced access to incentive funding.
Regulation/Legal	The report supports assurance against key regulatory and statutory duties (e.g., CQC requirements, PSIRF/MNSI reporting and Duty of Candour) and highlights that continued non-compliance with MIS safety actions may sustain external scrutiny and enforcement risk if not addressed.
CQC-Key line of enquiry	The report provides assurance and highlights gaps across CQC key lines of enquiry (Safe, Effective, Caring, Responsive and Well-led), particularly in relation to workforce capacity, training compliance, governance oversight and the impact of service suspensions on access and experience.
Green Plan	Actions should align with the Trust Green Plan by considering sustainability in service redesign and estates changes (e.g., minimising travel through digital-first approaches and reducing waste/energy impacts when implementing improvement and decant plans).

Main Report

March 2026 Perinatal Quality Oversight Report (February Data 2026)

1. Introduction

1.1. This report outlines nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHS England Perinatal Quality Oversight Model.

1.2. The purpose of the report is to inform the Trust Board of present or emerging concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team.

1.3. In line with the Perinatal Quality Oversight Model we are required to report the information outlined in the data measures proforma **as a minimum quarterly** to the Trust Board and this report covers:
- Structures and standards underpinning safer, personalised care, equitable care.
- Culture of learning, safety and support
- Workforce
- Listening to women and families

1.4. Data is for February 2026 except for where any exceptions are highlighted and the full operational report was viewed by the Quality and Performance Committee.

1.5. Next time the Board meet they will receive a quarterly report written to meet the NHS Resolution Maternity Incentive Scheme requirements for year 8 which was published in April 2026.

2. Structures and standards underpinning safer, personalised care, equitable care

2.1. **Three-Year Maternity and Neonatal Delivery Plan**

2.2. Current priorities are the CQC Section 31 plan, scanning, triage and community transformation, while awaiting the outcome of the national maternity and neonatal investigation and the new national plan expected in 2026.

2.3. **Perinatal Transformational Plan**

2.4. The Perinatal Transformation Board, supported by the Maternity and Neonatal Intensive Support Team Improvement Advisors, are reviewing and monitoring delivery of the prioritised improvement plans (including experience, scanning, transitional care, triage and community transformation), with exceptions and resourcing needs escalated through governance.

2.5. **Equitable care**

2.6. Perinatal Health Needs Assessment

2.7. The Health Needs Assessment has been presented to the Trust Board and identifies persistent inequalities; a Case for Change has been developed with programme governance and a defined timetable through the Integrated Care Board and Overview and Scrutiny, with solution development and consultation to follow.

2.8. **Data**

2.9. Perinatal Quality Dashboard - oversight

2.10. The Perinatal Quality Dashboard is used for Trust Board oversight of key safety and quality measures, including inequality monitoring through subgroup analysis, with any exceptions and required actions escalated through governance.

2.11. National Maternity Services Dashboard

2.12. Benchmarking via the National Maternity Services Dashboard is used to identify improvement priorities; current exceptions include third and fourth degree tears, with active review and a time-limited trial of the ONIRY Spectrometer to support accurate identification and learning associated with the detection and diagnosis/treatment of third and fourth degree tears.

2.13. **Quality Improvement work in maternity**

2.14. Quality improvement priorities are overseen through multidisciplinary governance, with focused workstreams on obstetric anal sphincter injury, massive obstetric haemorrhage review, avoiding term admission into neonatal units, and preparation for the maternal care bundle, escalating any exceptions through the Perinatal Oversight and Assurance Meeting.

2.15. Maternity Triage Improvement Programme

2.16. The maternity triage improvement plan is progressing (over 80% of actions complete or in progress) with performance stabilising, however a key risk remains the need for extensive estates work and safe temporary decanting to address capacity and line-of-sight issues for circa 15,000 attendances/annum, with potential disruption to workflow and staff areas being mitigated through option appraisal, risk assessment and executive-led oversight.

2.17. Saving Babies Lives Care Bundle version 3.2

2.18. Saving Babies Lives Care Bundle version 3.2 compliance has been declared to ICB set targets and is monitored through governance; key risks remain reduced fetal movement implementation and ultrasound capacity, and a recent reduction in uterine artery Doppler completion, with recovery actions and escalation in place. A briefing paper is due at the next Executive led Perinatal Delivery Group to further understand the improvement trajectory, risks and their controls.

3. Culture of learning, safety and support

Culture

3.1. Cultural Improvement Programme

3.2. A Perinatal Culture Improvement Plan is in place and progressing; Trust Board approval is required for MIS Year 8 compliance, and the key risks if not signed off and delivered are reduced staff confidence to speak up and learn, weaker multidisciplinary working and escalation behaviours, and continued external scrutiny where culture concerns are identified.

Safety

3.3. Maternity Incentive Scheme

3.4. The Maternity Incentive Scheme Year 7 submission and improvement plan were approved by Trust Board and submitted, with the key residual risks relating to previously non-compliant areas (perinatal mortality review processes, workforce and training assurance, and Board oversight), which are being managed through executive mandated support, named NHS England Maternity Improvement Advisor support, and tracked recovery actions through governance.

3.5. The final Maternity Incentive Scheme Year 7 submission report and action plan bid for discretionary funding was approved by Trust Board on 10th February 2026. It has been approved by the Integrated Care Board Accountable Officer and was submitted to NHS Resolution on 3rd March 2026. It has since been re-submitted to NHS Resolution on 1st April after a response that the funding requested could be increased.

3.6. Year 8 requirements have been received and a structured gap analysis is under way with named leads and governance oversight; the key risks are assurance gaps where the current reporting does not yet explicitly evidence minimum standards across workforce, training, learning, care bundles and Board oversight, and these are being managed through an agreed timetable to complete the evidence map and action plan, with escalation of any residual gaps for decision and support. These year 8 requirements will be all met in the next report to Trust Board.

3.7. **Patient Safety Incident Response Framework**

3.8. Perinatal Patient Safety Incidents Thematic Review and Response Plan

3.9. Assurance is provided that the perinatal service is aligned to the Trust Patient Safety Response Plan and Patient Safety Incident Response Framework, with the safety priority remaining delay in recognition and/or escalation of deterioration during pregnancy and/or delivery; improvement work is under way and monitored through governance, including implementation of Martha's Rule, strengthened postpartum haemorrhage risk assessment using the REDUCE checklist, fetal monitoring peer review and escalation processes, and early warning score

escalation (with preparation for national maternity early warning scores and Maternal Care Bundle implementation).

3.10. Patient Safety Incident Investigations and learning responses

3.11. Patient Safety Review Panel and the Safety and Experience Review Group provide oversight of open patient safety investigations and learning responses; the key risk is delay to completion or closure (including a deferred learning response awaiting further testing), and this is being managed through agreed action plans with scheduled review dates, with families informed and duty of candour undertaken where applicable.

3.12. There were 2 new Patient Safety Incident Investigations commissioned at Patient Safety Review Panel in February 2026.

3.13. Maternity and Newborn Safety Investigations programme

3.14. Maternity and Newborn Safety Investigations programme reporting is in place; no new reportable incidents were identified in February, three final reports were received and recommendations are being actioned through governance, with the key risks being timely closure of actions and receipt of the outstanding final report.

3.15. Themes in the reported cases relate to suspected hypoxic ischaemic encephalopathy and therapeutic cooling decisions, including cases progressed due to family or trust concerns and subsequent magnetic resonance imaging findings.

Table: MNSI cases and progress

Maternity and Newborn Safety Investigations programme reference	Reason for referral (summary)	Status	Family informed / duty of candour
MI-043955	Therapeutic cooling / potential hypoxic ischaemic encephalopathy	Final report received	Yes / Yes (24 June 2025)
MI-045356	Potential hypoxic ischaemic encephalopathy (not cooled)	Final report received	Yes / Yes (25 September 2025)
MI-046523	Therapeutic cooling / hypoxic ischaemic encephalopathy	Final report received	Yes / Yes (25 September 2025)
MI-046524	Therapeutic cooling / hypoxic ischaemic encephalopathy	Final report outstanding	Yes / Yes (23 September 2025)

3.16. Coroners Regulation 28 Report to Prevent Future Deaths (PFD)

3.17. There were no Coroner Inquests that concluded in February 2026. No PFD reports have been directly received by the Trust in February.

3.18. A Trust inquest was held in March 2026 and concluded with a narrative outcome, with no Prevention of Future Deaths report and no finding of neglect, providing assurance that learning has been identified and revised procedures have been implemented. The key learning relates to adherence to national neonatal resuscitation guidance (including timely administration of adrenaline), with implementation monitored through patient safety governance to ensure actions are sustained.

3.19. The service has also applied learning from a December 2025 Regulation 28 report (from another Trust) by updating infant feeding information in multiple languages on BadgerNet,

reinforcing that discussions must be specific to formula feeding, and strengthening access to translation and interpretation, with ongoing review of how families access information and support.

3.20. **Learning from Deaths - Perinatal Mortality Review Tool (PMRT)**

3.21. There were two stillbirths in February (with no maternal deaths, late fetal losses or neonatal deaths); cases are being reviewed through the Perinatal Mortality Review Tool with learning actions escalated and tracked through governance.

3.22. Findings of reviews of all perinatal deaths using Perinatal Mortality Review Tool (PMRT) (published reports)

3.23. Care is graded in terms of care up until point of baby having died and after confirmation of death, this review is undertaken by a multidisciplinary team panel with an external member, see table below.

Table: PMRT grading key

Key to PMRT grading	
Grade A	**No issues** identified that would have impacted on the outcome.
Grade B	Care issues which would have **made no difference** to the outcome
Grade C	Care issues which **may have made a difference** to the outcome
Grade D	Care issues which were **likely to have made a difference** to the outcome

3.24. Our current PMRT review position is that we have 17 open cases – 5 where GHNHSFT is the lead reviewer and 12 where an external Trust is the lead reviewer. There are no overdue GHNHSFT-led cases. The overdue position relates to external Trust-led reviews (i.e., reviews of care within their organisations rather than ours); this has improved from 10 significantly overdue cases to 3.

Table current open cases

Number of open cases with GHNHSFT as lead reviewer	**Number of cases with external Trust as lead reviewer**	**Number of cases overdue with GHNHSFT as lead reviewer**	**Number of cases overdue with external Trust as lead reviewer**
5	12	0	10

3.25. All Perinatal Mortality Review Tool cases where the Trust is the lead reviewer remain within the required six-month timeframe and are monitored through governance; the key risk is reliance on external Trust-led reviews (12 open, 10 significantly overdue, some originating from 2020), which may delay triangulated learning, and this is being managed through escalation and active tracking to completion, noting the outstanding reviews relate to care provided by other organisations.

3.26. Table: PMRT cases reviewed in February 2026

Case	**Care before death (grade/summary)**	**After confirmation of death (grade/summary)**	**Actions**
100570	C - missed growth scan appointment process	B - delayed follow-up of postnatal blood tests	Review ultrasound booking process; implement postnatal

Case	Care before death (grade/summary)	After confirmation of death (grade/summary)	Actions
			results follow-up pathway; investigation in progress.
99957	B - hypertension management learning (no outcome impact)	A - no issues identified	Update triage process: obstetric review before discharge when hypertension has normalised.

3.27. The service is proactively using data to prevent future deaths and is currently compliant with reporting requirements.

3.28. Table: Current compliance with Maternity Incentive Scheme (MIS) Safety Action

Required Standard; Are you reviewing the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2025 to November 2026 to the required standard	**Current position**
a) Notify all death: All eligible perinatal deaths should be notified to MBRRACE-UK/SPEN within 7 working days	100% We have had 3 eligible cases during this time frame, and this was reported within the 7-day timeframe
b) Seek parents' views of care: For at least 95% of all deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2025 onwards	100% of parents have been informed and follow up letter sent to support receipt of parent's perspectives
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multidisciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT	On target
d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2025	Monthly overview will be provided within the PQOM report with additional quarterly reviews for Board. PQOM report will be shared bi-monthly with the Trust

Required Standard; Are you reviewing the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2025 to November 2026 to the required standard	**Current position**
	Maternity and Board safety champions

3.29. Thematic learning from Perinatal Mortality Review Tool reviews (quarters 1-3)
3.30. The service has reviewed quarterly Perinatal Mortality Review Tool themes for quarters 1-3 and is using this learning to prioritise and evidence improvement.
3.31. Recurring themes across quarters 1-3 include maternity triage capacity and timeliness, communication, diabetes pathways, and core clinical fundamentals and escalation processes.
3.32. Improvement actions are in place or under way, including the triage improvement plan (with guideline review, study days, real-time dashboard and estates plan), communication learning embedded into mandatory training, and diabetes guideline benchmarking with additional training and workforce review.
3.33. Quarter 1 themes also drove strengthening of aspirin risk assessment and administration processes and targeted improvements to translation and interpretation access (including additional equipment and booking focus).
3.34. An annual thematic review and triangulation of safety intelligence will be included in the next quarterly report to provide Trust Board assurance on learning, action and impact.

3.35. **MBRRACE-UK perinatal mortality report: 2024 births within GHNHSFT**
3.36. The March 2026 MBRRACE-UK report provides benchmarking for 2024 births and indicates that overall stillbirth and extended perinatal mortality rates are broadly in line with peers, with neonatal mortality lower than peers; however, the key risks are that stillbirth and extended perinatal mortality excluding congenital anomalies are more than 5% higher than peers and the offer of post-mortem following stillbirth is lower than national.
3.37. Actions are in progress to validate data completeness/accuracy, ensure Perinatal Mortality Review Tool reviews are completed and learning implemented, strengthen post-mortem consent training and patient information (including accessible formats), and monitor delivery through perinatal governance with escalation by exception.

3.38. **Regulatory Activity and Notification of Concern (MNSI/NHSR/CQC)**
3.39. No new concerns were received from the Maternity and Newborn Safety Investigations programme, NHS Resolution, the Care Quality Commission or the Maternity Outcomes Signal System in February 2026; the service holds evidence that all Care Quality Commission Section 31 conditions have been met and will apply for removal once the September 2025 inspection report is received, with the key risk being ongoing external scrutiny while the report is awaited, managed through continued governance monitoring and readiness to respond to any additional actions identified.

3.40. **Trust Commissioned External Independent Perinatal Mortality Reviews (published September 2025)**
3.41. Two external independent reviews were commissioned by the Chief Executive Officer (one focused on neonatal mortality 2020-2023 and one on safety systems and maternal mortality 2017-2022) and are being managed through Trust governance to ensure learning is translated into action and sustained improvement.

3.42. Maternal Mortality Review (INC-34492)
3.43. Maternal mortality review (INC-34492): five improvement recommendations have been completed, with closure temporarily held pending further evidence for the venous thromboembolism action; controls/actions now in place include completion of the venous

thromboembolism audit, publication of the venous thromboembolism guideline and appointment of the venous thromboembolism lead obstetrician, with final assurance and closure scheduled through the May 2026 Safety and Experience Review Group and Perinatal Oversight and Assurance meeting.

3.44. Neonatal Mortality Review (INC-31171)

3.45. Neonatal mortality review (INC-31171): external reviewers identified nine cases for further consideration; four cases had already been investigated externally and all associated recommendations have been closed, one case required no further investigation by agreement with the family, and four cases were progressed through the Patient Safety Review Panel as Patient Safety Incident Investigations with terms of reference shaped with family input. The Patient Safety Incident Investigations have been completed and received through the Safety and Experience Review Group, action plans agreed and monitored to closure, with the key risks being timely completion of outstanding actions (including overdue actions) and sustained engagement where a family has been difficult to contact despite repeated attempts. The overarching action plan remains in place and the final date for all actions was end of April 2026.

Support

3.46. Perinatal Safety Champions Meetings/ Engagement Events

3.47. There was a Perinatal Safety Champions walk around 18th February 2026 in the Cheltenham Aveta Birth Centre.

3.48. Table: Perinatal Safety Champion Feedback

Feedback raised by staff	**Action and progress**
No concerns raised by staff	N/A
Feedback raised by service users	**Action and progress**
None received via safety champions	N/A
Additional safety champions intelligence	**Action and progress**
No new evidence	

3.49. **Maternity and Neonatal Improvement Support Team (previously the Maternity Safety Support Programme)**

3.50. Executive-led Maternity and Neonatal Improvement Support Team governance is in place and the current workstreams are being reviewed, with actions agreed and tracked to completion through the improvement plan and assurance board. Key progress includes stabilising the leadership model during recruitment, refining the perinatal improvement plan, completing the training needs analysis refresh and workforce strategy work (including postnatal workforce skill mix), progressing the Newborn Life Support training recovery plan, and embedding service-user voice through the fully recruited Maternity and Neonatal Voices Partnership and development of the Care Quality Commission Maternity Survey action plan.

3.51. The key risks remain funding gaps for safety-critical posts (including four whole time equivalent consultant obstetrician posts – which has now been resolved), potential interim leadership gaps during recruitment, and delivery of community transformation including safe reinstatement of homebirth under external scrutiny; these are being escalated through the leadership “quad” assurance route and system partners where required.

3.52. **National Maternity and Neonatal Investigation**

3.53. The Trust is one of 12 organisations under review; the investigation data request has been submitted and senior leader interviews completed, with the national report expected in late spring and the interim report Trust action plan in place to be monitored through governance.

4. Workforce: Safer Perinatal Staffing

4.1. **Training Compliance**

4.2. Training is aligned to the Maternity Core Competency Framework (version 2) and the refreshed Training Needs Analysis (including previously excluded staff groups) is being finalised; a current headroom gap is identified (21% against a minimum 24% and indicative need of 26%), alongside cross-divisional data gaps and capacity constraints due to vacancies in training administration and practice development. Recovery actions are in progress through governance, including additional training dates, recruitment actions and strengthened monitoring and reporting via divisional tools and the Perinatal Delivery Group and Quality and Performance Committee, and Newborn Life Support training/competence is being addressed through a recovery plan following a 31% spot-check with urgent reset training commenced in March.

4.3. **Obstetric and Midwifery Fill Rates and Vacancies**

4.4. Staffing cover in February remained stable (midwifery shift fill rates 91% day/97% night and obstetric rota gaps 100% filled), however vacancy pressures and reliance on locum cover remain key risks (including midwifery and neonatal nursing vacancies and delayed recruitment to additional consultant obstetrician posts pending Integrated Care Board funding), with mitigations in place through recruitment plans, workforce reviews and ongoing escalation through governance.

4.5. **Red flag reporting**

4.6. Red flag reporting is in place with 1:1 care in labour and supernumerary labour ward coordinator cover maintained in February; the key risk is poor compliance in recording red flags, and this is being addressed through an improvement plan (including review of the flow midwife role), with monitoring through governance.

4.7. Table: Red flags were reported during February 2026

Red flag (top occurrences - February 2026)	Maternity ward	Delivery suite	Gloucester Birth Unit	Total
Delay in providing pain relief	4	0	0	4
Delayed or cancelled time critical activity	1	2	0	3
Delay between admission for induction and beginning of process	2	1	0	3

4.8. **Closures and suspensions of services**

4.9. The maternity service continues to operate with three temporary service suspensions; the temporary county-wide homebirth suspension has attracted public and media attention and a time-critical action plan is being implemented to reopen the service as quickly as possible with safety foremost, while alternative birth choices remain available through Stroud and Gloucester Birth Unit with capacity and the impact on outcomes and experience is monitored and escalated through governance.

5. Listening to women and families

5.1. **Insights from service users and Maternity and Neonatal Voices Partnership co-production**

5.2. **CQC Maternity Survey 2024/2025**

5.3. Board assurance is provided that a co-produced Maternity Experience Improvement Plan is in place with the Maternity and Neonatal Voices Partnership, focused on the key themes of communication, maternity ward environment/responsiveness, maternity triage delays/communication and infant feeding.
5.4. Delivery is tracked through an action log with a RAG summary reported to governance (Complete: 9; Working towards: 1; On track: 3; Escalations/alert: 3), with mitigations agreed and monitored where actions are delayed.

5.5. **Cross Cultural Communication and Language Support**
5.6. A gap analysis against the Royal College of Obstetricians and Gynaecologists cross-cultural communication and language support standards (December 2025) is in progress and will complete by end April 2026; the key risk is communication inequity affecting informed consent and safe care, and this is being managed through interim controls to strengthen access to professional interpretation and translated information (and avoid reliance on informal interpreters), with delivery tracked through governance and escalated by exception. An initial report will be received by the Perinatal Oversight and Assurance Meeting.

5.7. **Birth Review and Reflect Service**
5.8. There remain risks to timely service delivery and equitable access for all women (including potential delays to debrief appointments). These are being managed through an active service review (including access routes), governance monitoring of waiting times and allocation, and embedding learning into training and standards, informed by service-user feedback with recurring themes centred on communication (including decision-making, expectations and documentation), maternity triage experience and maternity ward responsiveness.

5.9. **Friends and Family Test**
5.10. Experience data is reviewed monthly and translated into improvement actions: Friends and Family Test feedback continues to highlight strong staff support in labour and postnatal care, with recurring improvement themes and risks relating to pain management, use of birth plans, communication and responsiveness (including call bell response times), clinic delays and the postnatal ward environment.

5.11. **Complaints and Patient Advice and Liaison Service feedback and learning**
5.12. Complaints and Patient Advice and Liaison Service themes are monitored through governance; the current risk is timeliness of complaint responses due to a material backlog (open and overdue), and this is being managed through weekly case management with the complaints lead, prioritisation of overdue cases, and escalation of any safety themes into the patient safety governance route.

5.13. **Neonatal Transitional Care Action Plan**
5.14. The Neonatal Transitional Care action plan is being delivered and monitored through the monthly Transitional Care Working Group (with the majority of actions complete or on track); the key risk is continuity of the Neonatal Outreach Service following expiry of the fixed-term contract in December 2025, and this is being escalated for a decision on extension or permanent establishment to sustain safe delivery.

6. Conclusion

6.1. Overall, this report provides the Trust Board with assurance that governance systems, learning and oversight arrangements are in place and that priority improvement actions are being progressed, with escalation by exception through the service level Perinatal Oversight and Assurance Meeting and Executive level Mandated Support.
6.2. The principal risks requiring continued Trust Board attention are workforce capacity and training assurance (including Newborn Life Support recovery), delivery of the maternity triage

estates and decant programme, service suspensions (including the homebirth pathway) and external dependencies affecting timely completion of Perinatal Mortality Review Tool reviews. The Trust Board is asked to note the assurance position and exceptions.

Appendix 1 Perinatal Quality Dashboard (separate document) Appendix 2 Training Compliance (see next section)
FOI: Public

Appendix 2	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026
Training Compliance for all staff groups in Maternity						
Perinatal Day	Midwives 96% Maternity Care Assistants/Nurses 92%	Midwives 96% Maternity Care Assistants/Nurses 92% MCA/Nurses 92%	Midwives 93% MCA/Nurses 92%	Midwives 80% MCA/Nurses 84%	Midwives 80% MCA/Nurses 84%	
Fetal Monitoring	Midwives 94% Obstetric Consultant 100% Obstetric Registrar 86%	Midwives 94% Obstetric Consultant 100% Obstetric Registrar 86%	Midwives 95% Obstetric Consultant 100% Obstetric Registrar 86%	Midwives 92% Obstetric Consultant 93% Obstetric registrar 76%	Midwives 92% Obstetric Consultant 92% Obstetric registrar 70%	
PROMPT	Midwives 95% Midwives 95% Maternity Support Workers/Nurses 94% Obstetric Consultant 100% Obstetric Registrar 91% Obstetric Specialty Trainee year 1/2 100% Anaesthetist – Missing data Staff and Associate Specialist/Consultant 91% Anaesthetic Trainee 100% Obstetric Consultant 100% Obstetric Registrar 91% Obstetric ST1/2 100% Anaesthetist – Missing data SAS/Consultant 91% Anaesthetic Trainee 100%	Midwives 95% MCA/Nurses 94% Obstetric Consultant 100% Obstetric Registrar 92% Obstetric ST1/2 100% Anaesthetist –Missing data SAS/Consultant 96% Anaesthetic Trainee	Midwives 97% Maternity Care Assistants/Nurses 94% Obstetric Consultant 93% Obstetric Registrar 91% Obstetric Specialty Trainee year 1/2 100% Senior House Officer / General Practitioner / Foundation Year – 93% Anaesthetist – Staff and Associate Specialist/Consultant 95% Anaesthetic Trainee 100% MCA/Nurses 94% Obstetric Consultant 93% Obstetric Registrar 91% Obstetric ST1/2 100% SHO GP/FY – 93% Anaesthetist – SAS/Consultant 95% Anaesthetic Trainee 100%	Midwives 77% MCA/Nurses 78% Obstetric Consultant 71% Obstetric Registrar 76% Obstetric ST1/2 100% SHO GP/FY – 89% Anaesthetist – SAS/Consultant 82% Anaesthetic Trainee 85%	Midwives 92% MCA/Nurses 83% Obstetric Consultant 83% Obstetric Registrar 80% Obstetric ST1/2 100% SHO GP/FY – 100% Anaesthetist – SAS/Consultant 86% Anaesthetic Trainee 100%	

Newborn Life Support	Neonatal consultants 100% Neonatal juniors missing data Neonatal nurses MSD 98% Neonatal Nursing 72% Midwives 96% MSW 92%	Neonatal consultants 100% Neonatal juniors missing data Neonatal nurses 72% Neonatal nurses MSD 98% Midwives 96% MSW 92%	Neonatal consultants Neonatal juniors Neonatal nurses Neonatal nurses MSD Midwives 93% MSW 92%	Neonatal consultants Neonatal juniors Neonatal nurses Neonatal nurses MSD Midwives 80% MSW 84%	Midwives 80% MSW 84%	
Mandatory Training	Midwives 88% MSW 88% Neonatal Nursing 98%	Midwives 88% MSW 88% Neonatal Nursing 98%	Midwives – 89% MSW 87%	Midwives – 89% MSW – 89%	Midwives – 89% MSW – 91%	
Equality/ equity/ personalised care	Midwives 95% MSW	Midwives 95% MSW 94%	Midwives 97% MSW 94%	Midwives 77% MSW 78%	Midwives 92% MCA/Nurses 83%	
Care during labour and immediate post-natal period	Midwives 95% MSW 92%	Midwives 96% MSW 92%	Midwives 93% MSW 92%	Midwives 80% MSW 84%	Midwives 80% MSW 84%	
December						
Safeguarding Children's	Non-Medical	Medical	TBA			
Children L1	97%	n/a	Non-medical – 97% Medical – n/a	Non-medical 98% Medical - na	Non-medical 100% Medical - na	
Children L2	94%	74%	Non-medical 97% Medical 74%	Non-medical 94% Medical 71%	Non-medical 94% Medical 71%	
Children Multiagency Day	92%	71%	Non-medical 92% Medical 71%	Non-medical 94% Medical 72%	Non-medical 94% Medical 77%	
Children L3 (1 Year)	85%	68%	Non-Medical 85% Medical 68%	Non-medical 81% Medical 77%	Non-medical 81% Medical 77%	
Adults L1	98%	n/a	Non-medical n/a Medical -98%	Non-medical 98% Medical -na	Non-medical 100% Medical - na	
Adults L2	90%	54%	Non-medical n/a Medical 90%	Non-medical 88% Medical - na	Non-medical 89% Medical - na	
Adults L3			Non-medical 85% Medical 54%	Non-medical 83% Medical 51%	Non-medical 80% Medical – 48%	

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Perinatal Dashboard

March PQOM (February Data 2026)

caring | inclusive | compassionate | accountable

Perinatal Quality Oversight Dashboard Executive Summary

Alert
Several indicators show **recent variation and emerging special-cause signals**, particularly in **mode of birth (caesarean sections, inductions)** and **activity measures** (registrable births and deliveries). While most safety and experience metrics remain within expected limits, these trends warrant **continued oversight to ensure sustainability and avoid unintended impact on outcomes**.

Advise
Maintain **focused review through Perinatal Quality Oversight**, triangulating dashboard signals with **case review, workforce pressures, and pathway capacity**. Priority attention should be given to **drivers of intervention rates**, alongside ongoing monitoring of **timeliness (triage)** and **early engagement with maternity services** to support prevention and equity.

Executive summary (continued)

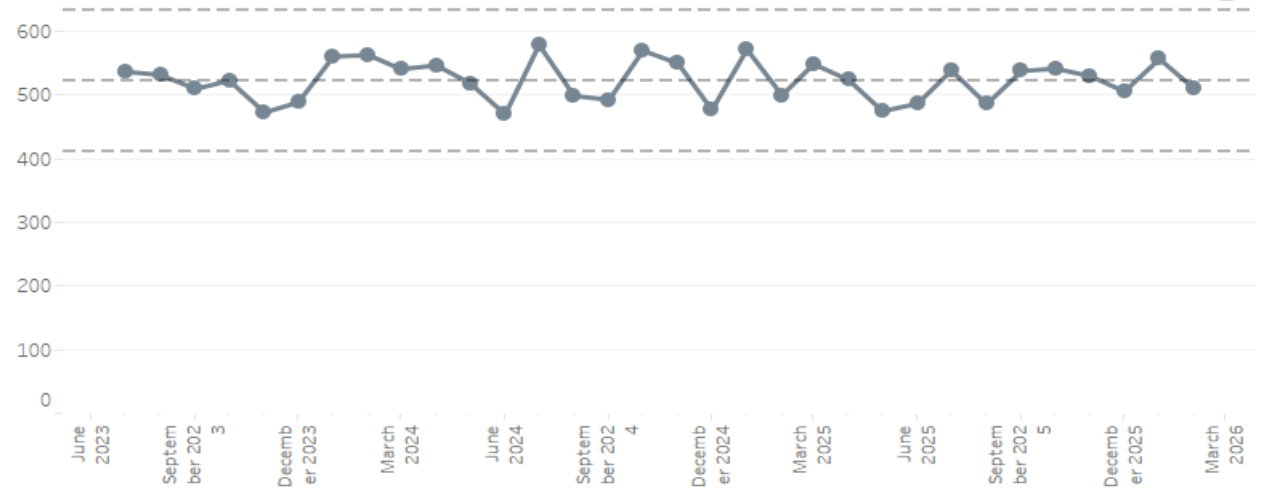
Assure
Key measures of **early access to care**, **breastfeeding initiation**, and **triage timeliness** remain **stable and largely within expected variation**, providing assurance that **core safety and experience processes are being delivered consistently** despite service pressures. No widespread adverse system deterioration is indicated.

Applaud
The dashboard demonstrates **strong data completeness, regular SPC application, and transparent reporting**, enabling timely identification of variation and supporting a **mature quality surveillance approach**. Stable performance across several outcome and experience measures reflects **sustained clinical and operational effort across maternity and neonatal teams**.

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

Category: Access

Number of Bookings



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	523.0	474.0	486.0	538.0	485.0	537.0	541.0	529.0	505.0	556.0	509.0

Data Observations:

Common cause - no significant change

Metric Info:

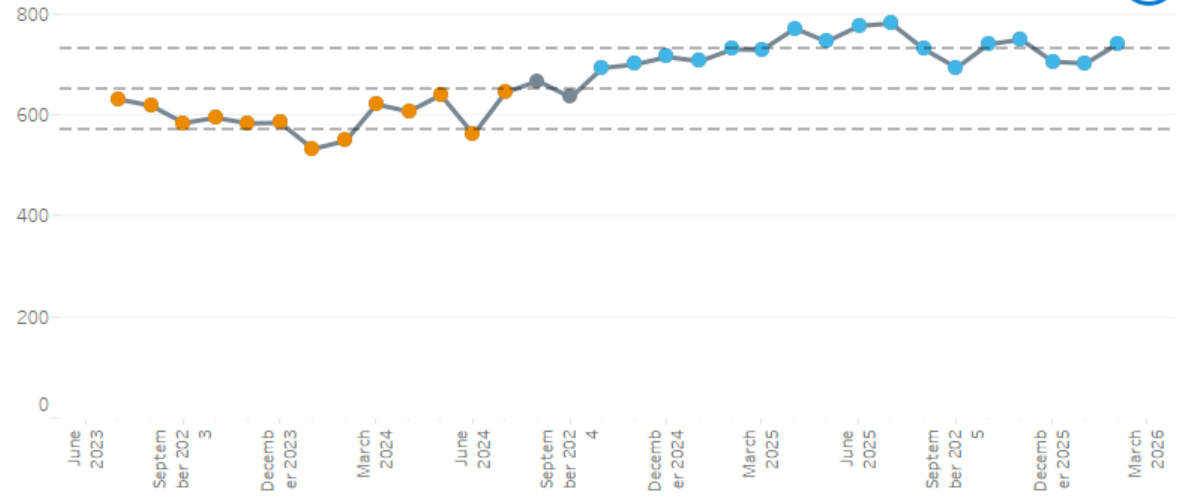
Number of: **GHT Bookings**

Foundations for safe staffing and capacity decisions

- Provides an early indicator of future demand across antenatal, intrapartum and postnatal pathways
- Informs midwifery, obstetric, neonatal and triage workforce planning and escalation thresholds
- Supports clinic, triage and delivery suite capacity modelling and rostering decisions
- Enables proactive mitigation of pressure before impacts on safety, timeliness or experience occur
- Distinguishes genuine changes in demand from normal fluctuation, preventing inappropriate over- or under-response

Category: Access

Booked by 10+0 Weeks Gestation



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	770.6	744.7	775.7	780.7	729.9	692.7	739.4	748.6	705.0	701.4	740.7

Data Observations:

Special cause of improving nature or lower pressure due to (H)igher values

Metric Info:

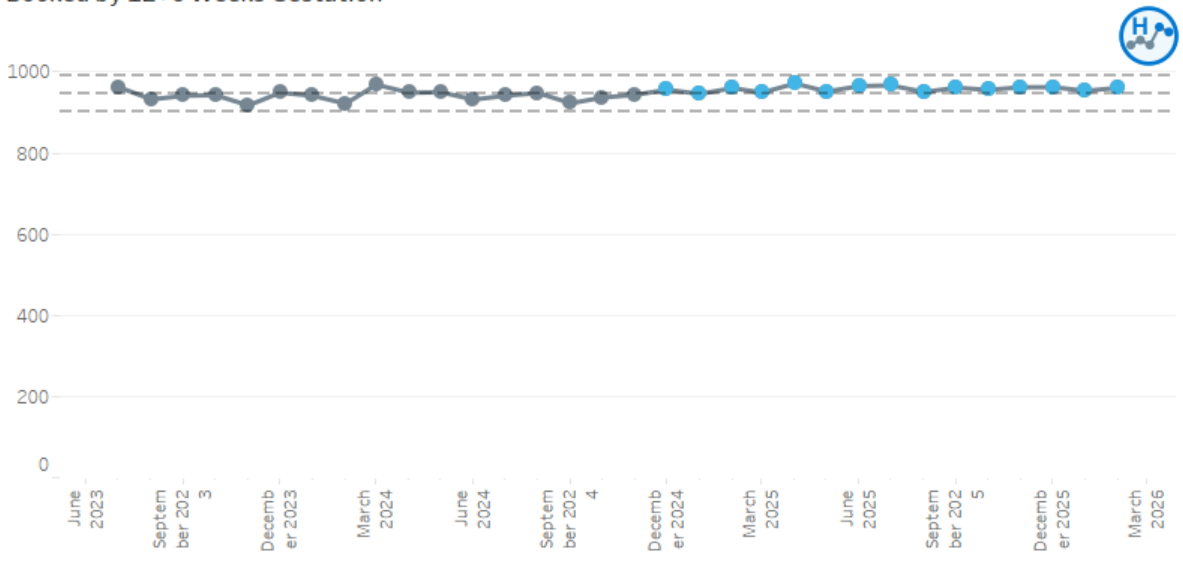
Rate of: Booked by 10+0 Weeks

Per 1,000: GHT Bookings

Slide 5 demonstrates whether women are booking into maternity care by 10 weeks' gestation over time, and this is important because early booking is a key driver of safety, prevention and health-inequality reduction, providing assurance that timely access to care is being sustained or highlighting where targeted improvement is required.

Category: Access

Booked by 12+6 Weeks Gestation



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	971.3	951.5	965.0	966.5	950.5	960.9	955.6	962.2	962.4	953.2	960.7

Data Observations:

Special cause of improving nature or lower pressure due to (H)igher values

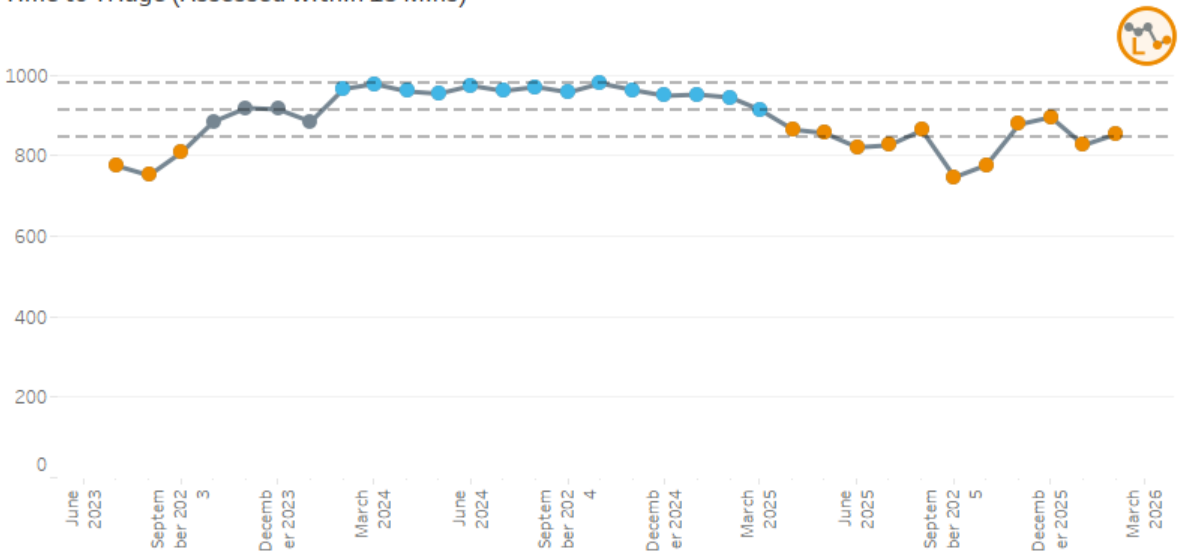
Metric Info:

Rate of: Booked by 12+6 Weeks

Per 1,000: GHT Bookings

Category: Access

Time to Triage (Assessed within 15 Mins)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	865.5	856.6	821.3	826.4	863.6	747.2	777.2	878.3	896.2	826.8	854.3

Data Observations:

Special cause of concerning nature or higher pressure due to (L)ower values

Metric Info:

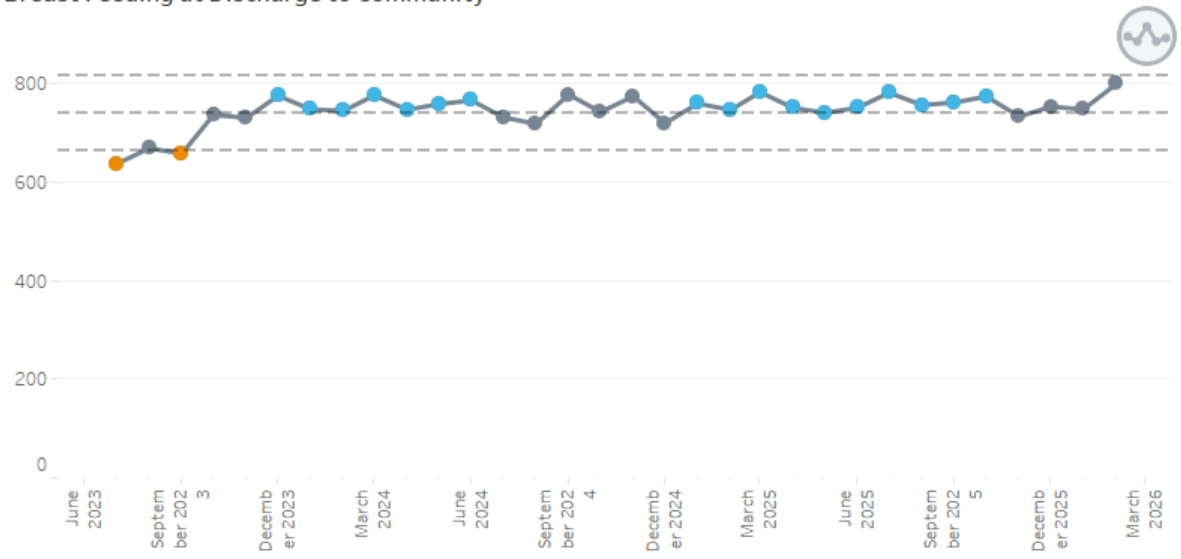
Rate of: Initial Triage Assessment within 15 Mins

Per 1,000: Triage Attendances

Slide 7 demonstrates performance against the maternity triage timeliness standard (assessment within 15 minutes) over time using SPC, and this is important because timely triage is a critical safety control that provides assurance women are being clinically assessed promptly and highlights early warning signs of pressure, risk, or deterioration requiring quality improvement action.

Category: Feeding

Breast Feeding at Discharge to Community



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	751.3	741.3	751.3	782.1	757.0	762.3	774.4	733.9	753.5	748.7	800.0

Data Observations:

Common cause - no significant change

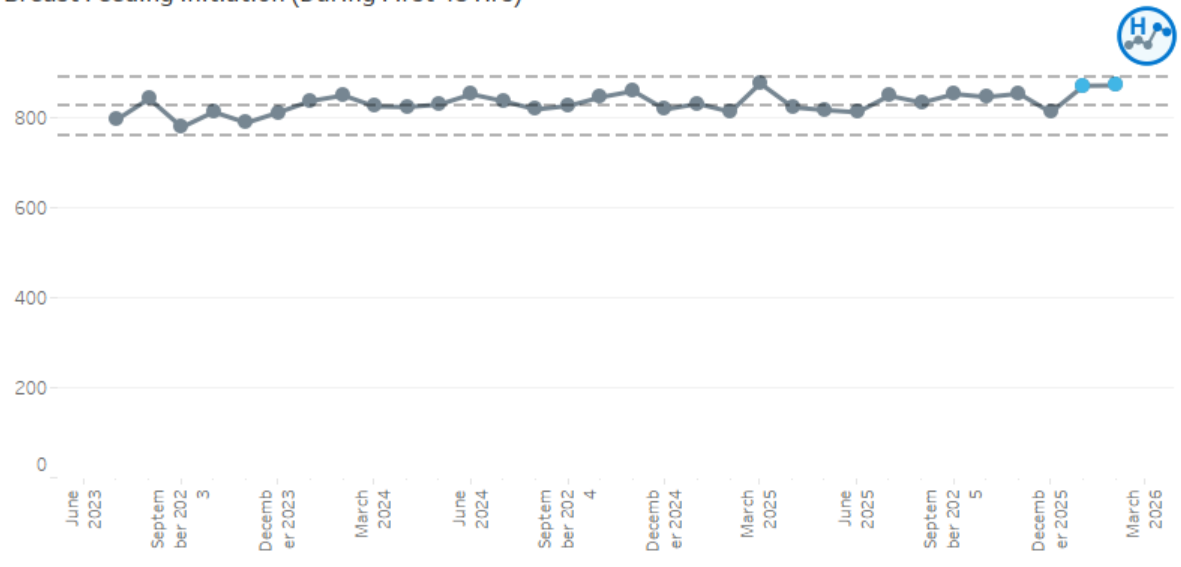
Metric Info:

Rate of: Breast Feeding at Discharge

Per 1,000: Women with Recorded Transfer to Community Feeding Update

Category: Feeding

Breast Feeding Initiation (During First 48 Hrs)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	822.4	816.4	811.5	848.1	832.9	852.0	845.3	852.7	811.2	870.3	871.1

Data Observations:

Special cause of improving nature or lower pressure due to (H)igher values

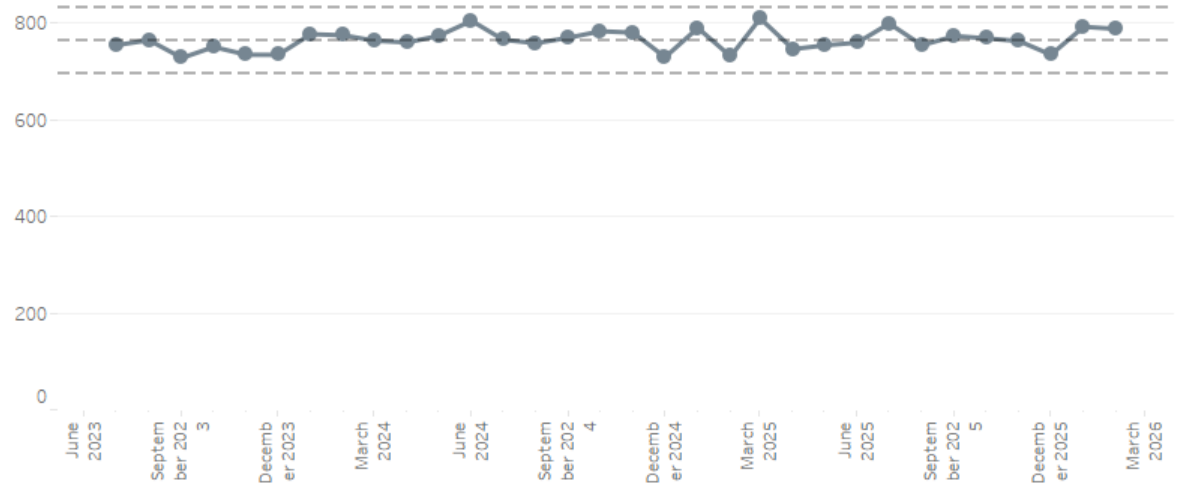
Metric Info:

Rate of: Breast Feeding Initiated

Per 1,000: Women with Recorded Feeding Update (First 48 Hrs)

Category: Feeding

First Feed Breast Milk



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	746.6	754.4	760.0	799.6	754.6	773.6	768.9	763.2	734.9	792.7	788.4

Data Observations:

Common cause - no significant change

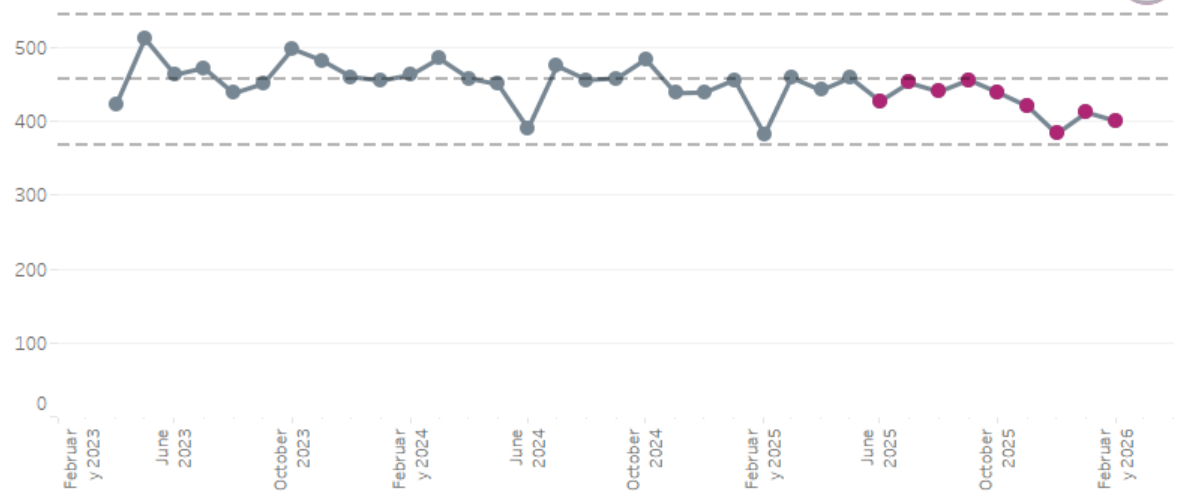
Metric Info:

Rate of: First Feed Breast Milk

Per 1,000: Babies with Recorded First Feed

Category: Births & Deliveries

Number of Registerable Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	442.0	459.0	427.0	452.0	440.0	456.0	439.0	420.0	383.0	412.0	400.0

Data Observations:

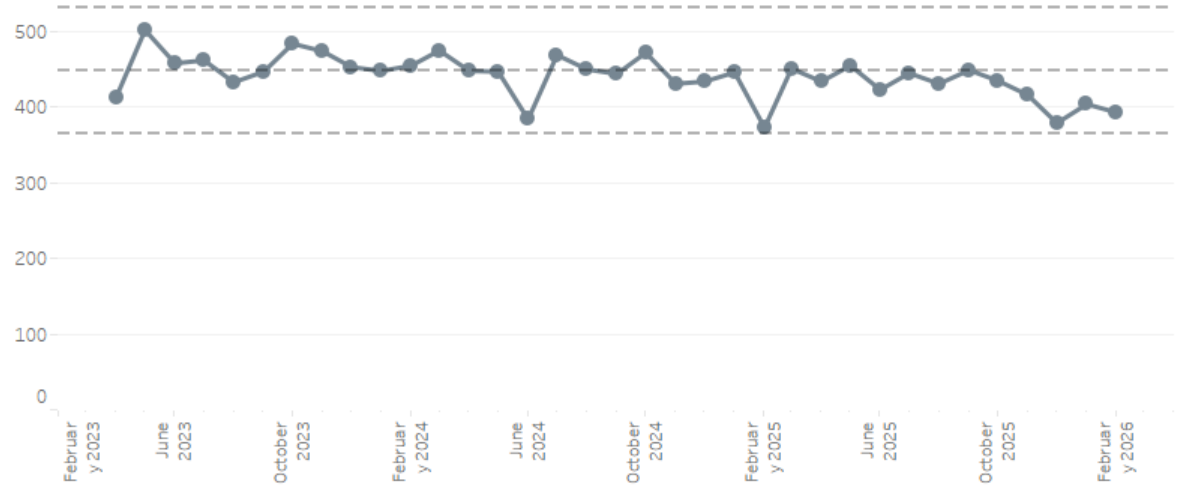
Special cause variation due to (H)igher or (L)ower values

Metric Info:

Number of: **Registerable Births**

Category: Births & Deliveries

Number of Registerable Deliveries



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	434.0	455.0	423.0	445.0	431.0	449.0	435.0	416.0	379.0	404.0	393.0

Data Observations:

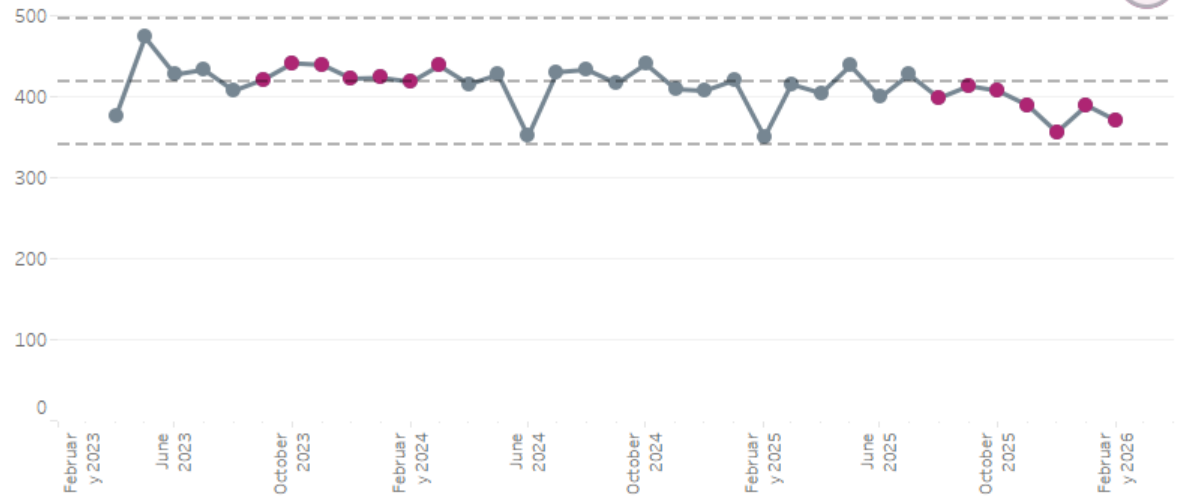
Common cause - no significant change

Metric Info:

Number of: **Registerable Deliveries**

Category: Births & Deliveries

Number of Term Births



Data Observations:

Special cause variation due to (H)igher or (L)ower values

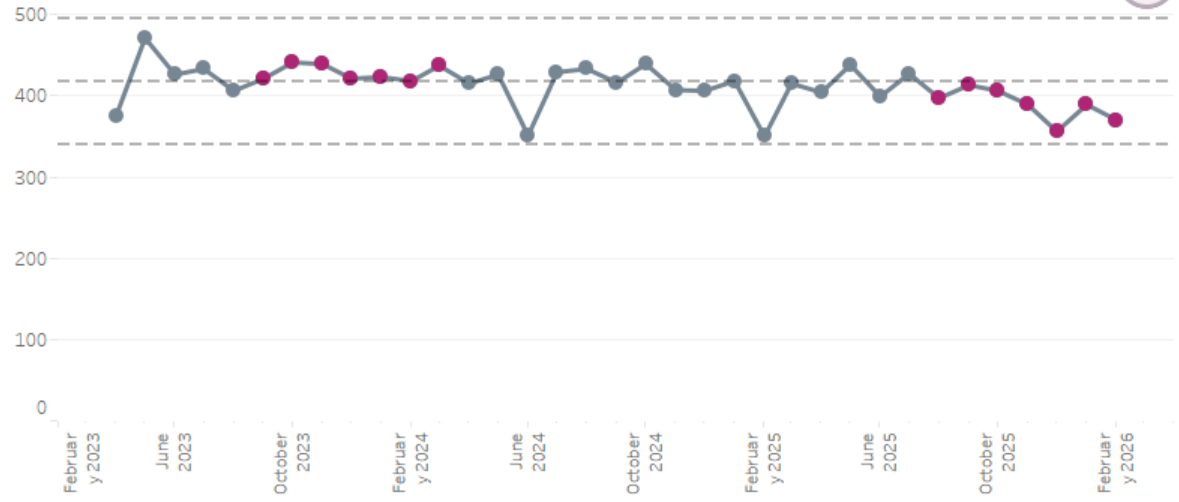
Metric Info:

Number of: **Term Births**

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	404.0	438.0	399.0	427.0	398.0	413.0	407.0	389.0	356.0	389.0	370.0

Category: Births & Deliveries

Number of Term Live Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	404.0	438.0	399.0	427.0	397.0	413.0	406.0	389.0	356.0	389.0	370.0

Data Observations:

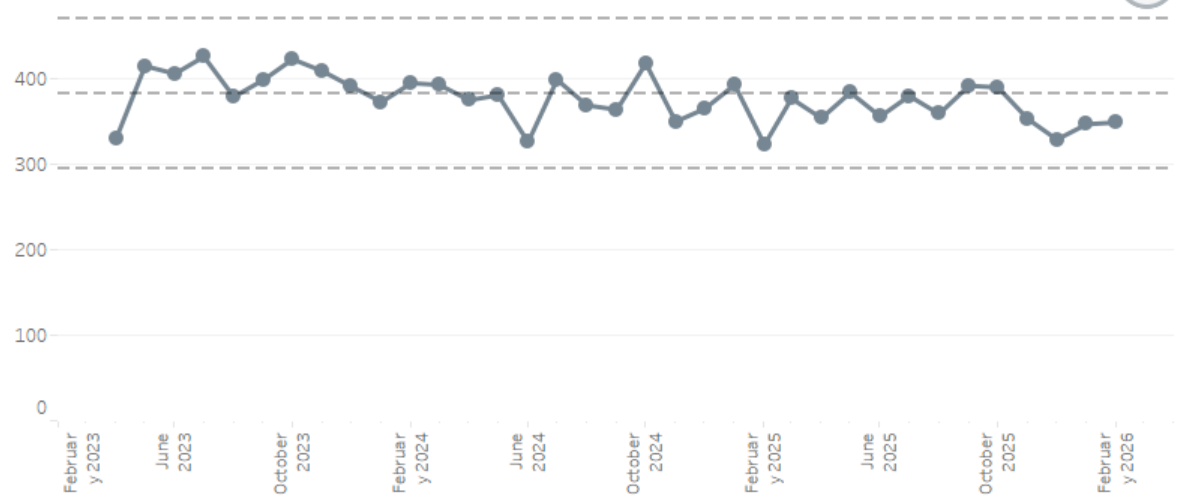
Special cause variation due to (H)igher or (L)ower values

Metric Info:

Number of: **Term Live Births**

Category: Births & Deliveries

Number of Births - Delivery Suite Gloucester



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	354.0	384.0	356.0	380.0	359.0	392.0	390.0	353.0	329.0	347.0	349.0

Data Observations:

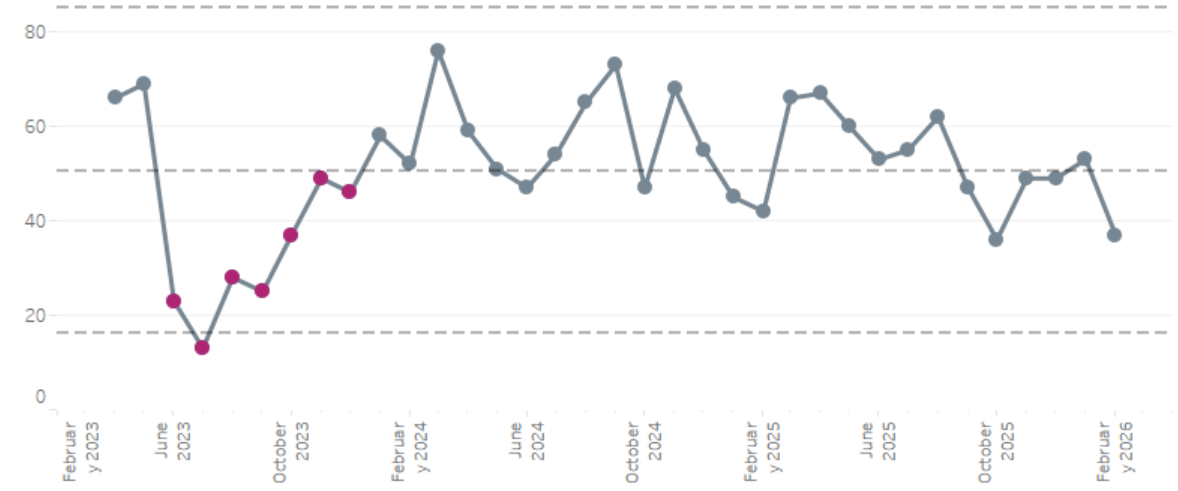
Common cause - no significant change

Metric Info:

Number of: **Registerable Births (CDS)**

Category: Births & Deliveries

Number of Births - Gloucester Birth Unit



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	67.0	60.0	53.0	55.0	62.0	47.0	36.0	49.0	49.0	53.0	37.0

Data Observations:

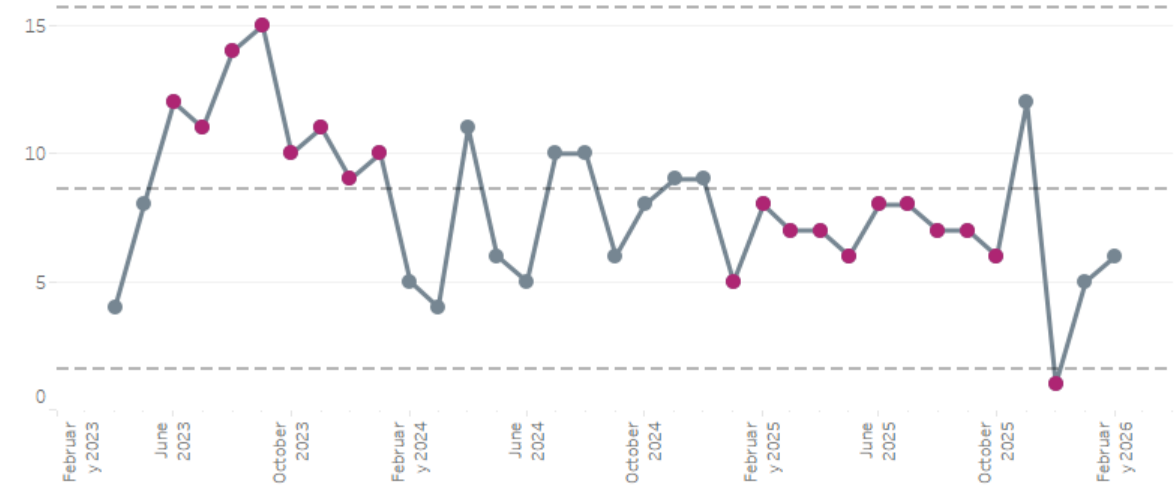
Common cause - no significant change

Metric Info:

Number of: **Registerable Births (GBU)**

Category: Births & Deliveries

Number of Births - Stroud Maternity



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	7.0	6.0	8.0	8.0	7.0	7.0	6.0	12.0	1.0	5.0	6.0

Data Observations:

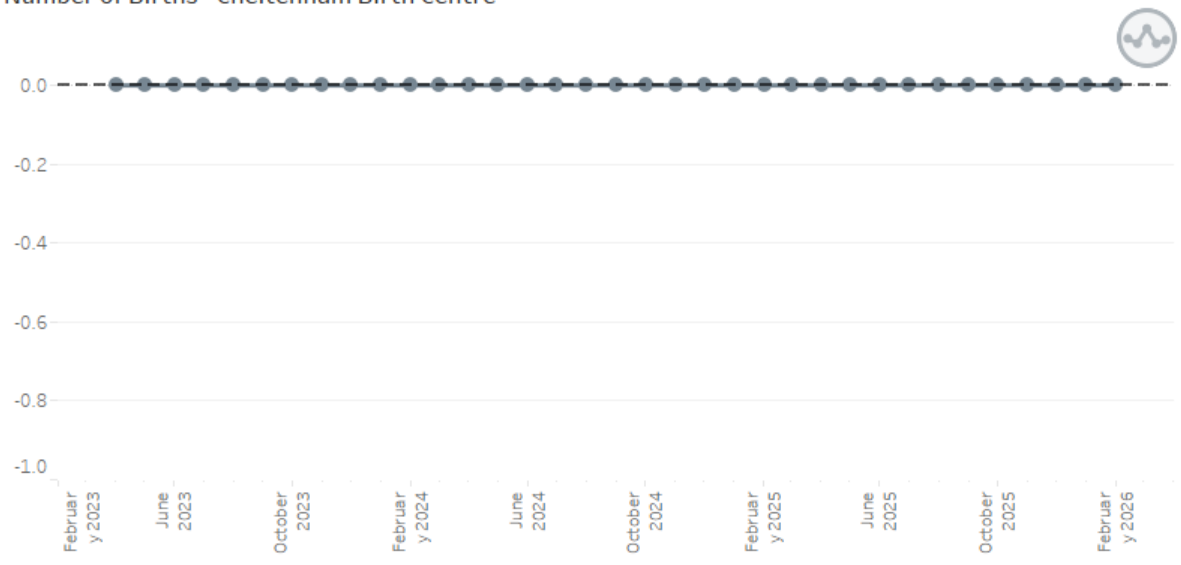
Common cause - no significant change

Metric Info:

Number of: **Registerable Births (STM)**

Category: Births & Deliveries

Number of Births - Cheltenham Birth Centre



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Data Observations:

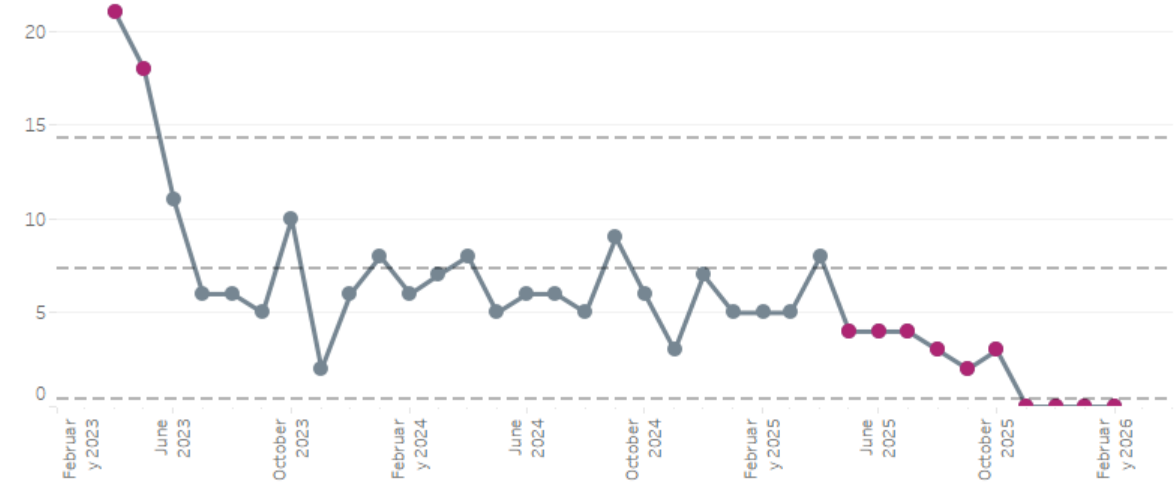
Common cause - no significant change

Metric Info:

Number of: **Registerable Births (Chelt)**

Category: Births & Deliveries

Number of Planned Home Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	8.0	4.0	4.0	4.0	3.0	2.0	3.0	0.0	0.0	0.0	0.0

Data Observations:

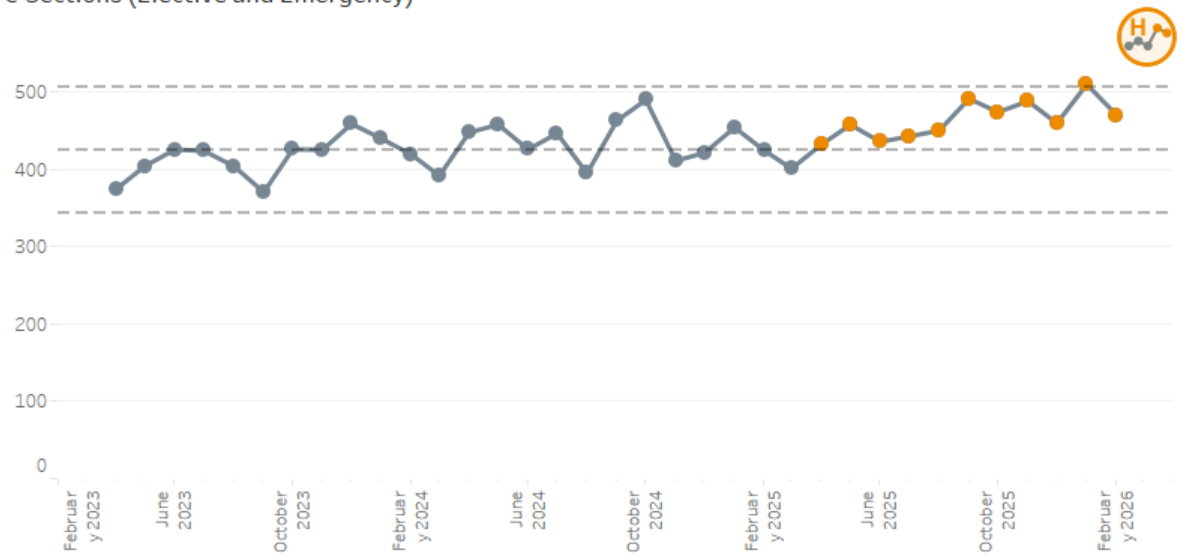
Special cause variation due to (H)igher or (L)ower values

Metric Info:

Number of: **Planned Home Births (Registerable)**

Category: Births & Deliveries

C-Sections (Elective and Emergency)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	432.1	457.5	435.6	442.5	450.0	491.2	473.8	488.1	459.5	509.7	470.0

Data Observations:

Special cause of concerning nature or higher pressure due to (H)igher values

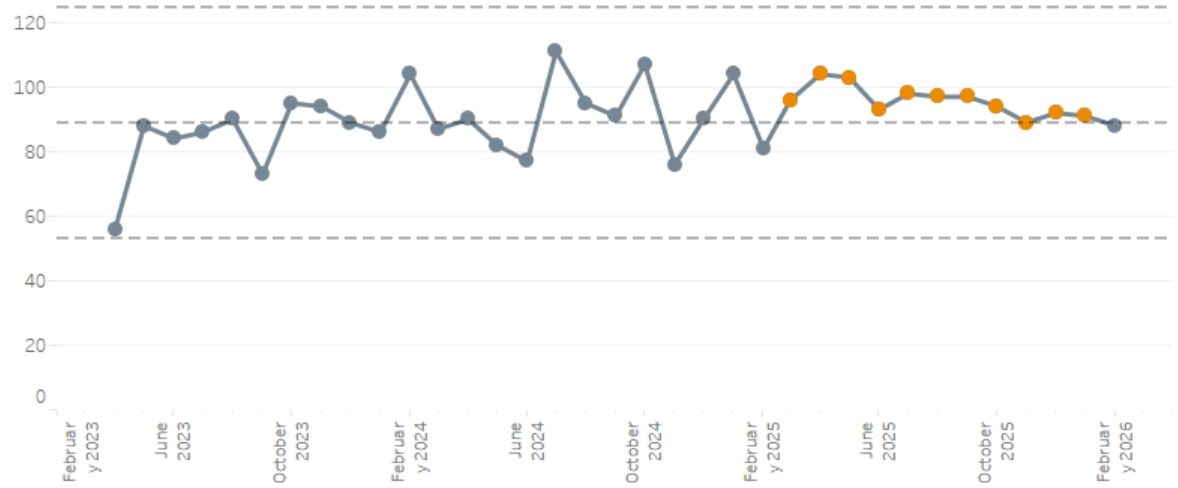
Metric Info:

Rate of: C-Section Births (Registerable)

Per 1,000: Registerable Births

Category: Births & Deliveries

Number of Elective C-Sections



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	104.0	103.0	93.0	98.0	97.0	97.0	94.0	89.0	92.0	91.0	88.0

Data Observations:

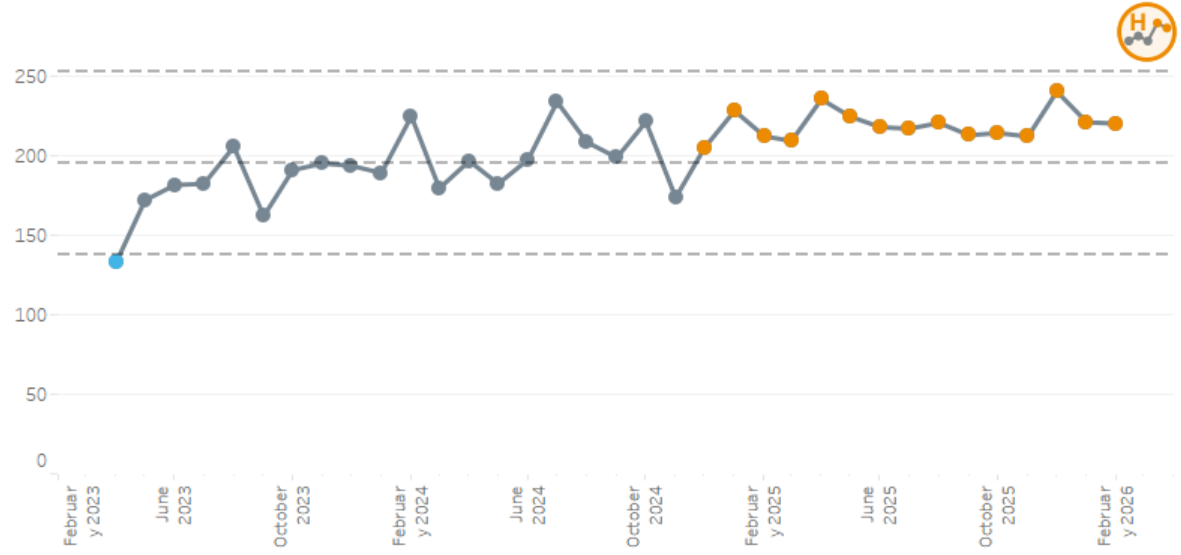
Common cause - no significant change

Metric Info:

Number of: **Elective C-Section Births (Registerable)**

Category: Births & Deliveries

Elective C-Sections



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	235.3	224.4	217.8	216.8	220.5	212.7	214.1	211.9	240.2	220.9	220.0

Data Observations:

Special cause of concerning nature or higher pressure due to (H)igher values

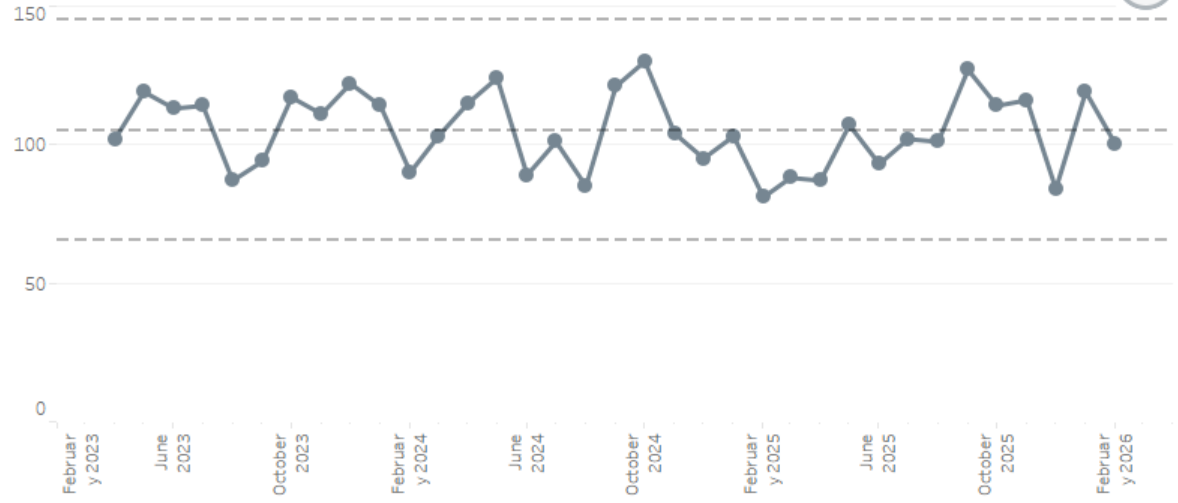
Metric Info:

Rate of: Elective C-Section Births (Registerable)

Per 1,000: Registerable Births

Category: Births & Deliveries

Number of Emergency C-Sections



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	87.0	107.0	93.0	102.0	101.0	127.0	114.0	116.0	84.0	119.0	100.0

Data Observations:

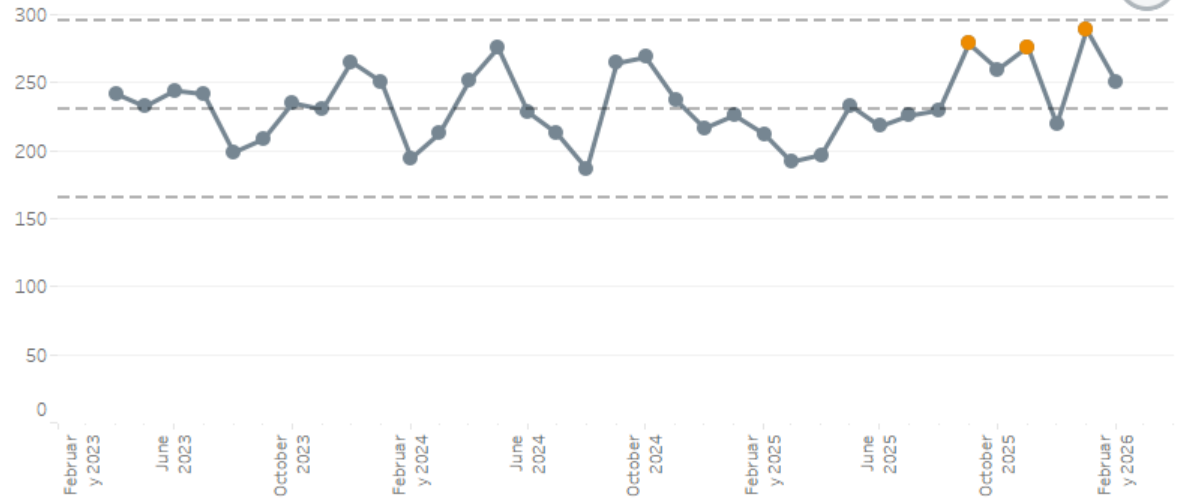
Common cause - no significant change

Metric Info:

Number of: **Emergency C-Section Births (Registerable)**

Category: Births & Deliveries

Emergency C-Sections



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	196.8	233.1	217.8	225.7	229.5	278.5	259.7	276.2	219.3	288.8	250.0

Data Observations:

Common cause - no significant change

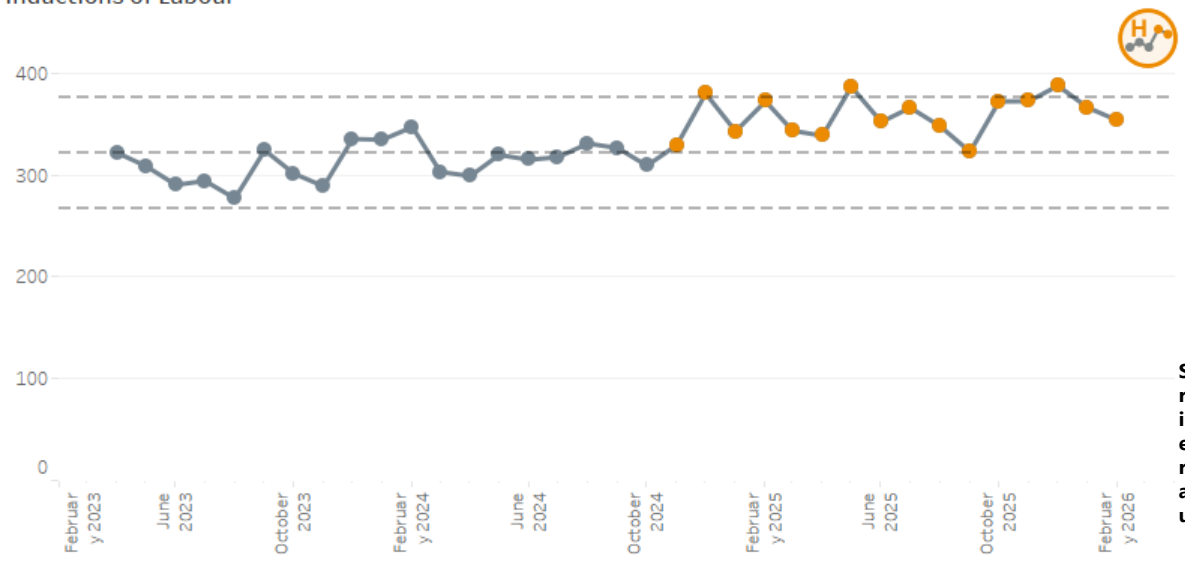
Metric Info:

Rate of: Emergency C-Section Births (Registerable)

Per 1,000: Registerable Births

Category: Births & Deliveries

Inductions of Labour



Data Observations:

Special cause of concerning nature or higher pressure due to (H)igher values

Metric Info:

Rate of: Induced Deliveries (Registerable)

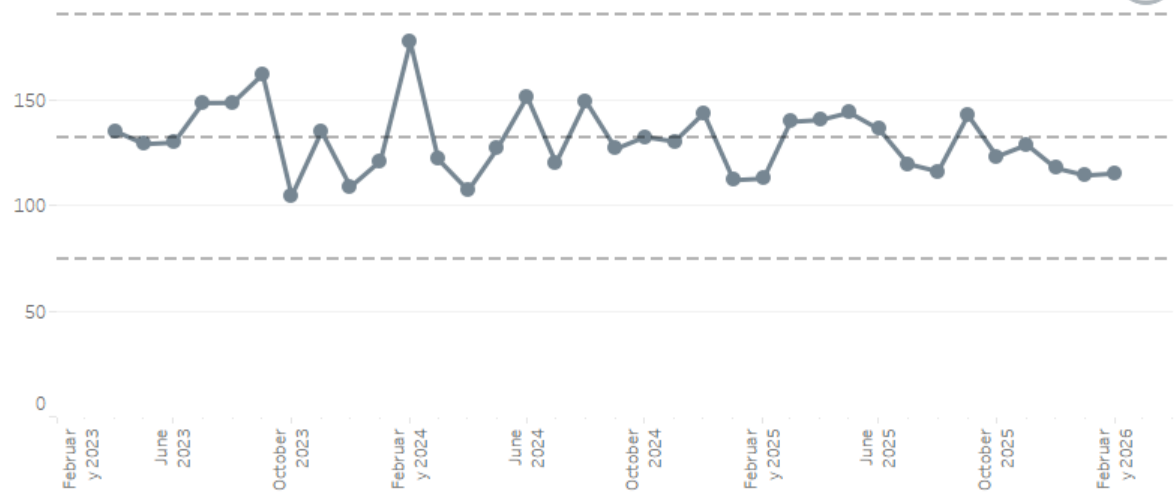
Per 1,000: Registerable Deliveries

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	338.7	386.8	352.2	366.3	348.0	322.9	372.4	372.6	387.9	366.3	353.7

Slide 25 demonstrates variation in induction of labour rates over time using SPC, and this is important because induction is a key driver of intervention, workload and experience, with sustained or special-cause increases requiring focused clinical review to ensure appropriateness, capacity alignment and avoidance of unintended harm.

Category: Births & Deliveries

Instrumental Births



Data Observations:

Common cause - no significant change

Metric Info:

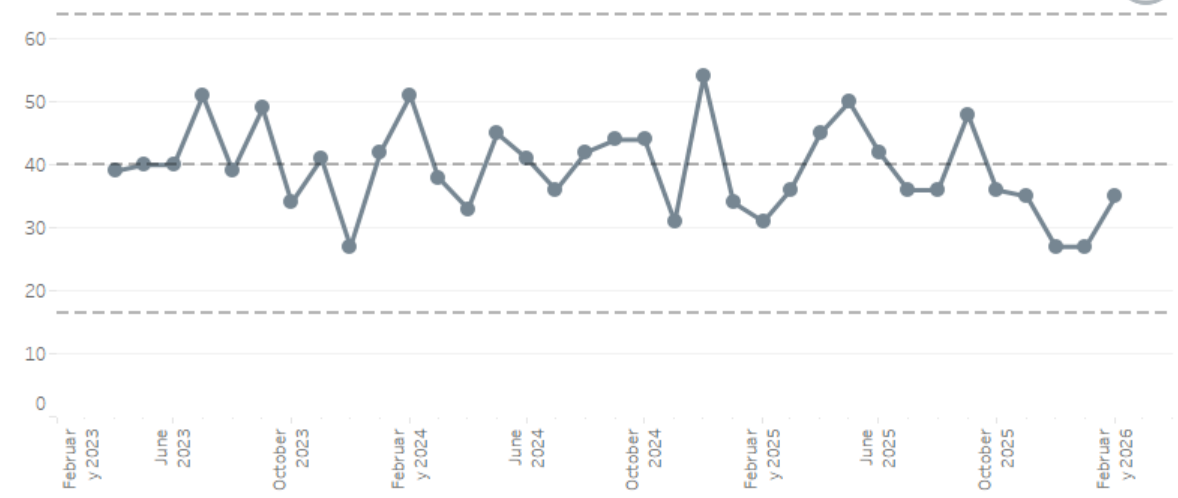
Rate of: Ventouse and Forceps Births (Registerable)

Per 1,000: Registerable Births

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	140.3	143.8	135.8	119.5	115.9	142.5	123.0	128.6	117.5	114.1	115.0

Category: Births & Deliveries

Number of Forceps Births (Registerable)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	45.0	50.0	42.0	36.0	36.0	48.0	36.0	35.0	27.0	27.0	35.0

Data Observations:

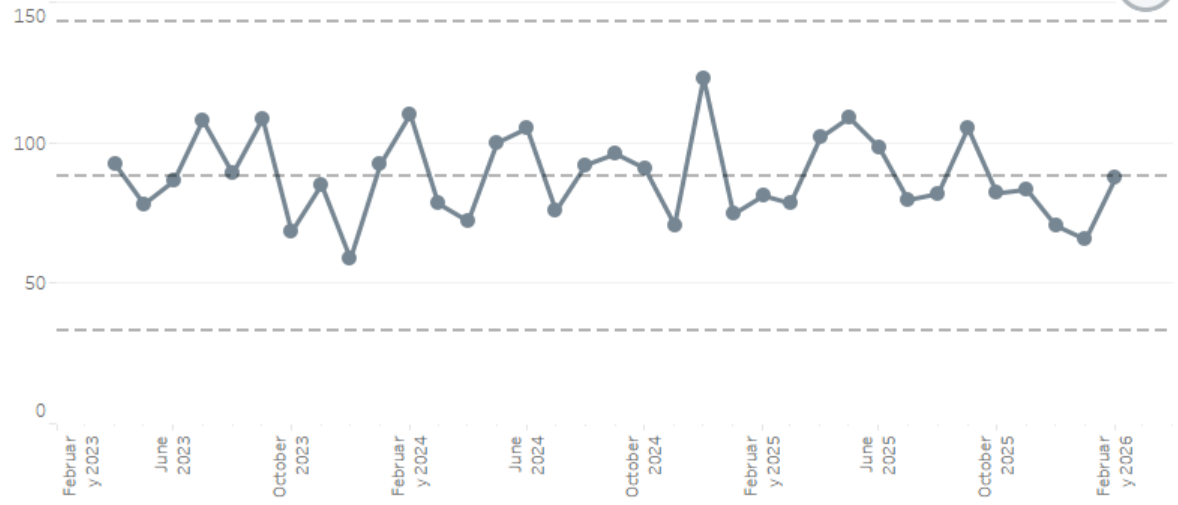
Common cause - no significant change

Metric Info:

Number of: **Forceps Births (Registerable)**

Category: Births & Deliveries

Forceps Births (Registerable)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	101.8	108.9	98.4	79.6	81.8	105.3	82.0	83.3	70.5	65.5	87.5

Data Observations:

Common cause - no significant change

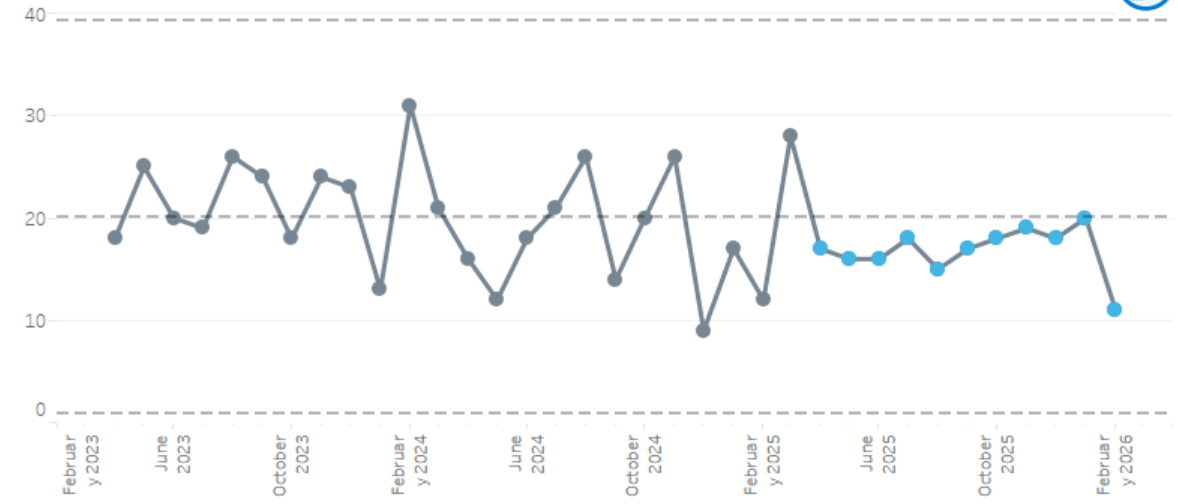
Metric Info:

Rate of: Forceps Births (Registerable)

Per 1,000: Registerable Births

Category: Births & Deliveries

Number of Ventouse Births (Registerable)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	17.0	16.0	16.0	18.0	15.0	17.0	18.0	19.0	18.0	20.0	11.0

Data Observations:

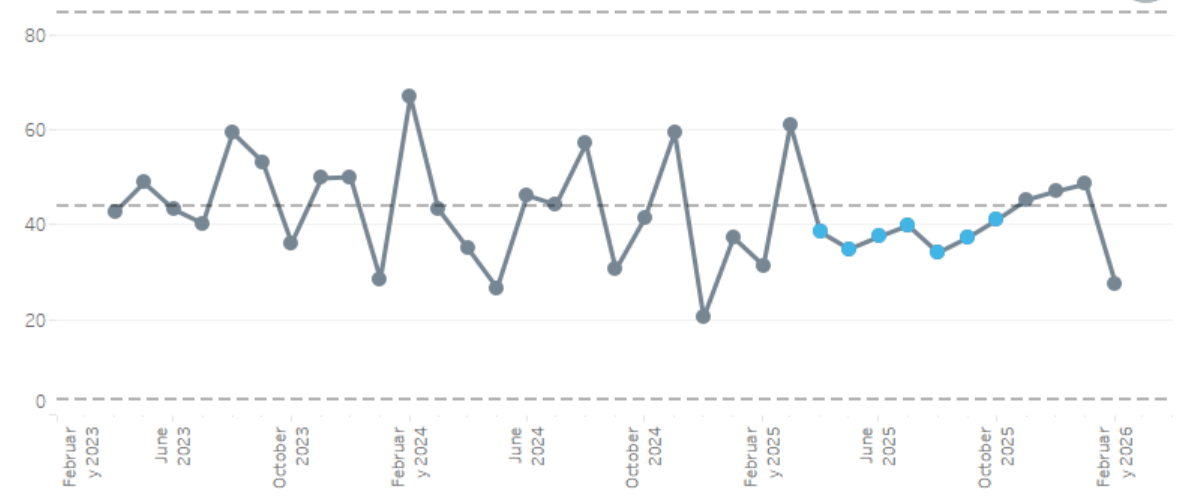
Special cause of improving nature or lower pressure due to (L)ower values

Metric Info:

Number of: **Ventouse Births (Registerable)**

Category: Births & Deliveries

Ventouse Births (Registerable)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	38.5	34.9	37.5	39.8	34.1	37.3	41.0	45.2	47.0	48.5	27.5

Data Observations:

Common cause - no significant change

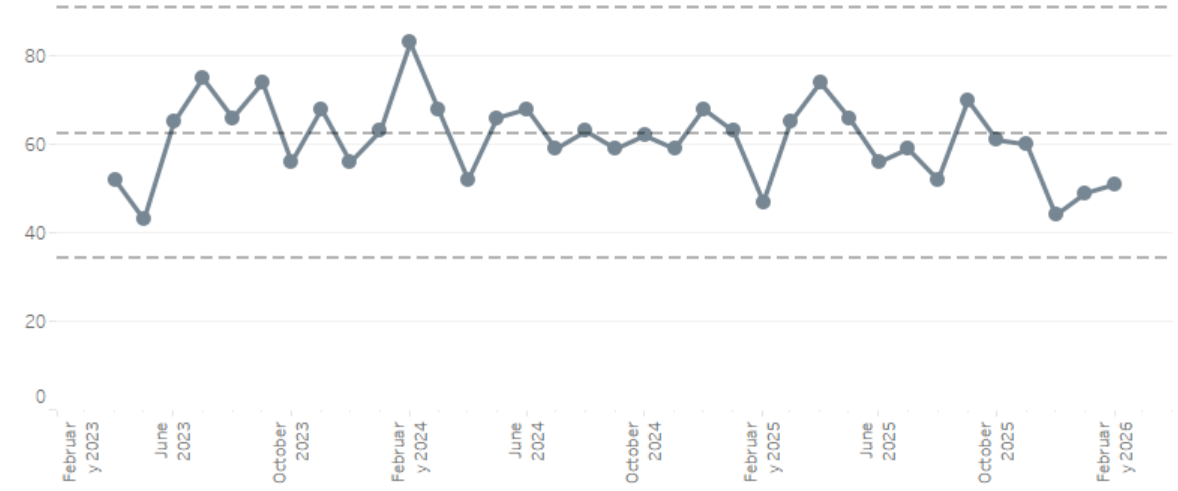
Metric Info:

Rate of: Ventouse Births (Registerable)

Per 1,000: Registerable Births

Category: Births & Deliveries

Number of Episiotomies



Data Observations:

Common cause - no significant change

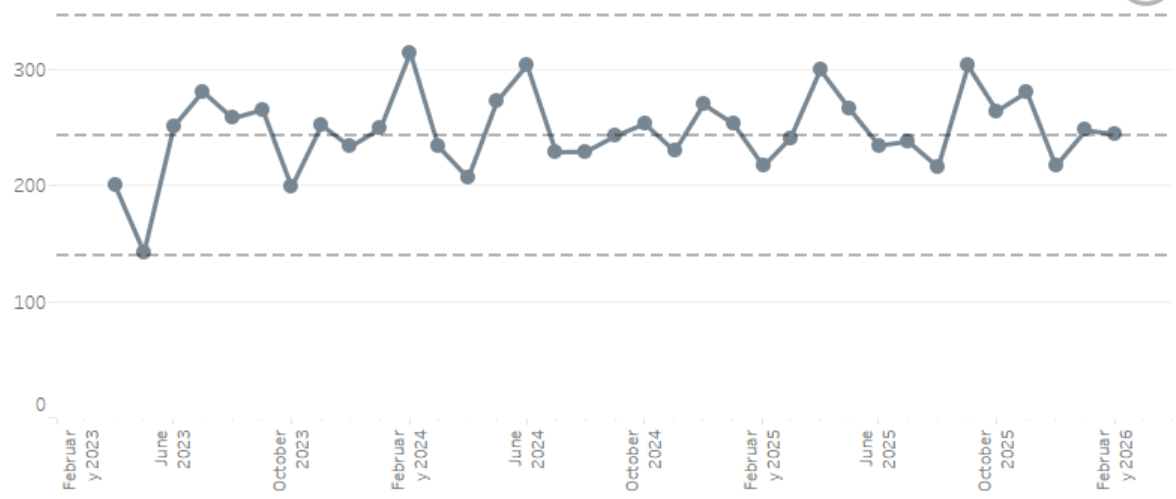
Metric Info:

Number of: **Episiotomies**

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	74.0	66.0	56.0	59.0	52.0	70.0	61.0	60.0	44.0	49.0	51.0

Category: Births & Deliveries

Episiotomies (Vaginal Deliveries)



Data Observations:

Common cause - no significant change

Metric Info:

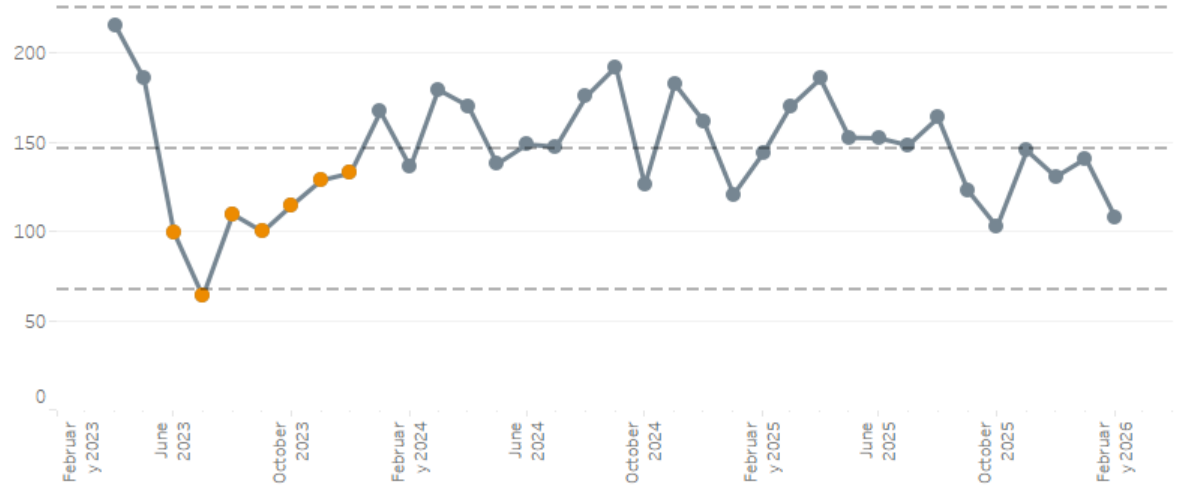
Rate of: Episiotomies (Vaginal Deliveries)

Per 1,000: Vaginal Deliveries

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	299.6	266.1	234.3	237.9	215.8	303.0	264.1	280.4	216.7	247.5	244.0

Category: Births & Deliveries

MLU/Home Births



Data Observations:

Common cause - no significant change

Metric Info:

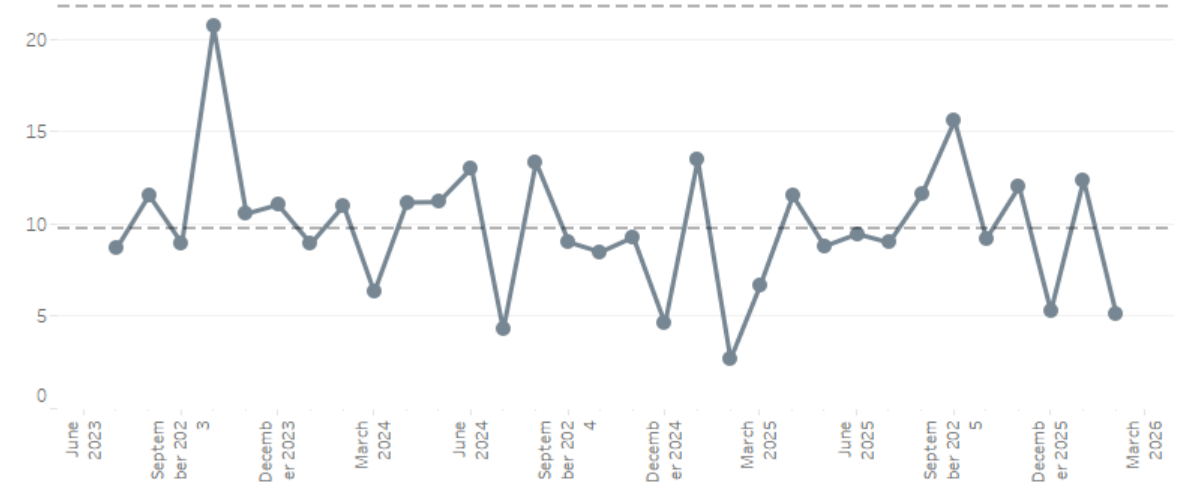
Rate of: MLU/Home Births (Registerable)

Per 1,000: Registerable Births

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	185.5	152.5	152.2	148.2	163.6	122.8	102.5	145.2	130.5	140.8	107.5

Category: Births & Deliveries

Freebirth and BBA Deliveries



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	11.5	8.8	9.5	9.0	11.6	15.6	9.2	12.0	5.3	12.4	5.1

Data Observations:

Common cause - no significant change

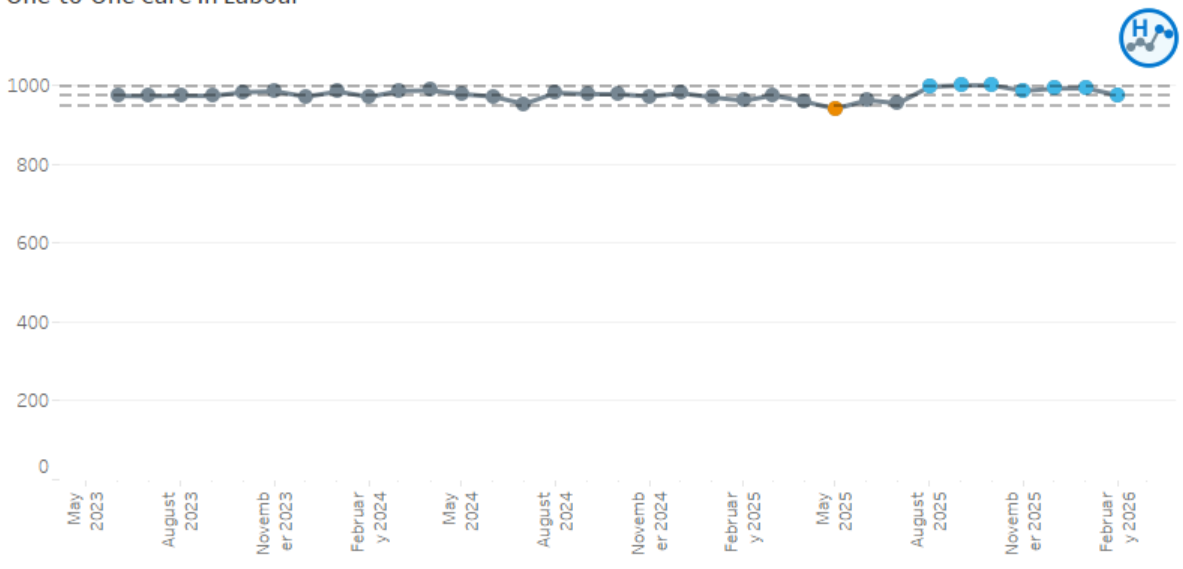
Metric Info:

Rate of: Freebirths & BBAs

Per 1,000: Registerable Deliveries

Category: Births & Deliveries

One-to-One Care in Labour



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	958.8	940.6	962.6	954.7	996.7	1,000.0	1,000.0	986.1	992.2	992.6	974.6

Data Observations:

Special cause of improving nature or lower pressure due to (H)igher values

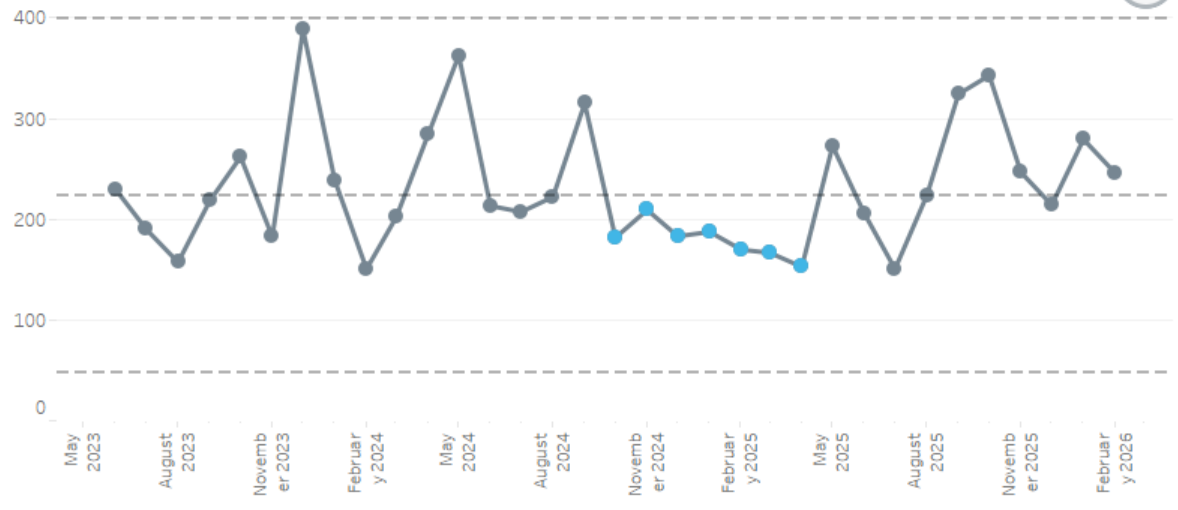
Metric Info:

Rate of: Recieved One to One Care

Per 1,000: Vaginal and Emergency C-Section Deliveries

Category: Births & Deliveries

Robson Group 1 - C-Section Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	152.8	272.7	205.9	150.7	223.5	324.3	342.9	246.6	214.3	279.4	245.9

Data Observations:

Common cause - no significant change

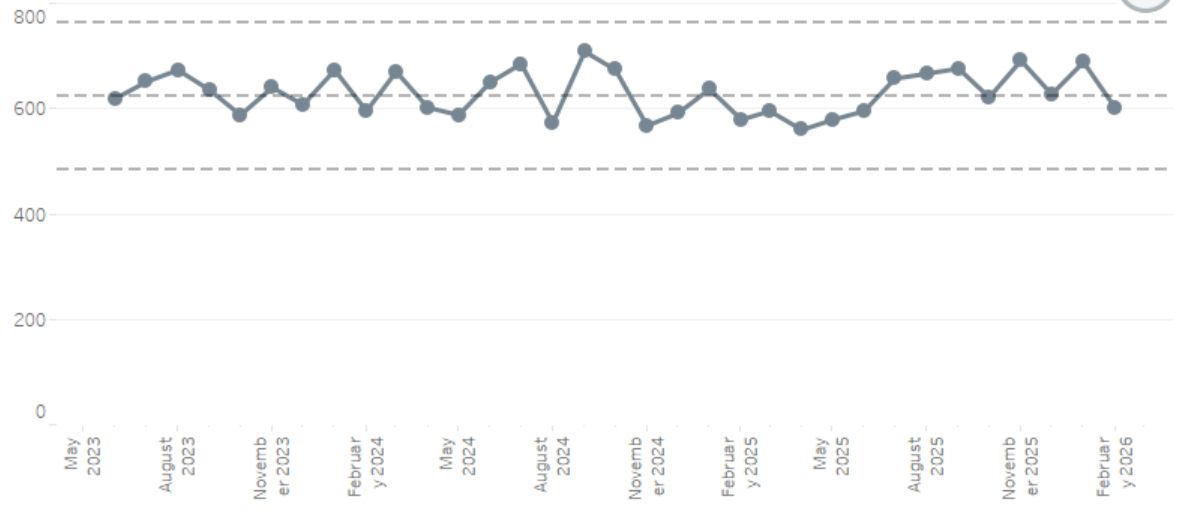
Metric Info:

Rate of: Robson Group 1 - C-Section Births

Per 1,000: Robson Group 1 Births

Category: Births & Deliveries

Robson Group 2 - C-Section Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	560.0	578.9	595.7	657.4	666.7	676.5	621.8	691.6	627.7	688.7	602.0

Data Observations:

Common cause - no significant change

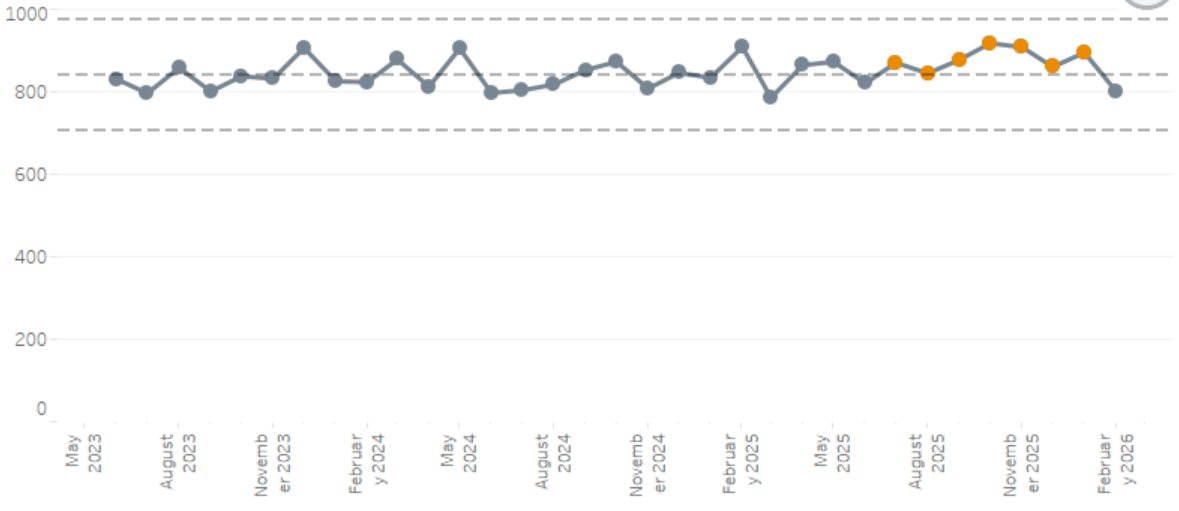
Metric Info:

Rate of: Robson Group 2 - C-Section Births

Per 1,000: Robson Group 2 Births

Category: Births & Deliveries

Robson Group 5 - C-Section Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	863.6	871.8	819.7	869.6	843.8	876.7	916.7	907.4	859.4	893.9	800.0

Data Observations:

Common cause - no significant change

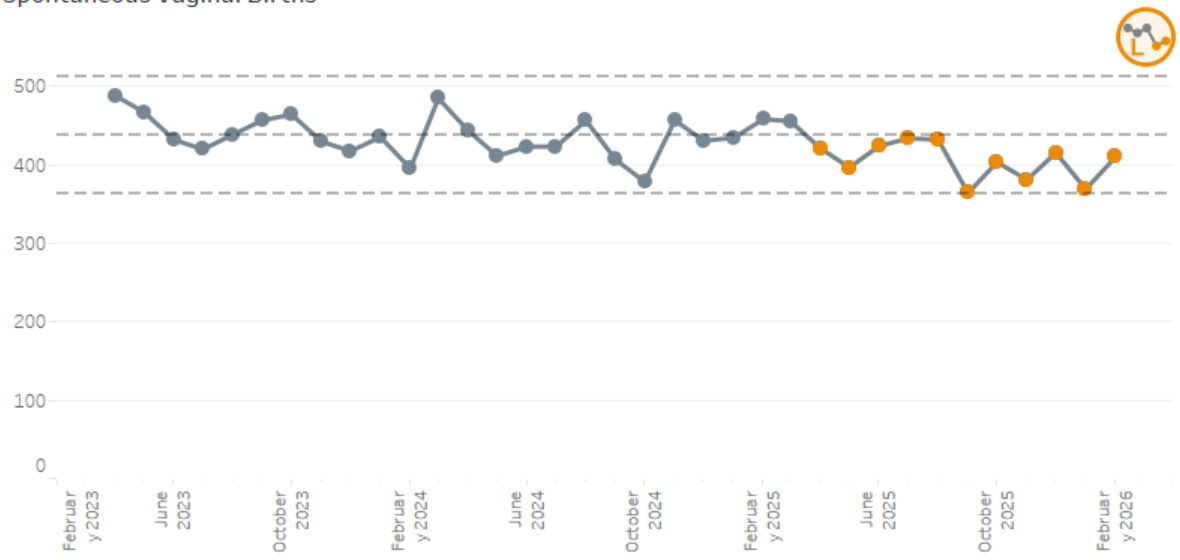
Metric Info:

Rate of: Robson Group 5 - C-Section Births

Per 1,000: Robson Group 5 Births

Category: Births & Deliveries

Spontaneous Vaginal Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	420.8	396.5	423.9	433.6	431.8	364.0	403.2	381.0	415.1	368.9	410.0

Data Observations:

Special cause of concerning nature or higher pressure due to (L)ower values

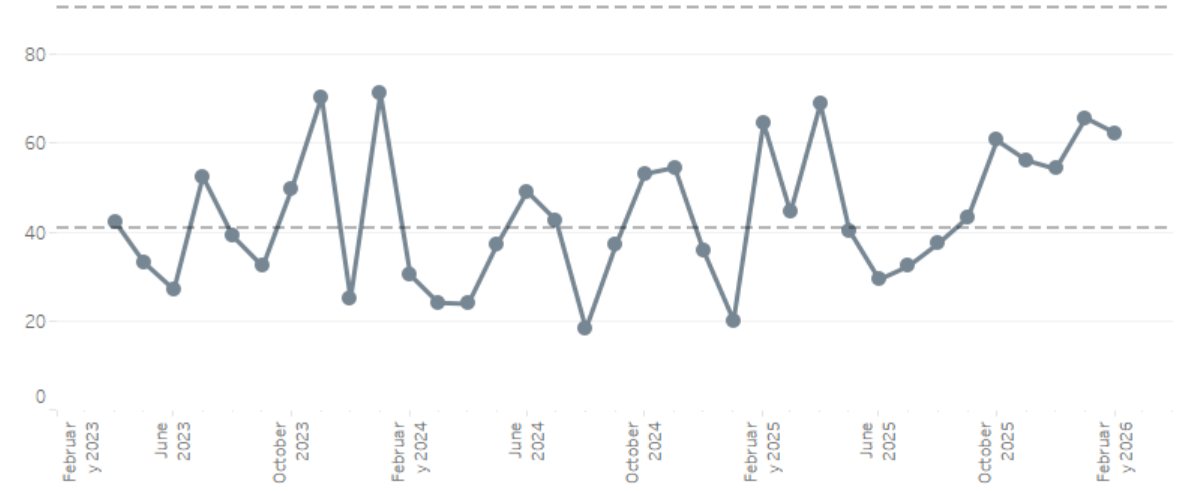
Metric Info:

Rate of: Spontaneous Vaginal Births (Registerable)

Per 1,000: Registerable Births

Category: Maternal Morbidity & Mortality

Obstetric Anal Sphincter Injuries (Vaginal Deliveries)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	68.8	40.3	29.3	32.3	37.3	43.3	60.6	56.1	54.2	65.7	62.2

Data Observations:

Common cause - no significant change

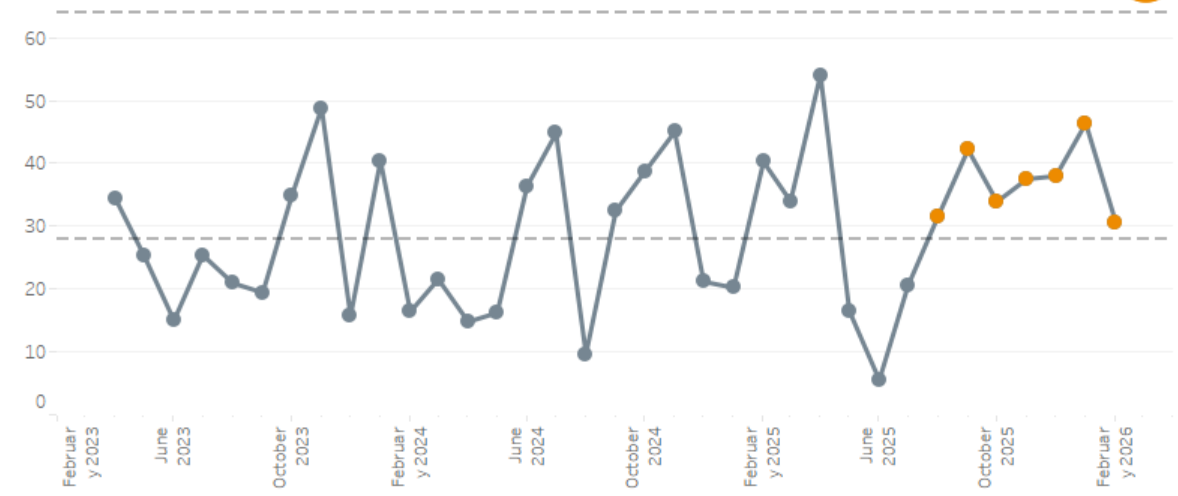
Metric Info:

Rate of: **OASIs (Vaginal Deliveries)**

Per 1,000: **Registerable Vaginal Deliveries**

Category: Maternal Morbidity & Mortality

Obstetric Anal Sphincter Injuries (Spontaneous)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	54.1	16.5	5.5	20.6	31.6	42.2	33.9	37.5	38.0	46.4	30.7

Data Observations:

Special cause of concerning nature or higher pressure due to (H)igher values

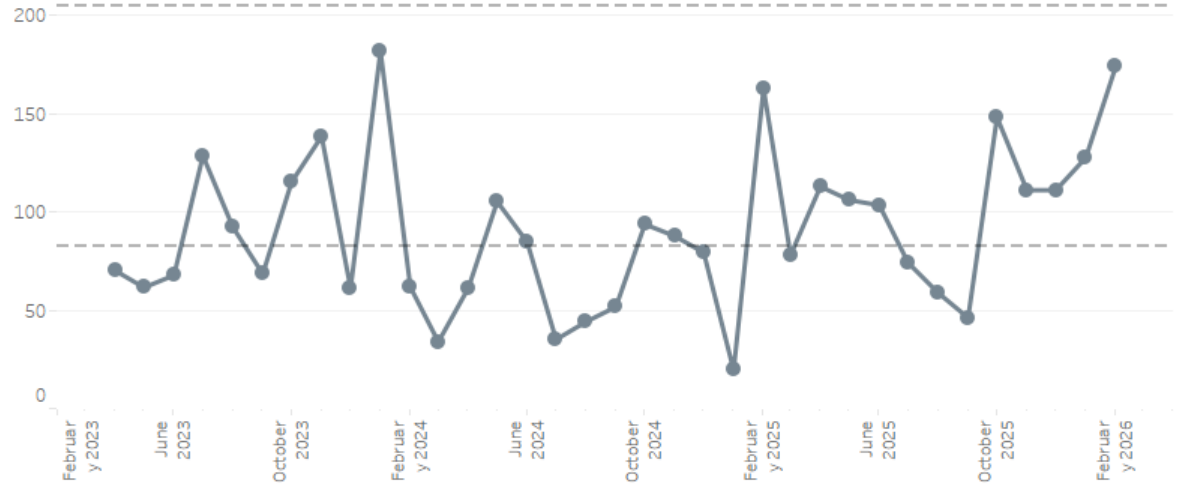
Metric Info:

Rate of: OASIs (Spontaneous Deliveries)

Per 1,000: Registerable Spontaneous Deliveries

Category: Maternal Morbidity & Mortality

Obstetric Anal Sphincter Injuries (Instrumental)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	112.9	106.1	103.4	74.1	58.8	46.2	148.1	111.1	111.1	127.7	173.9

Data Observations:

Common cause - no significant change

Metric Info:

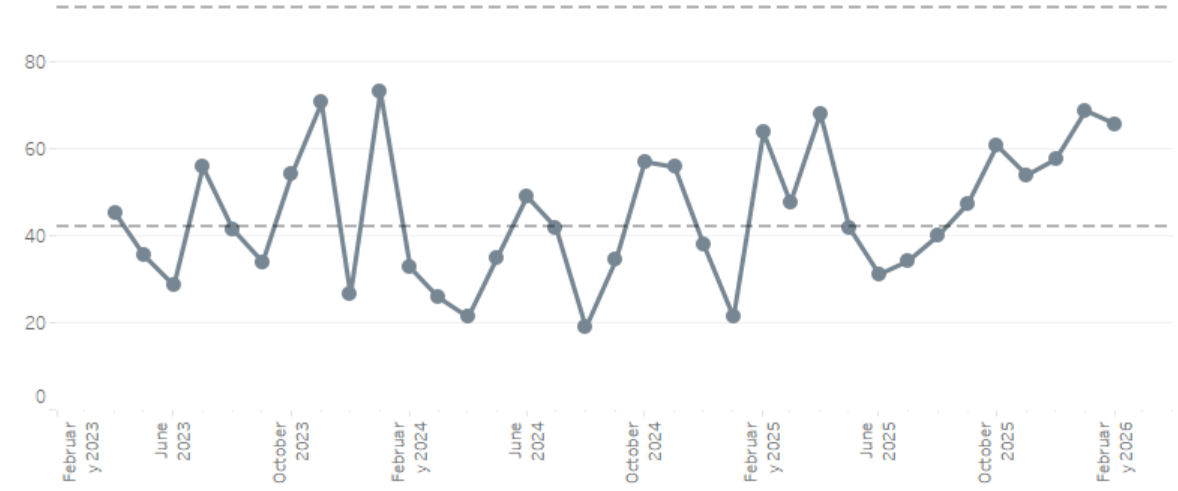
Rate of: **OASIs (Instrumental)**

Per 1,000: **(Instrumental) Deliveries**

This slide shows OASI rates over time and we have a QI project looking to reduce rates.

Category: Maternal Morbidity & Mortality

Obstetric Anal Sphincter Injuries (Term, Singleton, Excluding Breech)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	68.1	41.8	31.1	34.2	40.0	47.4	60.7	53.9	57.6	68.8	65.7

Data Observations:

Common cause - no significant change

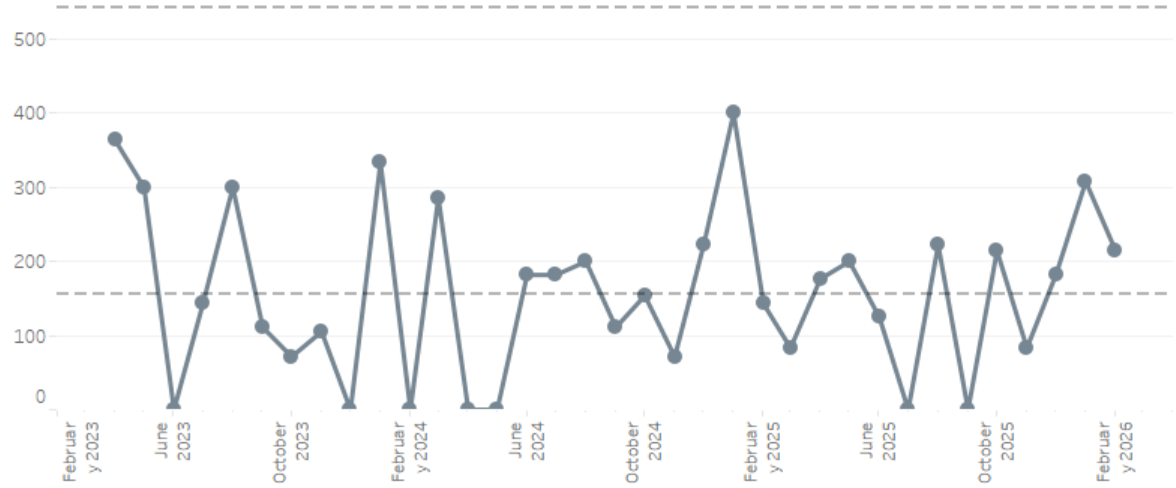
Metric Info:

Rate of: OASIs (Term, Singleton, Excluding Breech)

Per 1,000: (Term, Singleton, Excluding Breech) Deliveries

Category: Maternal Morbidity & Mortality

Obstetric Anal Sphincter Injuries with PPH 1,500 ml



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	176.5	200.0	125.0	0.0	222.2	0.0	214.3	83.3	181.8	307.7	214.3

Data Observations:

Common cause - no significant change

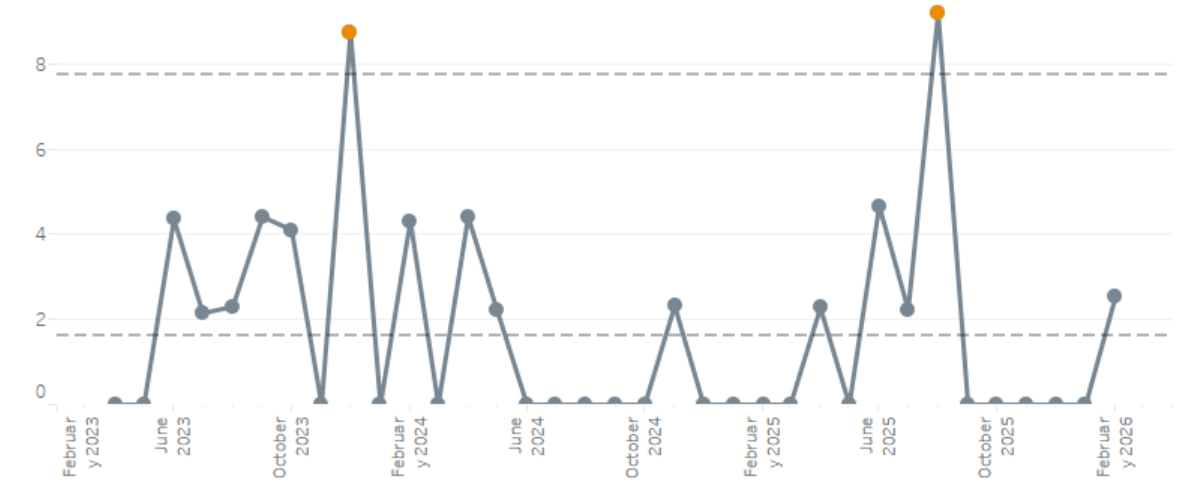
Metric Info:

Rate of: **OASIs with PPH 1,500 ml**

Per 1,000: **OASIs**

Category: Maternal Morbidity & Mortality

ITU Admissions



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	2.3	0.0	4.7	2.2	9.2	0.0	0.0	0.0	0.0	0.0	2.5

Data Observations:

Common cause - no significant change

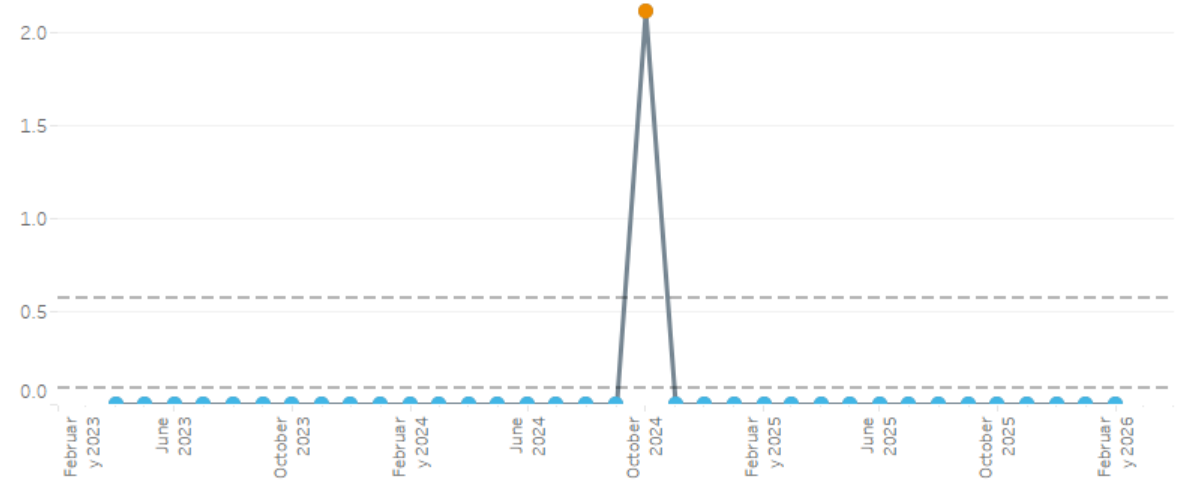
Metric Info:

Rate of: **ITU Admissions**

Per 1,000: **Deliveries**

Category: Maternal Morbidity & Mortality

Maternal Deaths



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Data Observations:

Special cause of improving nature or lower pressure due to (L)ower values

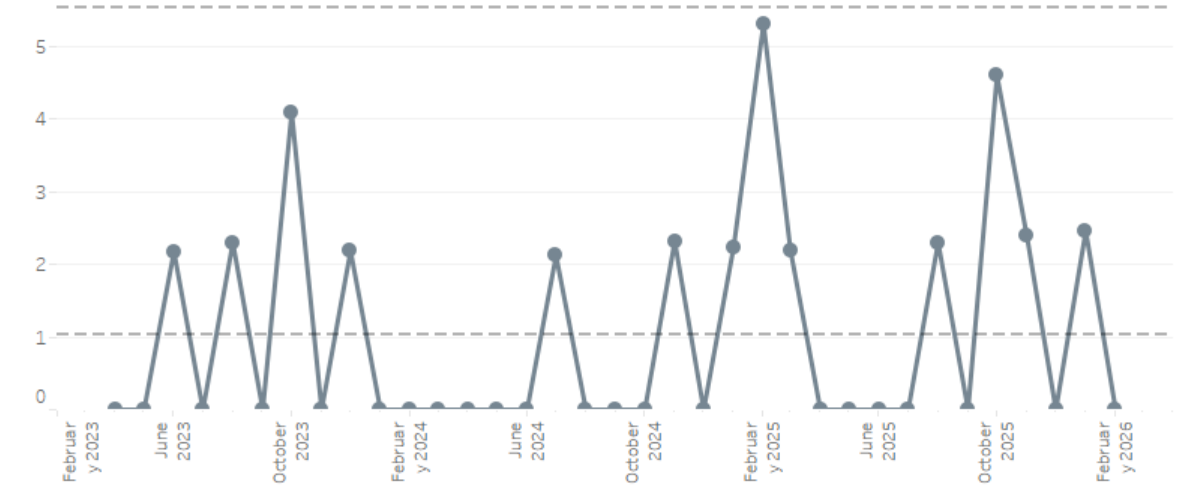
Metric Info:

Rate of: Maternal Deaths

Per 1,000: Maternities (Deliveries over 24 Weeks/Maternal Deaths)

Category: Maternal Morbidity & Mortality

Postpartum Hysterectomies/Laparotomies



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	0.0	0.0	0.0	2.3	0.0	4.6	2.4	0.0	2.5	0.0

Data Observations:

Common cause - no significant change

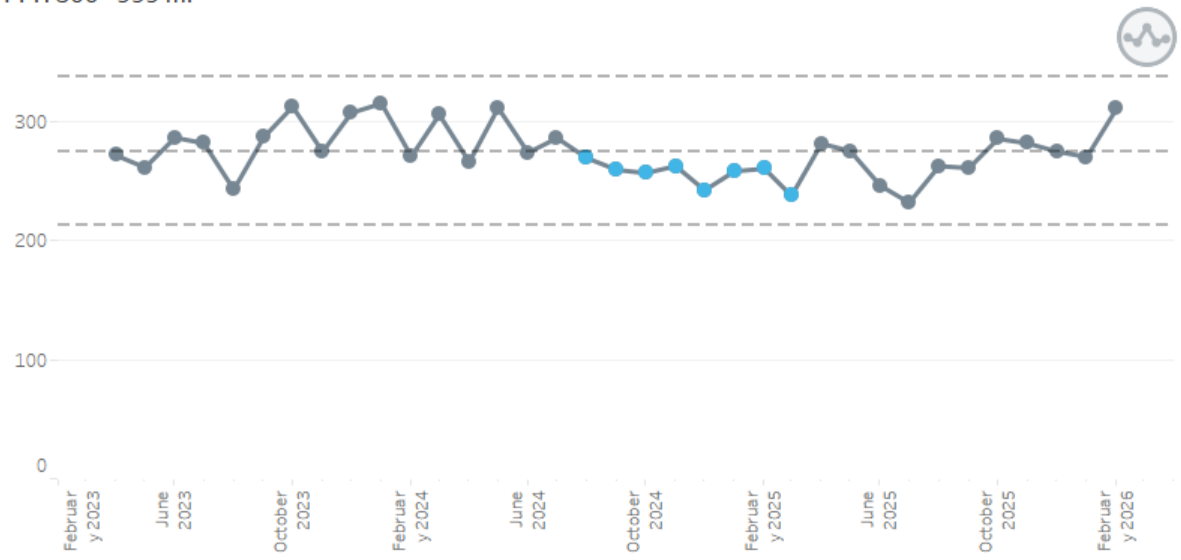
Metric Info:

Rate of: PP Hysterectomy/Laparotomy

Per 1,000: Deliveries

Category: Maternal Morbidity & Mortality

PPH 500 - 999 ml



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	281.1	274.7	245.9	231.5	262.2	260.6	285.1	281.3	274.4	269.8	310.4

Data Observations:

Common cause - no significant change

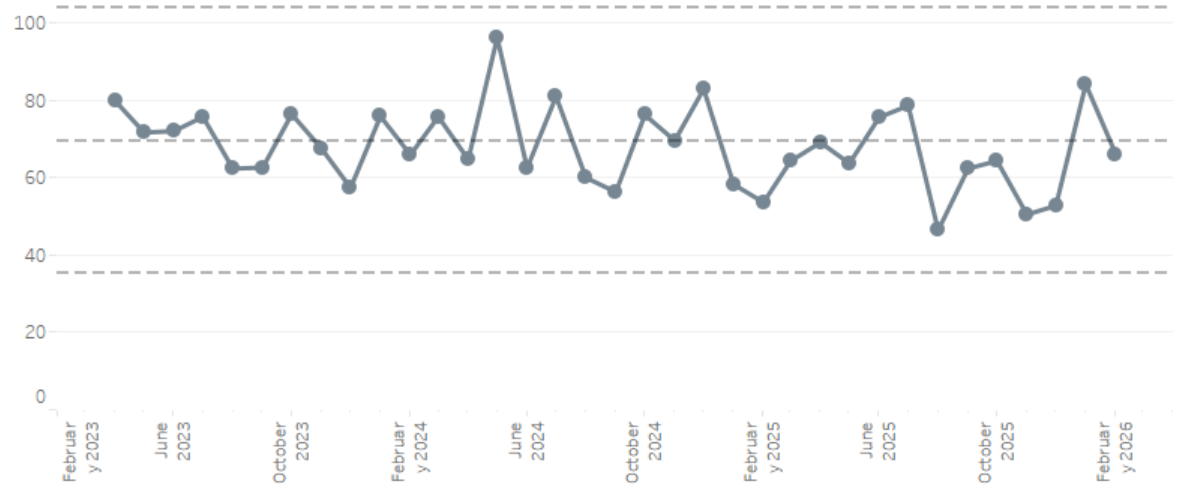
Metric Info:

Rate of: PPH 500 - 999 ml

Per 1,000: Registerable Deliveries

Category: Maternal Morbidity & Mortality

PPH 1,000 - 1,499 ml



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	69.1	63.7	75.7	78.7	46.4	62.4	64.4	50.5	52.8	84.2	66.2

Data Observations:

Common cause - no significant change

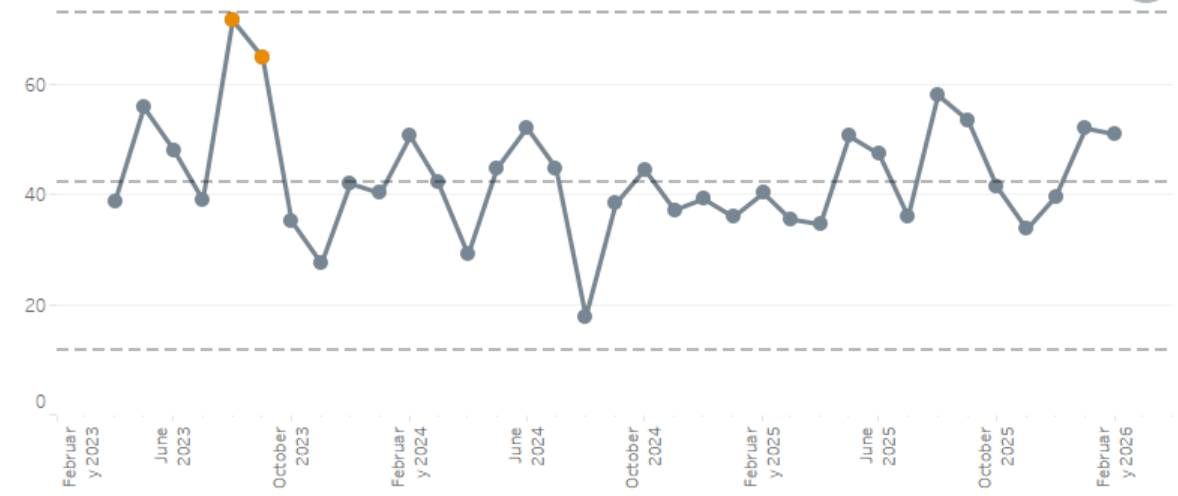
Metric Info:

Rate of: **PPH 1,000 - 1,499 ml**

Per 1,000: **Registerable Deliveries**

Category: Maternal Morbidity & Mortality

PPH 1,500 ml



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	34.6	50.5	47.3	36.0	58.0	53.5	41.4	33.7	39.6	52.0	50.9

Data Observations:

Common cause - no significant change

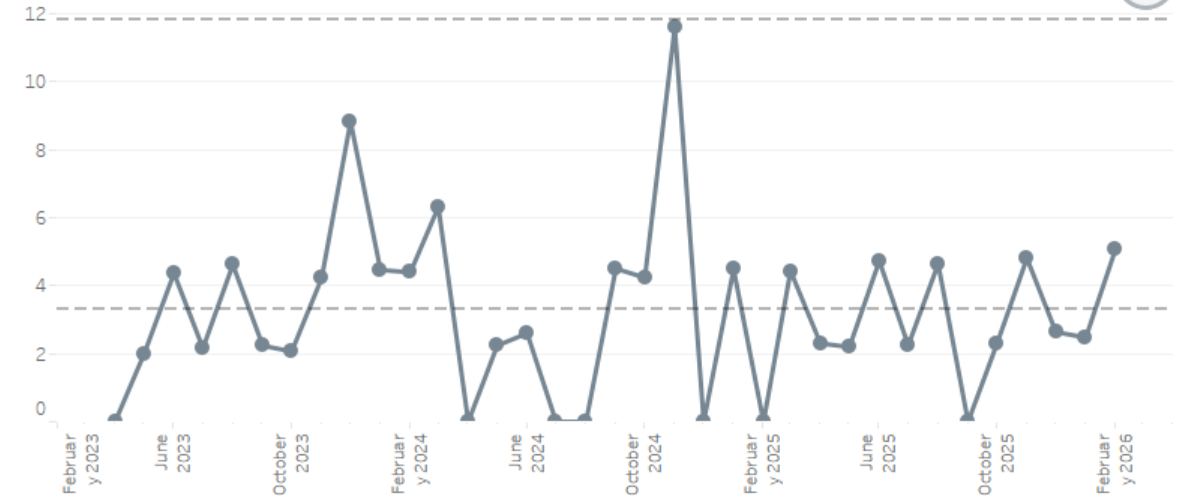
Metric Info:

Rate of: PPH 1,500 ml

Per 1,000: Registerable Deliveries

Category: Maternal Morbidity & Mortality

PPH 3,000 ml



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	2.3	2.2	4.7	2.2	4.6	0.0	2.3	4.8	2.6	2.5	5.1

Data Observations:

Common cause - no significant change

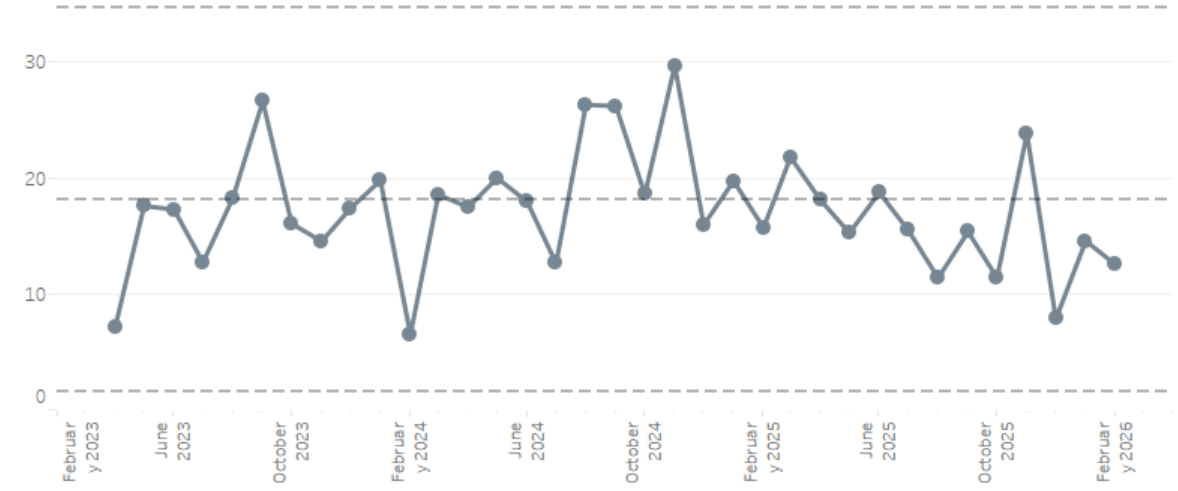
Metric Info:

Rate of: PPH 3,000 ml

Per 1,000: Registerable Deliveries

Category: Neonatal Morbidity & Mortality

Shoulder Dystocia



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	18.1	15.3	18.7	15.5	11.4	15.4	11.4	23.8	7.8	14.6	12.5

Data Observations:

Common cause - no significant change

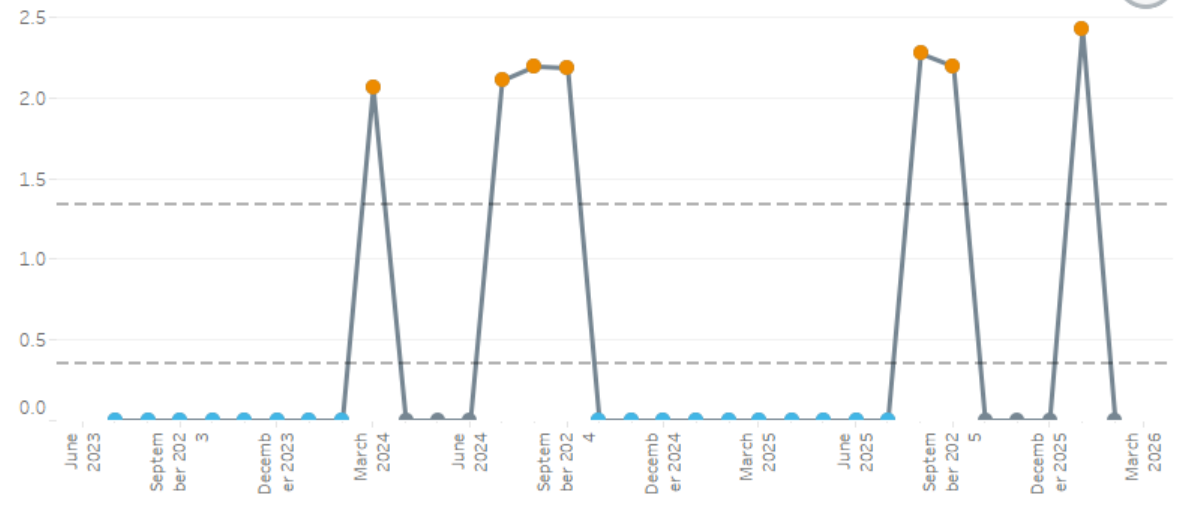
Metric Info:

Rate of: Shoulder Dystocia (Registerable Births)

Per 1,000: Registerable Births

Category: Neonatal Morbidity & Mortality

Cord Prolapse



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	0.0	0.0	0.0	2.3	2.2	0.0	0.0	0.0	2.4	0.0

Data Observations:

Common cause - no significant change

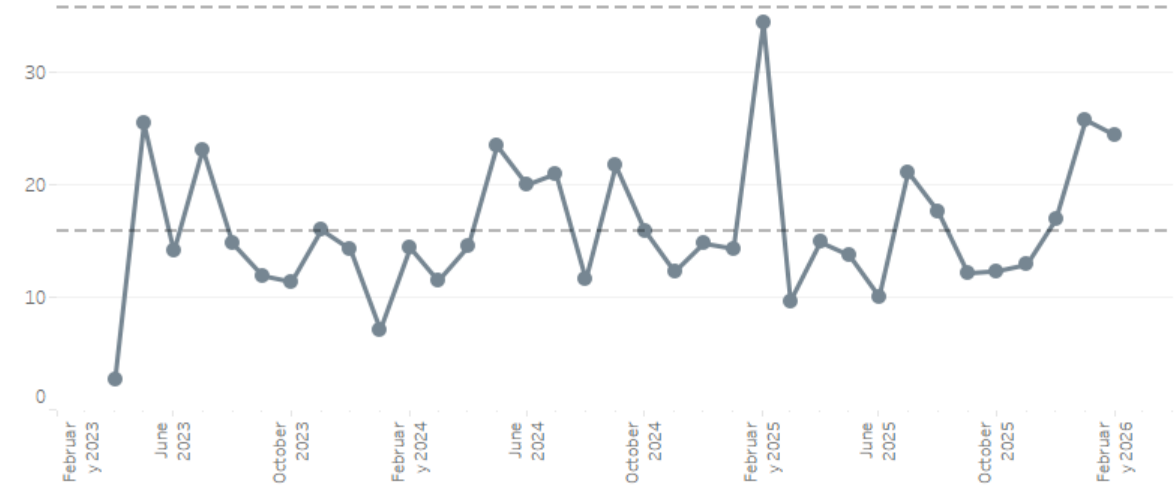
Metric Info:

Rate of: Cord Prolapse (Registerable Births)

Per 1,000: Registerable Births

Category: Neonatal Morbidity & Mortality

5-Minute APGAR Score <7 (Term Births)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	14.9	13.7	10.0	21.1	17.6	12.1	12.3	12.9	16.9	25.7	24.3

Data Observations:

Common cause - no significant change

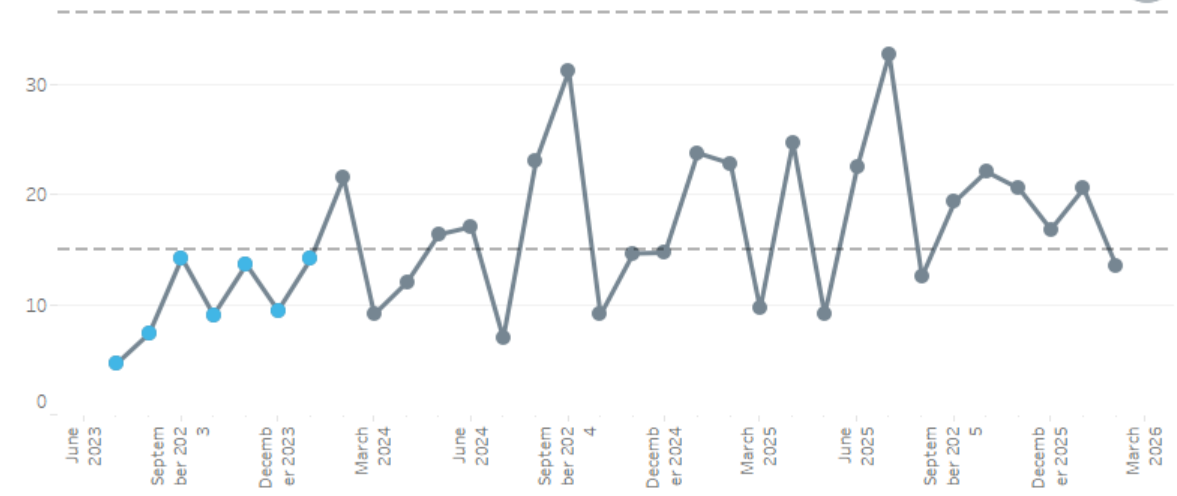
Metric Info:

Rate of: 5-Minute APGAR Score <7 (Term Births)

Per 1,000: Term Births

Category: Neonatal Morbidity & Mortality

Arterial Base Excess <= -12



Data Observations:

Common cause - no significant change

Metric Info:

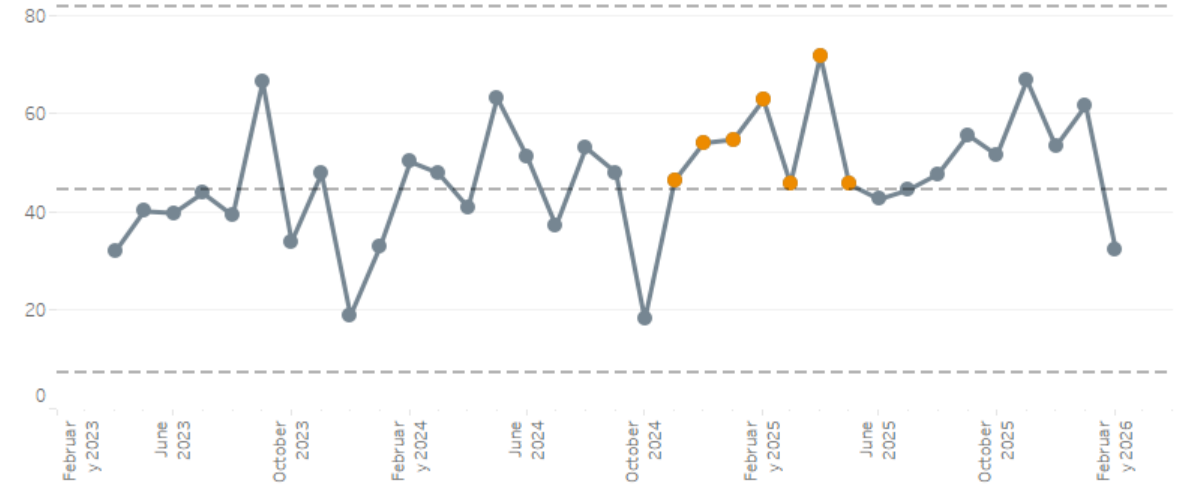
Rate of: A-BE <= -12

Per 1,000: Term Births

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	24.8	9.1	22.6	32.8	12.6	19.4	22.1	20.6	16.9	20.6	13.5

Category: Neonatal Morbidity & Mortality

Arterial pH at Delivery <= 7.1



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	71.8	45.7	42.6	44.5	47.7	55.7	51.6	66.8	53.4	61.7	32.4

Data Observations:

Common cause - no significant change

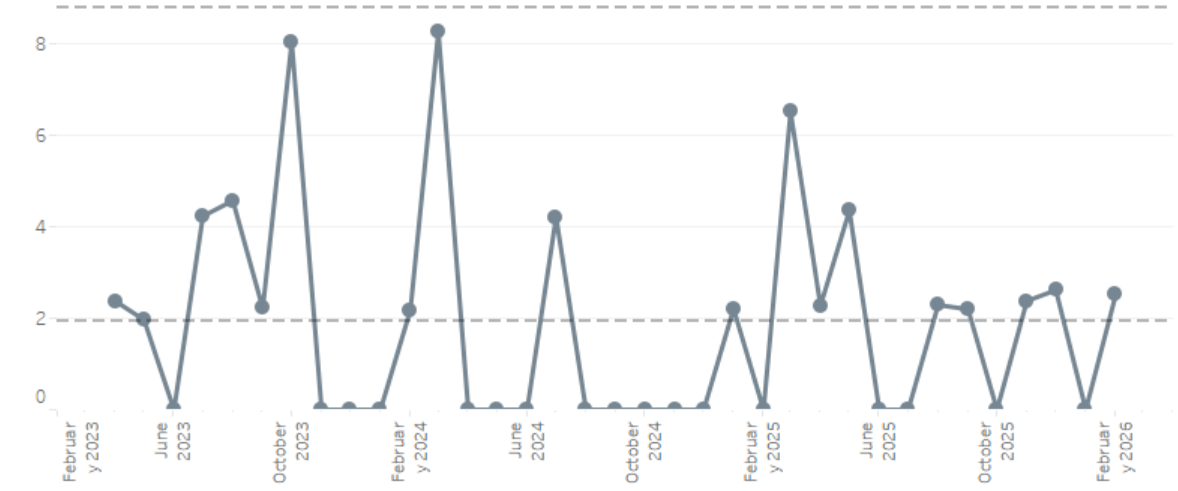
Metric Info:

Rate of: A-pH <= 7.1

Per 1,000: Term Births

Category: Neonatal Morbidity & Mortality

Live Births <27 Wks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	2.3	4.4	0.0	0.0	2.3	2.2	0.0	2.4	2.6	0.0	2.5

Data Observations:

Common cause - no significant change

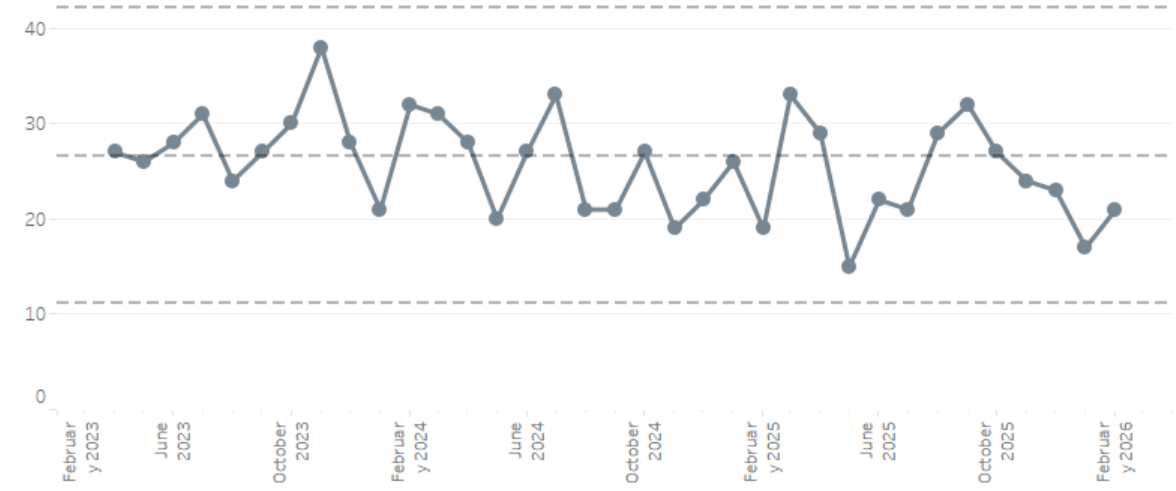
Metric Info:

Rate of: **Live Births <27 Wks**

Per 1,000: **Live Births**

Category: Neonatal Morbidity & Mortality

Number of Preterm Births (Live Singletons - 22-37 Wks)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	29.0	15.0	22.0	21.0	29.0	32.0	27.0	24.0	23.0	17.0	21.0

Data Observations:

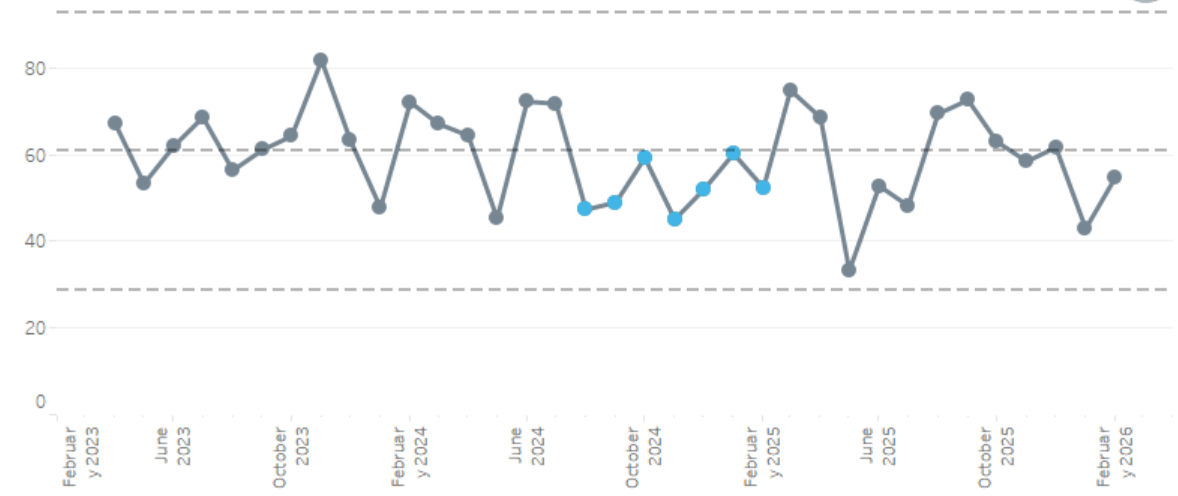
Common cause - no significant change

Metric Info:

Number of: Live Singletons 22-37 Wks

Category: Neonatal Morbidity & Mortality

Preterm Births (Live Singletons - 22-37 Wks)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	68.6	33.3	52.8	48.2	69.4	72.6	62.9	58.4	61.7	42.9	54.8

Data Observations:

Common cause - no significant change

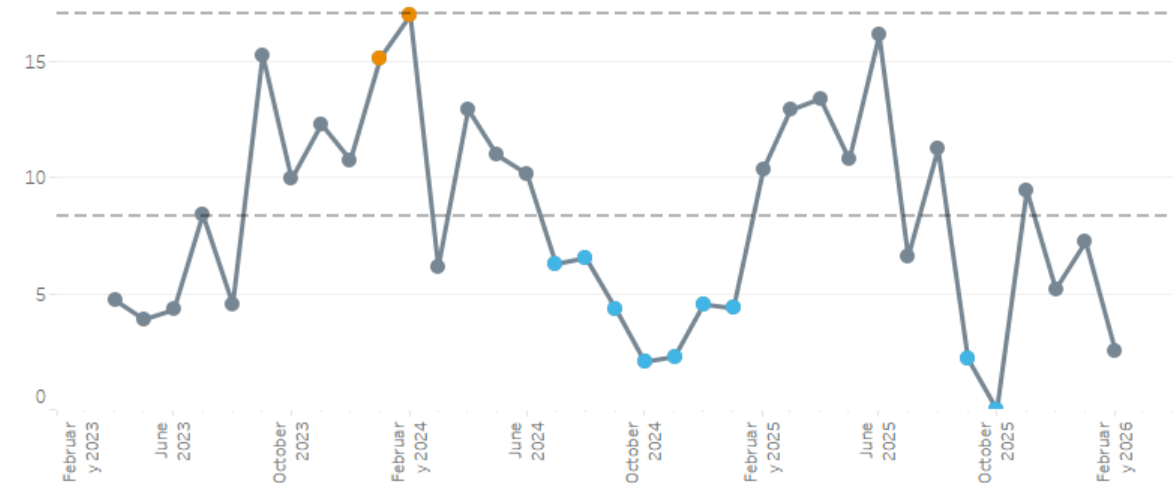
Metric Info:

Rate of: Live Singletons 22-37 Wks

Per 1,000: Live Singletons 22-45 Wks

Category: Neonatal Morbidity & Mortality

Late Fetal Losses (16-23+6 Wks)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	13.4	10.8	16.1	6.6	11.2	2.2	0.0	9.4	5.2	7.2	2.5

Data Observations:

Common cause - no significant change

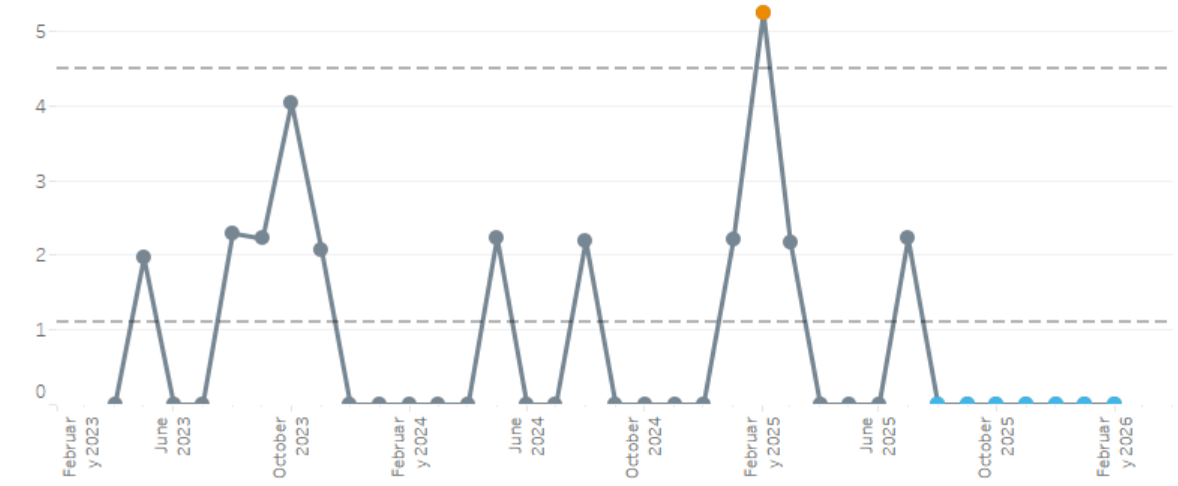
Metric Info:

Rate of: Late Fetal Losses

Per 1,000: Births

Category: Neonatal Morbidity & Mortality

Neonatal Deaths >=22 Wks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	0.0	0.0	2.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Data Observations:

Special cause of improving nature or lower pressure due to (L)ower values

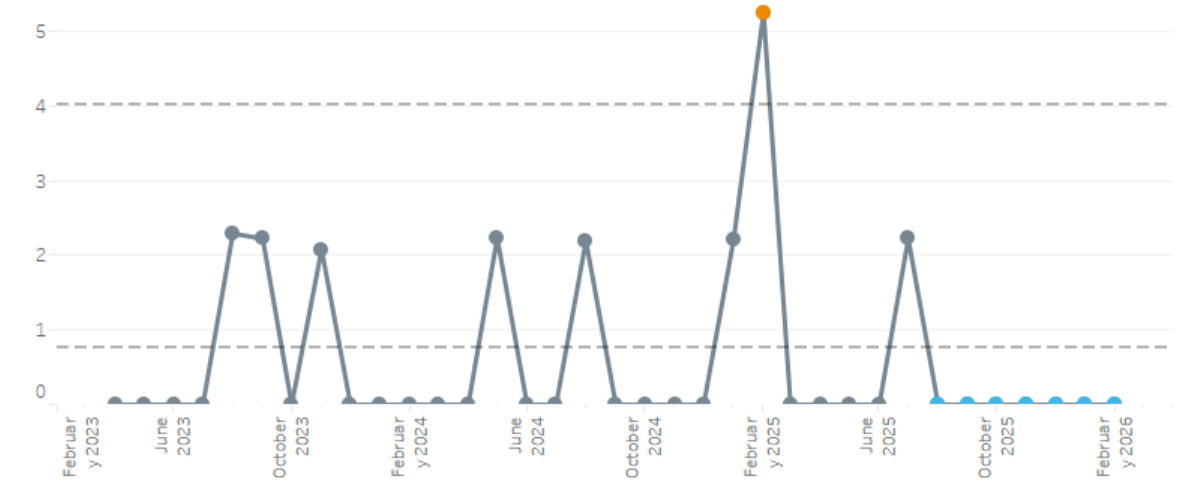
Metric Info:

Rate of: Neonatal Deaths >=22 Wks

Per 1,000: Live Births >=22 Weeks

Category: Neonatal Morbidity & Mortality

Neonatal Deaths >=24 Wks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	0.0	0.0	2.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Data Observations:

Special cause of improving nature or lower pressure due to (L)ower values

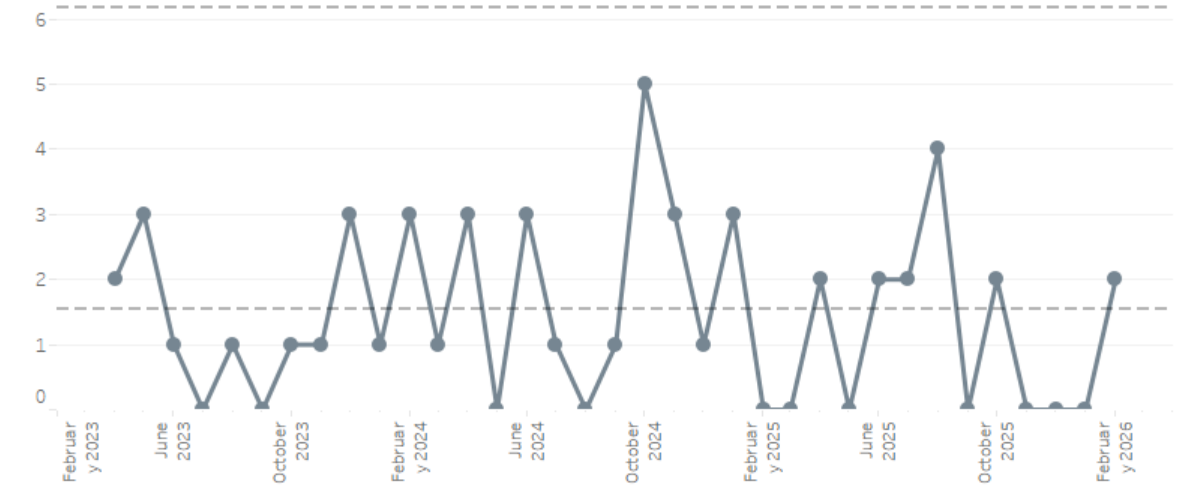
Metric Info:

Rate of: Neonatal Deaths >=24 Wks

Per 1,000: Live Births >=24 Weeks

Category: Neonatal Morbidity & Mortality

Number of Stillbirths >= 24 Wks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	2.0	0.0	2.0	2.0	4.0	0.0	2.0	0.0	0.0	0.0	2.0

Data Observations:

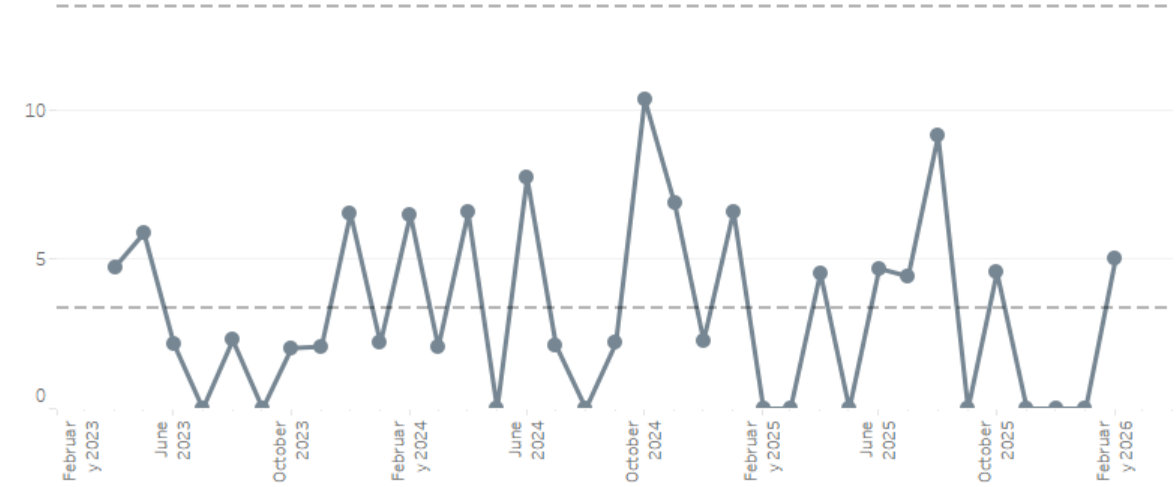
Common cause - no significant change

Metric Info:

Number of: Stillbirths >= 24 Wks

Category: Neonatal Morbidity & Mortality

Stillbirths >= 24 Wks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	4.5	0.0	4.7	4.4	9.1	0.0	4.6	0.0	0.0	0.0	5.0

Data Observations:

Common cause - no significant change

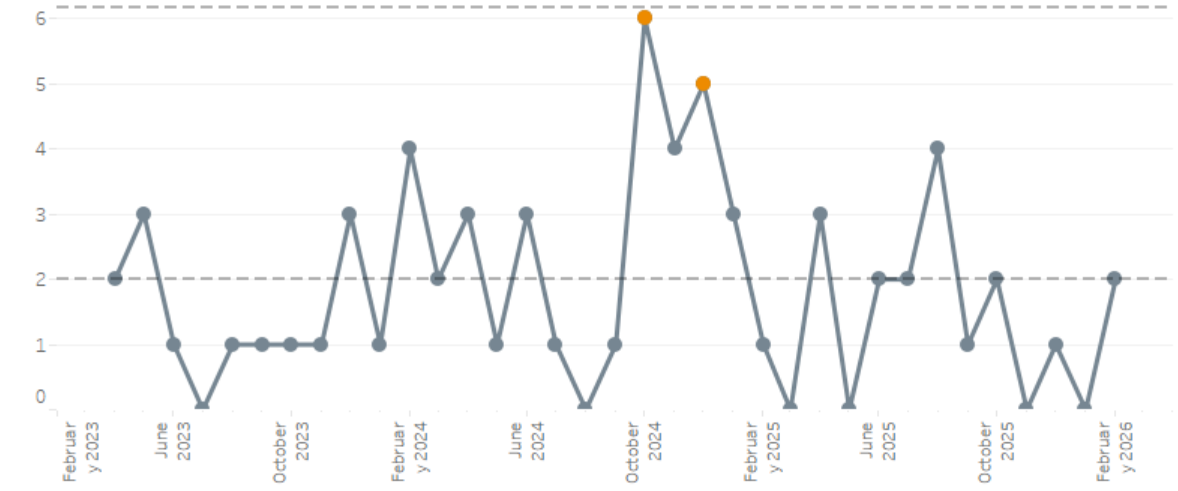
Metric Info:

Rate of: Stillbirths >= 24 Wks

Per 1,000: Births >= 24 Wks

Category: Neonatal Morbidity & Mortality

Number of Stillbirths >= 24 Wks (Including Terminations of Pregnancy >= 24 Weeks)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	3.0	0.0	2.0	2.0	4.0	1.0	2.0	0.0	1.0	0.0	2.0

Data Observations:

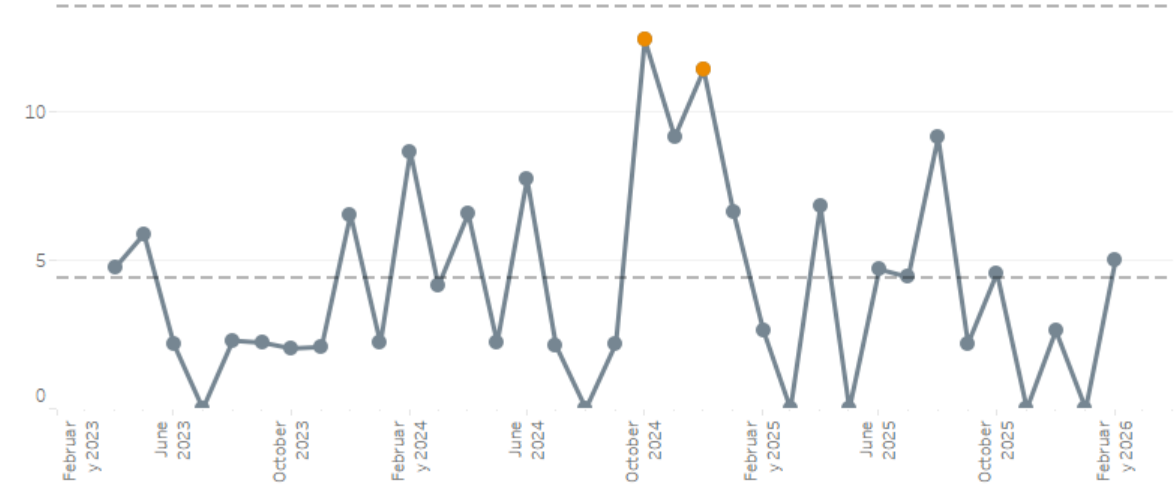
Common cause - no significant change

Metric Info:

Number of: Stillbirths >= 24 Wks (Including TOPs)

Category: Neonatal Morbidity & Mortality

Stillbirths >= 24 Wks (Including Terminations of Pregnancy >= 24 Weeks)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	6.8	0.0	4.7	4.4	9.1	2.2	4.6	0.0	2.6	0.0	5.0

Data Observations:

Common cause - no significant change

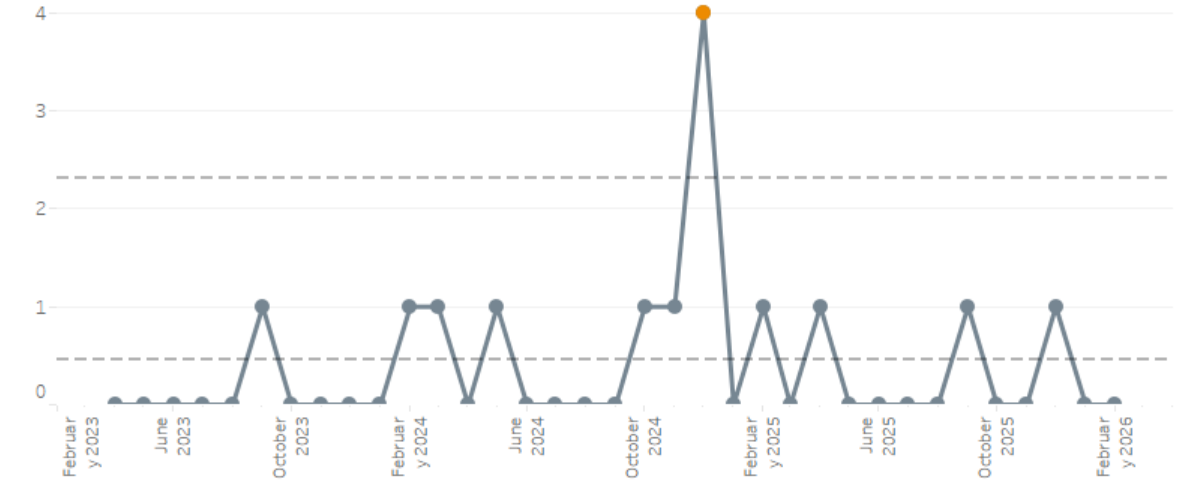
Metric Info:

Rate of: Stillbirths >= 24 Wks (Including TOPs)

Per 1,000: Births >= 24 Wks

Category: Neonatal Morbidity & Mortality

Number of Terminations of Pregnancy >= 24 Weeks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0

Data Observations:

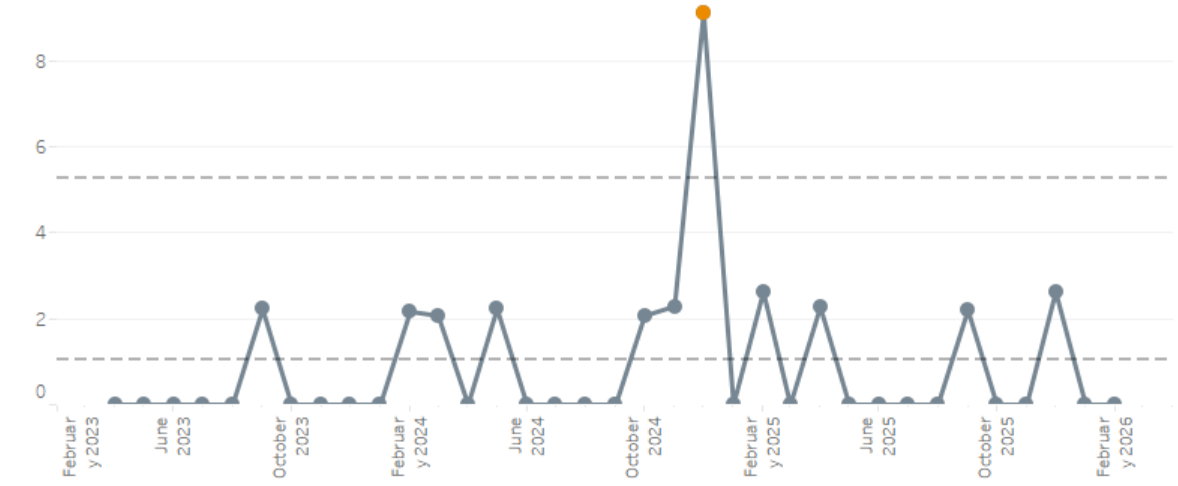
Common cause - no significant change

Metric Info:

Number of: TOPs >= 24 Wks

Category: Neonatal Morbidity & Mortality

Terminations of Pregnancy >= 24 Weeks



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	2.3	0.0	0.0	0.0	0.0	2.2	0.0	0.0	2.6	0.0	0.0

Data Observations:

Common cause - no significant change

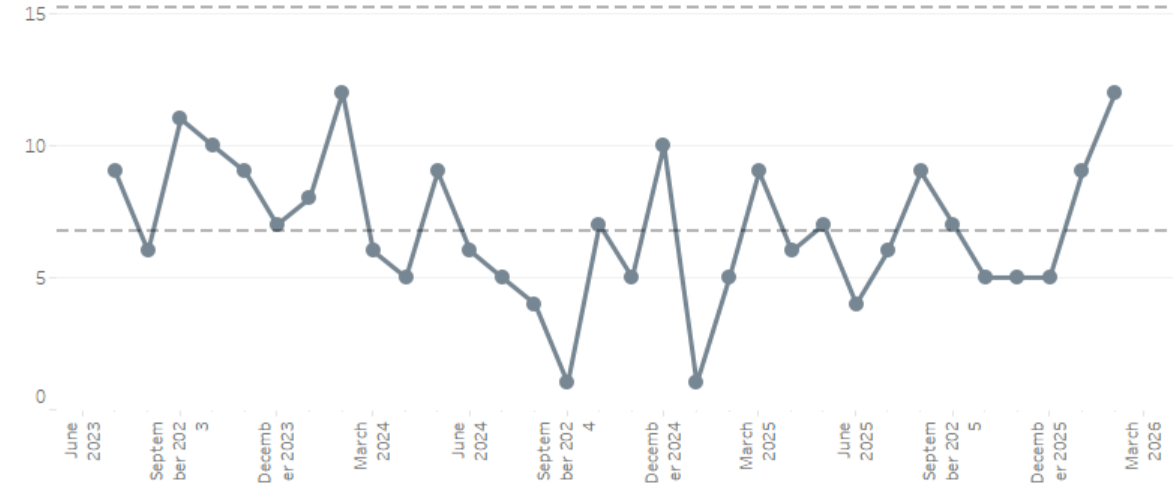
Metric Info:

Rate of: TOPs >= 24 Wks

Per 1,000: Births >= 24 Wks

Category: Neonatal Morbidity & Mortality

Number of <3rd Centile Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	6.0	7.0	4.0	6.0	9.0	7.0	5.0	5.0	5.0	9.0	12.0

Data Observations:

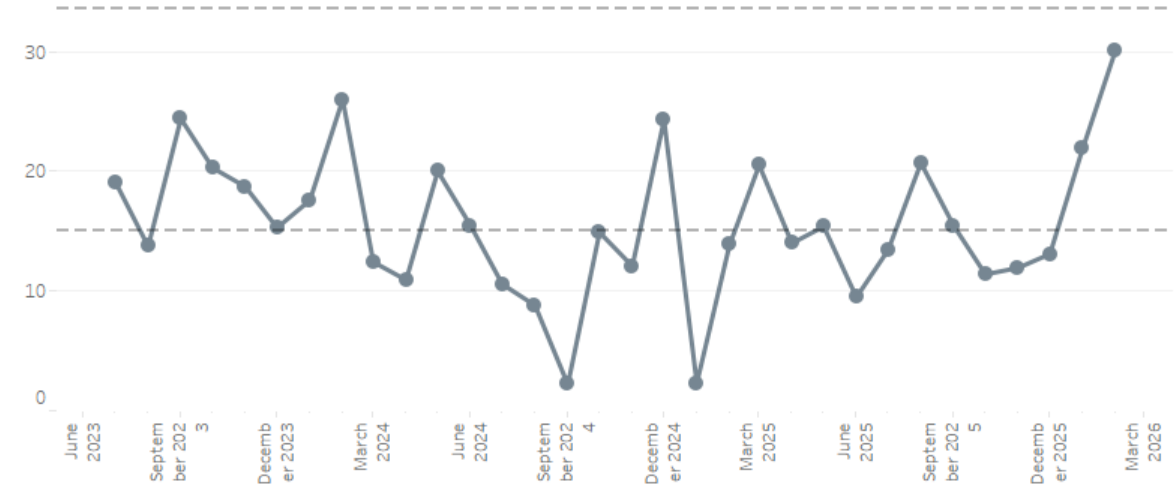
Common cause - no significant change

Metric Info:

Number of: <3rd Centile Births

Category: Neonatal Morbidity & Mortality

<3rd Centile Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	14.0	15.4	9.5	13.4	20.7	15.5	11.4	11.9	13.1	21.9	30.1

Data Observations:

Common cause - no significant change

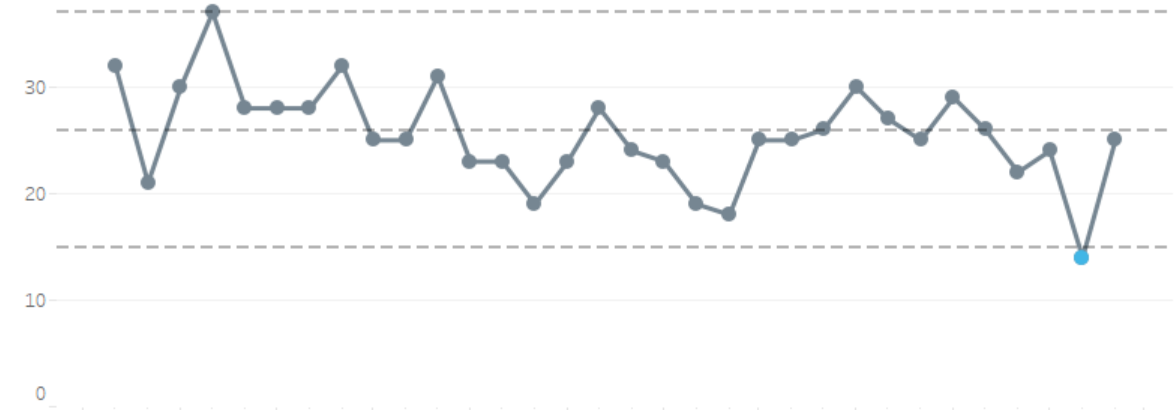
Metric Info:

Rate of: <3rd Centile Births

Per 1,000: Births with Recorded Intergrowth Centile

Category: Neonatal Morbidity & Mortality

Number of <10th Centile Births



Data Observations:

Common cause - no significant change

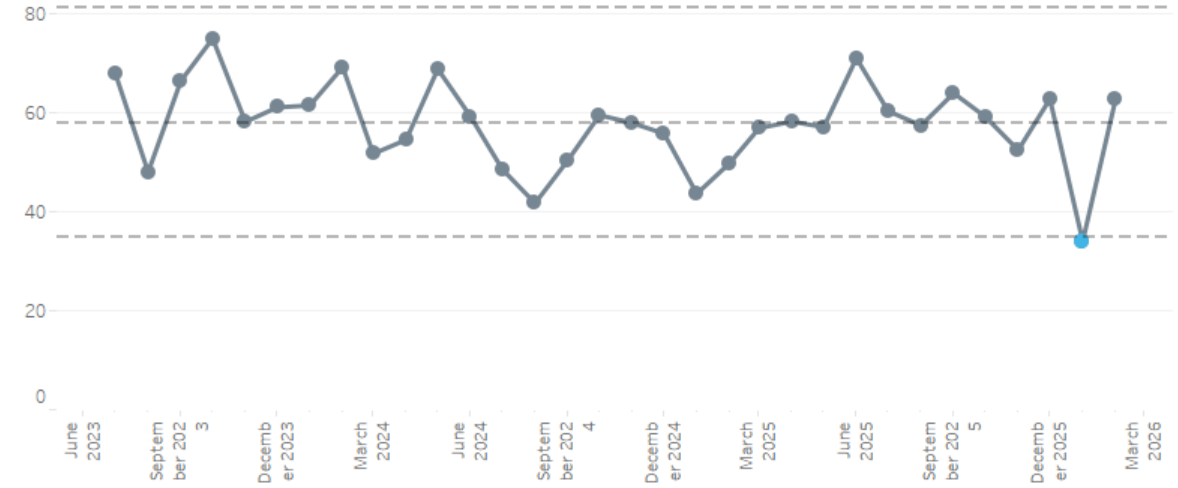
Metric Info:

Number of: <10th Centile Births

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	25.0	26.0	30.0	27.0	25.0	29.0	26.0	22.0	24.0	14.0	25.0

Category: Neonatal Morbidity & Mortality

<10th Centile Births



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	58.3	57.1	71.1	60.4	57.5	64.0	59.2	52.5	62.8	34.1	62.7

Data Observations:

Common cause - no significant change

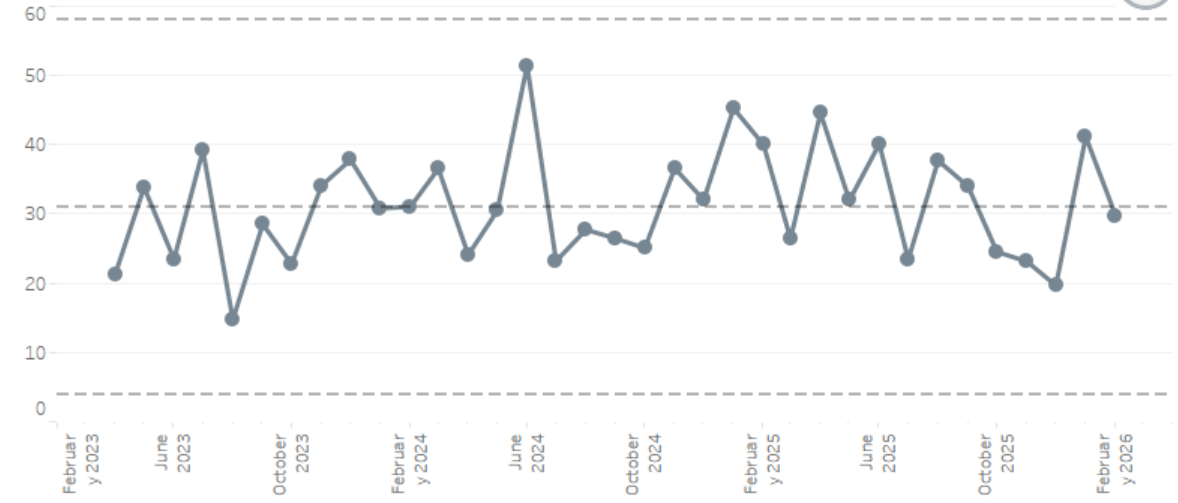
Metric Info:

Rate of: <10th Centile Births

Per 1,000: Births with Recorded Intergrowth Centile

Category: Neonatal Morbidity & Mortality

Term Admissions to Neonatal Unit (ATAIN Admission Reasons)



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	44.6	32.0	40.1	23.4	37.7	34.0	24.5	23.1	19.7	41.1	29.7

Data Observations:

Common cause - no significant change

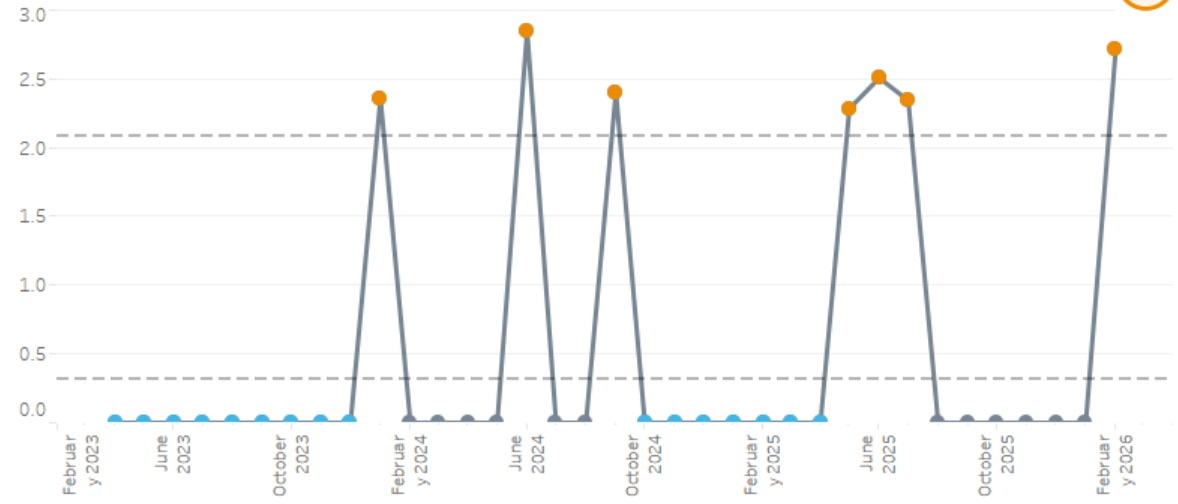
Metric Info:

Rate of: Term Admissions (Admission Reason: Respiratory Disease, Infection Suspected, Hypoglycaemia, Jaundice, Monitoring & HIE)

Per 1,000: Term Births

Category: Neonatal Morbidity & Mortality

Term Readmissions to Neonatal Unit



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	0.0	2.3	2.5	2.3	0.0	0.0	0.0	0.0	0.0	0.0	2.7

Data Observations:

Special cause of concerning nature or higher pressure due to (H)igher values

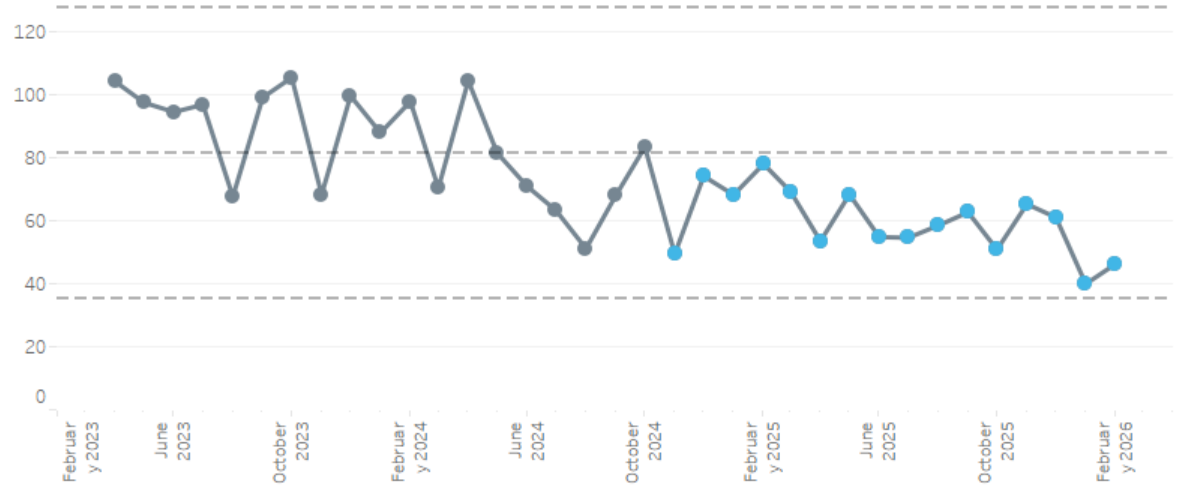
Metric Info:

Rate of: **Term Readmissions**

Per 1,000: **Term Births**

Category: Smoking

Smoking at the Time of Delivery



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2025/26	53.5	68.3	54.8	54.5	58.4	62.6	50.8	65.2	61.0	39.9	46.3

Data Observations:

Special cause of improving nature or lower pressure due to (L)ower values

Metric Info:

Rate of: Smoking at Delivery

Per 1,000: Deliveries (with Smoking Status Update)

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	14 May 2026
Report title	Case for Change: Maternity Services Report
Sponsoring Director/Author	Matt Holdaway Chief Nurse and Director of Quality

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

Executive Summary

Executive summary

This paper summarises the published *Case for Change* for Gloucestershire's NHS Maternity Services (March 2026) and sets out why services must evolve to remain safe, equitable and sustainable and to meet the changing needs of women, babies and families in Gloucestershire.

The Case for Change describes a maternity system commissioned by NHS Gloucestershire ICB and delivered primarily by Gloucestershire Hospitals NHS Foundation Trust, alongside key partners including Gloucestershire Health and Care NHS Foundation Trust, primary care, Family Hubs and the voluntary and community sector. It should be read alongside the Maternity Health Needs Assessment, which provides additional evidence about population need and inequalities.

Key drivers for change include:

- Rising clinical complexity and changing patterns of care, including increasing consultant-led care, rising induction and caesarean section rates, and growing demand for specialist input, theatres, post-operative capacity and ultrasound.
- Persistent and widening inequalities in access, experience and outcomes, linked to deprivation, ethnicity, language and inclusion health factors. In 2023/24, around 40% of births were to women living in the three most deprived deciles; in 2024/25, around 23% of births were to women from ethnic minority communities, and 11.8% of women did not speak English as their first language.
- Outcomes vary by deprivation and ethnicity (including higher stillbirth and neonatal mortality rates in the most deprived communities and for some ethnic minority groups, and higher rates of pre-term birth in deprived areas), requiring culturally sensitive, trauma-informed and more proactive, preventative models of care.
- Prevention opportunities across the pathway (including preconception and targeted antenatal care) to address modifiable risk factors such as smoking, obesity and alcohol

use (including fetal alcohol spectrum disorder), as well as domestic abuse, poor mental health and unmanaged long-term conditions.
- Workforce and infrastructure pressures, including the need to maintain safe staffing and appropriate skill mix (with a high proportion of newly qualified midwives) and increasing pressure across obstetric, anaesthetic and theatre teams.
- Ongoing national and regulatory scrutiny and expectations for demonstrable improvement following CQC inspection outcomes and wider national maternity investigations and policy changes (noting that the 2025 CQC maternity survey reported better-than-expected results for labour and birth locally, alongside areas requiring further improvement).

The Case for Change is not a proposed service model; it provides the evidence base, vision and principles to support a system-led, co-designed approach to developing maternity services that deliver safe, personalised, equitable care and improved outcomes while operating within a finite financial envelope. It also describes the outcomes the system is seeking, including reducing inequalities, improving and making experience more consistent for women and families, improving staff satisfaction, and improving value for money and financial sustainability.

This paper is presented to Board for **approval**, **discussion** and **information**, to provide assurance on the rationale for change, the Trust's current improvement work, and the proposed approach to governance and oversight as the next phase of engagement, co-design and options development progresses.

Previously considered by	ICB Board Due at Health and Overview Scrutiny Committee (HOSC) 26 May 2026

Recommendations:

The Board is asked to:

- RECEIVE the Gloucestershire ICB Maternity *Case for Change* (March 2026) and NOTE the key drivers for change, including rising clinical complexity, inequalities in outcomes and experience, workforce/capacity constraints, and the requirement to deliver improvement within a finite financial envelope.
- ENDORSE the principles that underpin the vision in the Case for Change and SUPPORT the outcomes described, including reducing inequalities, improving and making experience more consistent for women and families, improving staff satisfaction, and improving value for money and sustainability.
- NOTE that the Trust is progressing improvements that are within its gift, including actions to strengthen quality and safety, support a positive culture, and continue recruitment, retention and professional development for the maternity workforce.
- SUPPORT the Executive team in working through the Provider Collaborative, Maternity and Neonatal Voices Partnership (MNVP), and with county council and voluntary/community partners to co-design an evidence-based delivery plan to address inequalities in outcomes and experience, including a focus on preconception and targeted antenatal care.
- NOTE the Trust's maternity and neonatal equity dashboard and AGREE the proposed route for ongoing reporting and oversight (e.g., through the Quality & Performance Committee and/or via the Board strategy cycle), aligned to system governance as options are developed.
- DISCUSS the implications for the Trust (quality, safety, workforce, capacity and financial sustainability) and the level of assurance and ongoing oversight required as the system progresses through co-design and options development.

- NOTE the proposed next steps: continued engagement with women, families, staff and stakeholders (including MNVP), alignment with the maternity health needs assessment, and development of potential future service options for formal consideration through system and provider governance routes.

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?
SR1 – Inability to deliver safe and effective care against statutory and regulatory requirements *SR1 impacts include a heightened risk of regulatory action and loss of assurance (e.g., continued "inadequate" CQC position/Warning Notices), increased risk of patient harm and adverse outcomes, and escalating operational/financial pressures (workforce, capacity and potential litigation) if safe maternity care cannot be consistently delivered.*

Implications on:	
Equality, Diversity and Inclusion	The Case for Change has implications for equality, diversity and inclusion as service redesign must actively address known maternity health inequalities and ensure equitable access, experience and outcomes for women and families from disadvantaged and minoritised groups.
Health Inequalities	The Case for Change has clear health inequalities implications, as failure to implement sustainable service improvements risks perpetuating existing disparities in maternity access, experience and outcomes for women and babies from deprived and marginalised communities.
Finance and Resource	The Case for Change has financial and resource implications for the Trust, as failure to deliver sustainable maternity improvements risks continued reliance on short-term mitigations, increased workforce and litigation costs, and ongoing pressure on acute capacity and resources.

Regulation/Legal	The Case for Change has regulatory and legal implications. It responds to national and local requirements to provide safe services, to meet the expectations of regulators and commissioners, and to demonstrate improvement in quality governance, learning from incidents, and compliance with relevant standards and guidance.
CQC-Key line of enquiry	The Case for Change has implications for CQC key lines of enquiry, particularly the requirement to demonstrate that services are safe, effective, caring, responsive and well-led. This includes strengthening staffing models, governance and assurance, improving experience (including communication and postnatal support), and addressing inequalities in outcomes and experience.
Green Plan	The Case for Change has Green Plan implications, as service redesign and pathway changes provide an opportunity to reduce avoidable travel, improve estate and workforce efficiency, and support delivery of the Trust's net-zero and sustainability commitments if environmental impact is considered during implementation.

Main Report

Main report

Enclosures
Gloucestershire's NHS Maternity Services: *Our Case for Change* (March 2026) (public document).

1. Background and purpose
The Gloucestershire NHS Maternity Services *Case for Change* (March 2026) sets out the rationale for developing maternity services that are fit for the future. It describes the changing needs of the local maternity population, current services, challenges in delivery and outcomes, and why change is required. It is not an options appraisal or a proposed redesign; it is intended to provide the evidence base (alongside the maternity health needs assessment) for a co-designed approach to future service development.

2. Current service model (high level)
- Commissioned by NHS Gloucestershire ICB and provided by Gloucestershire Hospitals NHS Foundation Trust, with key partner services including health visiting and specialist perinatal mental health provided by Gloucestershire Health and Care NHS Foundation Trust, and support from primary care and Family Hubs.
- Antenatal and postnatal care delivered across the county; intrapartum care delivered mainly through a consultant-led unit at Gloucestershire Royal Hospital and a midwifery-led birth unit at Gloucester (alongside).
- Freestanding midwifery-led units exist at Stroud and Cheltenham; however, Cheltenham Birth Unit and Stroud postnatal beds have been temporarily closed since 2022 to support safe staffing (including the requirement for 1:1 care in labour). Home birth was temporarily suspended in November 2025 following safety concerns raised by staff.

- A 24/7 maternity triage and advice service is provided at Gloucestershire Royal Hospital, alongside routine and additional ultrasound scanning, and a local neonatal unit for babies requiring specialist care.

3. Key drivers for change

3.1 Rising clinical complexity and changing patterns of care

- The local birth rate has reduced since 2016 and is expected to remain broadly stable until around 2032 before a modest increase; however, complexity is increasing, driving higher dependency and specialist demand.
- There is an increasing proportion of consultant-led care, alongside rising induction and caesarean section rates (including growing pressure on theatres and post-operative capacity) and increasing ultrasound demand driven by policy and clinical guidance changes.
- Drivers include rising maternal age, obesity, perinatal mental health needs, and more women entering pregnancy with multiple long-term conditions.

3.2 Persistent inequalities in access, experience and outcomes

- The county includes pockets of significant deprivation; 40% of births in 2023/24 were to women living in the three most deprived deciles, with known links to poorer outcomes.
- Diversity is increasing: nearly a quarter of births in 2024/25 were to women who did not identify as White British, and 11.8% did not speak English as their first language.
- The Case for Change highlights ongoing inequalities for deprived and ethnic minority communities and for women experiencing severe and multiple disadvantage (e.g., domestic abuse, homelessness, substance misuse and mental ill health), requiring trauma-informed, culturally sensitive and accessible models and stronger interagency working.

3.3 Experience, quality and regulatory expectations

- Women's feedback describes an inconsistent experience, with strengths in compassionate intrapartum care but recurring themes around communication, continuity and postnatal support (including feeding support and mental health/birth trauma support), as well as concerns about digital tools.
- CQC inspections since 2022 have identified significant concerns and have resulted in Warning Notices and ongoing improvement requirements. The Case for Change also reflects the national focus on maternity safety and improvement, including learning from independent reviews and forthcoming national recommendations.
- External independent reviews were commissioned to learn from maternal and neonatal deaths, and whilst improvements have been made, sustained work is required to embed consistency and assurance.

3.4 Workforce, capacity and financial sustainability

- Midwifery staffing has improved through recruitment and retention, but the workforce includes a high number of newly qualified midwives and there are ongoing pressures on obstetric, anaesthetic, theatre and post-operative care capacity associated with rising intervention rates.
- The current community midwifery model and caseload allocation require review to better reflect population need, reduce inequity and improve continuity, safety and staff wellbeing.
- System spend on maternity has increased significantly since 2020/21 alongside increasing complexity and out-of-county activity. The Case for Change emphasises the need to improve outcomes and experience while operating within a finite financial envelope and delivering better value for money.

4. What "good" looks like (vision and expected benefits)

The Case for Change sets out a vision for a future maternity service that delivers safe, equitable and personalised care; reduces inequalities; improves women's experience and babies' start in life; supports staff wellbeing; provides value for money; and joins up care across maternity, health visiting, primary care, Family Hubs, perinatal mental health and the voluntary and community sector.
Expected benefits described include reduced inequalities in outcomes, more consistent experience for women, improved staff satisfaction, and improved financial sustainability through limiting cost growth and targeting resources where need is greatest.

4. What Gloucestershire Hospitals has achieved
Over the past two years, Gloucestershire's maternity services have made clear and sustained improvements to make care safer, better organised and more focused on women, babies and families. The service has strengthened staffing and leadership, improved how risks like heavy bleeding after birth are identified and managed, and put clearer systems in place to spot problems early and escalate concerns quickly. Governance and oversight have been tightened so there is clearer accountability from the frontline through to the Trust Board, supported by better use of data and dashboards. Women's experiences and feedback now play a stronger role in shaping improvements, complaints are handled more effectively, and learning from incidents is used more consistently to prevent harm. Together, these changes mean maternity care in Gloucestershire is more reliable, better monitored and more centred on the needs and safety of the people who use it.

5. Conclusion and next steps
The Case for Change concludes that ensuring future sustainability will require a model that responds to increasing complexity and inequalities, supports informed choice where this can be delivered safely, and improves productivity and value for money. Next steps include further engagement with women, families, staff and stakeholders (including MNVP) to share the Case for Change, consider evidence of what works elsewhere, and co-design potential future service options for the next stage of decision-making through system and provider governance.

FOI: *Public*

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Our Case for Change

Making Gloucestershire's NHS Maternity Services Fit for the Future

Why do we need a case for change?

A 'case for change' presents the rationale for developing services that are fit for the future. This document sets out the Gloucestershire NHS Maternity Services Case for Change.

It explains the current and future needs of our local maternity population, existing services, the challenges facing maternity care in Gloucestershire, and why change is needed. It does not present solutions for a maternity service redesign, but together with the maternity health needs assessment, it provides the foundation for the codesign of a maternity service that is the very best it can be: a service that consistently delivers safe, equitable and high-quality care for every woman[1], baby and family. To achieve this, we must ensure everyone in the county has an equal chance of a healthy pregnancy and postnatal period, and consider how our service model supports us in reaching that goal.

Over recent years, our maternity services have faced significant changes, including an increasing number of complex[2] pregnancies, new national policy, changes in women's choices, and workforce pressures. These challenges are not unique to Gloucestershire. There is a national focus on improving maternity care, driven by findings from recent independent investigations and reports such as the Ockenden Report, along with the commitment to implement the upcoming recommendations of the National Maternity and Neonatal Investigation, due later in 2026. At the same time, the NHS 10-Year Plan encourages a stronger focus on wellbeing, prevention, and supporting people to maintain their health and independence – particularly during pregnancy and the crucial early years.

The feedback to our Gloucestershire 5-Year Plan engagement in 2025/26: Getting ready for the Future NOW! confirmed that a set of principles developed with input from local people and communities 10 years ago still held true to help guide the development of health and care services and support for the future:

- A greater amount of the budget should be spent on supporting people to take more control of their own health
- There should be a greater focus on prevention and self-care
- We should develop joined up community health and care services
- We should bring some specialist hospital services together in one place
- We should focus on caring for people with the greatest health and care needs.

Approximately 80% of people who participated in the survey also agreed that services and support that people use most frequently should be available as close to people's own homes as possible and that it is reasonable for people to travel further for services they don't need as often, perhaps once or twice a year, including more specialist care.

The local 5-Year Plan engagement responses also identified supporting parents and families, and health education and prevention in early years, as a priority.

We have looked carefully at how our services are performing and how well they are meeting the needs of our changing maternity population. This has been done alongside listening to the experiences of women and families, the insights of staff, and understanding the clinical, demographic and societal changes happening both locally and nationally. It is clear that our current service was not designed for the needs of today's population, nor the needs we expect in the future.

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[1]Note on terminology: This document uses the terms 'women' or 'mothers' throughout. These should be taken to include people who do not identify as a woman, but who are pregnant or have had a baby.

[2]Pregnancies may be considered 'complex' for a variety of reasons including pre-existing health conditions, age, social factors, or other factors affecting the pregnancy such as twins. Complex pregnancies will require additional input and specialist care.

What is our vision for the future of our maternity service?

Our vision has been developed with our Maternity Service Review project group and board. Members include Gloucestershire Maternity and Neonatal Voices Partnership (MNVP), clinicians and managers from Gloucestershire Hospitals NHS Foundation Trust (GHT), NHS England Regional Maternity Team, NHS Gloucestershire Integrated Care Board (ICB), and Public Health at Gloucestershire County Council.

Gloucestershire's maternity service needs to be fit for the future to meet the changing needs of the population, codesigned with women, birthing people, and stakeholders.

This means:

Delivering safe, equitable, personalised, high-quality care for women, babies, and their families

Reducing inequalities in access and outcomes across protected characteristics and particularly ethnicity, inclusion health groups, deprivation and urban/rural status

Providing good outcomes and experiences for women and the best start in life for babies

Ensuring high levels of staff engagement, satisfaction, and wellbeing

Providing a service that provides value for money and meets the needs of all women in Gloucestershire while continuing to provide choice

Joining up care across professional groups e.g. midwives, health visitors, and GPs, and between services e.g. maternity services, family hubs, perinatal mental health, health visiting, social care, and voluntary and community sector organisations, to make it easier for women to get the right help and support when it is needed.

Current state: Maternity services in Gloucestershire

The services we provide

NHS maternity services in Gloucestershire are commissioned by NHS Gloucestershire ICB and provided by Gloucestershire Hospitals NHS Foundation Trust (GHT). Health visiting and the specialist perinatal mental health service is provided by Gloucestershire Health and Care NHS Foundation Trust (GHC). General Practitioners work alongside maternity services to support women during and after pregnancy.

These services include **antenatal care** (care during pregnancy), **intrapartum care** (care during labour and birth), and **postnatal care** (care for the mother and baby after birth).

The maternity services include the following:

Midwifery-led care:

Routine antenatal and postnatal care across Gloucestershire's six districts, and intrapartum care for low-risk women at home or in a midwifery-led birth unit.

Consultant-led care:

Antenatal, intrapartum and postnatal care, including outpatient clinics and day assessment unit, for higher risk women requiring additional monitoring. These clinics are supported by a range of specialist midwives (for women with additional or complex health or social needs, and include tobacco dependency, substance and alcohol support, safeguarding, bereavement, and perinatal mental health), other health care professionals, a regional Maternal Medicine Network (specialist care for women with significant pre-existing or pregnancy-related medical conditions) and a regional Fetal Medicine Network (specialist care relating to fetal medicine).

Maternity triage and advice line:

Triage is a 24/7 in-person assessment service at Gloucestershire Royal Hospital, and is available along with a maternity advice phone line for women who are more than 16 weeks pregnant or are recently postnatal and experiencing non-emergency or concerning symptoms.

Maternity ultrasound:

Routine antenatal scans for all pregnant women and additional scans for women with higher risk pregnancy.

Local neonatal unit:

For babies more than 27 weeks' gestation requiring specialist neonatal care.

These services are primarily concentrated in Gloucester and Cheltenham, with limited satellite provision for ultrasound and some consultant-led clinics across the rest of the county.

There is a choice of options for place of birth. The full range of choice is not currently available due to temporary closures, but would consist of:

- One alongside midwifery-led birth unit (AMU): Gloucester birth unit in the Women's Centre at Gloucestershire Royal Hospital.
- Two freestanding midwifery-led units (FMU): Stroud Maternity Unit (birthing suite and 6 postnatal beds) at Stroud General Hospital, and Cheltenham Birth Unit (birthing suite) at Cheltenham General Hospital.
- Home birth.
- A consultant-led unit in the Women's Centre at Gloucestershire Royal Hospital (intrapartum care in a delivery suite, and a combined antenatal/postnatal maternity ward).

Cheltenham birth unit and the postnatal beds in Stroud maternity unit have been temporarily closed since 2022, both due to midwifery shortages and to support safety, including the quality standard of 1-1 care in labour across services in Gloucestershire. In November 2025, the home birth service was suspended following safety concerns raised by staff. This decision was made after careful consideration to ensure the safety of mothers, babies, and staff.

Our workforce

Since 2022, Gloucestershire has faced midwifery staffing challenges impacting on safety, with the workforce not fully recruited to permanent posts. Focused recruitment and retention efforts have led to significantly improved levels of staffing (although this consists of a high number of newly-qualified midwives), and staff are supported by a new leadership structure.

There has been increasing pressure on the obstetric workforce (doctors) with the changing trends towards increased medical intervention, including caesarean births. This has led to a review of the obstetric workforce supported by NHS England, and obstetric staffing levels have subsequently been increased since 2022[3].

Performance of our services

GHT maternity services have been on an improvement journey over the last few years, overseen and supported by GHT's Board, the ICB, and NHS England's Maternity and Neonatal Improvement Support Team Programme.

Care Quality Commission (CQC) inspections

2022

An inspection of all GHT's maternity services by the CQC in April 2022 led to a rating of 'inadequate', with a section 29A Warning Notice issued for safe care, workforce, and governance processes and systems.

2023

In April 2023, the CQC reinspected the maternity service at Gloucestershire Royal Hospital only, again rating them as inadequate, with a section 29A Warning Notice. A separate CQC inspection in December 2023 of Stroud Maternity Unit led this part of the service to be rated as 'requires improvement'.

2024

In March 2024, the maternity service at Gloucestershire Royal Hospital only was reinspected and again rated as 'inadequate' (the CQC report was delayed and published in January 2025), and the Trust was served a section 31 Warning Notice over concerns relating to: learning from incidents; the provision of safe care; workforce; and governance processes.

[3]Since 2022, investment in the obstetric workforce has enabled new posts, including a 7-day Registrar presence in triage, additional consultant cover for unscheduled care, dedicated 24/7 obstetric and gynaecology on-call roles, and strengthened governance. However, further consultant expansion is required to meet rising clinical complexity.

Maternal and neonatal death reviews

As part of the work to improve quality, experience and safety following CQC inspections, two external reviews were commissioned in 2024 to identify what more GHT could learn from seven maternal deaths (2017–2023) and 44 neonatal deaths (2020–2023). The reviews made a number of recommendations and highlighted some failings in care. GHT has undertaken a substantial programme of work to identify where improvements have already been made and where further action is needed. A robust plan is in place to address any outstanding areas for improvement. The Trust also engaged with the families involved in these reports to acknowledge failings, listen to their experiences and concerns, and ensure they felt confident in the steps the Trust was taking. See more information here.

Progress

There has been some good progress in maternity services. Specific improvements include:

- Increased staffing levels: reduced vacancies in midwifery since 2025, and additional obstetrician posts created and recruited to since April 2022
- New leadership structure and strengthened governance
- Improved staff induction process for agency staff
- Electronic access to maternity notes for women and families (2023)
- Following latest best practice for risk assessment and reducing major bleeding after birth
- Improving blood clot risk assessments
- Strengthening the internal Freedom to Speak Up service
- Providing a range of support for families and staff.

Despite pressures, the 2025 CQC survey focusing on women's recent experiences positions Gloucestershire Hospitals Trust as performing 'Better Than Expected' in labour and birth, highlighting staff dedication and quality of care, whilst underlining the need for consistency of antenatal information and sustained improvement in postnatal experience.

Future state: Changing needs of our population

The maternity health needs assessment provides a comprehensive overview of the demographics and clinical characteristics of Gloucestershire's birthing population. The full needs assessment can be viewed here, and below is a summary of the key findings.

Although there have been a number of improvements to the maternity service, the findings from the needs assessment reveal that we face significant challenges, including health inequalities, inconsistent experiences of people using services, changes in women's choices, and increasing levels of clinical complexity, while needing to operate within a finite financial envelope.

A changing birth rate

The trend in live births in Gloucestershire overall follows the national picture: in 2016 there were 6,739 registered live births, but the rate has decreased since then to just over 5,800 in each of the years 2022-2024.

Birth numbers are expected to **remain stable until around 2032, before a projected modest increase** with district-level variation. This pattern will require adaptable planning for workforce, estate, and community-based services.

Changing demographics

Gloucestershire has a mix of urban and rural areas, and although it is generally affluent and is among the 20% of least deprived counties nationally, there are pockets of significant deprivation. Gloucester and the Forest of Dean have above-average levels of deprivation compared with England as a whole, and these two districts include 12 neighbourhoods ('Lower Super Output Areas') which are in the most deprived 10% nationally, accounting for 3.1% of the county's population. The fertility rate amongst deprived communities is disproportionately high: 40% of births in 2023/24 were to women living in the three most deprived deciles.

Nearly a quarter of births in Gloucestershire in 2024/25 were to women who identified as having an ethnicity that was not white British, with the majority of these being in Gloucester, followed by parts of Cheltenham. 11.8% of women who birthed in Gloucestershire in 2024/25 did not speak English as their first language.

Health inequalities remain a defining issue and are expected to shape future maternity need and provision. Women from deprived areas and ethnic minority communities already experience disproportionately poorer outcomes and greater barriers to care. Future service design will need to focus on reducing inequality of outcomes between our different demographic groups and prioritise culturally sensitive and accessible care.

Local data shows inequality of outcomes in the county among those from deprived areas and/or ethnic minority communities:

- Higher stillbirth and neonatal mortality rates among women in the most deprived deciles and/or among ethnic minorities.
- Babies in the most deprived areas are significantly more likely to be born preterm.
- Asian and British Asian women are more likely to experience third- or fourth-degree perineal tears.
- Women who are of Black, Brown or Mixed ethnicity are more likely to have a postpartum haemhorrhage.

National data continues to show persistent inequalities, with higher rates for both stillbirth and neonatal mortality among families from deprived areas and/or ethnic minority communities as follows:

- Despite an 8% decrease in stillbirth rates for babies born to mothers from the most deprived areas (from 4.60 per 1,000 total births in 2022 to 4.23 per 1,000 total births in 2023), these rates remain much higher than those for babies born to mothers from the least deprived areas (2.46 per 1,000 total births).
- Inequalities in neonatal mortality rates by socioeconomic deprivation widened in 2023. Rates increased for babies born to mothers from the most deprived areas (from 2.38 per 1,000 live births in 2022 to 2.50 in 2023), a rate now more than double that of babies born to mothers in the least deprived areas, where the rate decreased from 1.18 per 1,000 live births in 2022 to 1.03 in 2023.
- Stillbirth rates decreased in 2023 for babies of Black and White ethnicities but increased by 9.8% for babies of Asian ethnicity, compared to 2022. Babies of Black ethnicity remain more than twice as likely to be stillborn than babies of White ethnicity (Black: 5.84 per 1,000 total births; White: 2.71 per 1,000 total births). The MBRRACE (2025) report does not identify a single explicit cause for this increase in stillbirths in Asian babies, but it is likely part of a broader pattern of ethnic and socioeconomic inequalities in perinatal outcomes.
- Neonatal mortality rates decreased in 2023 for babies of all ethnicities compared to 2022. However, babies of both Asian and Black ethnicity continue to have much higher rates of neonatal mortality than babies of White ethnicity (Asian: 2.35 per 1,000 live births; Black: 2.28 per 1,000 live births; White: 1.50 per 1,000 live births).

Other inequalities experienced nationally by Black, Brown and Mixed ethnicity women include:

- **Miscarriage rates are 40% higher in Black women, and Black ethnicity is now regarded as a risk factor for miscarriage.**
- **Public Health England's 2020 report found that prematurity (preterm birth) is a major cause of long-term infant morbidity. Black mothers, particularly those of Black Caribbean background, are twice as likely to give birth before 37 weeks.**
- **UK studies show that women from ethnic minority communities are more likely to suffer from common mental health disorders, yet are less likely to access treatment.**

Women experiencing social exclusion and/or severe and multiple disadvantage (SMD) (those who face multiple challenges such as domestic abuse, homelessness, substance misuse, and mental health issues) face significantly greater risks in pregnancy than those without these experiences. These women are at the highest risk of severe maternal morbidity and maternal death, reflecting both heightened need and the systemic barriers they encounter.

These intersecting inequalities highlight the importance of ensuring maternity provision for these women is trauma informed, flexible and aligned with current guidance so that women receive appropriate and equitable care, and improved outcomes. It is also essential to improve interagency collaboration between maternity services, other healthcare services, social care, Family Hubs and voluntary and community organisations to support women who experience severe and multiple disadvantage to ensure enhanced and joined-up care.

Maternal age is linked to increasing clinical complexity in pregnancy, but older mothers can also have greater socio-economic status and access to care. The average maternal age continues to rise, with the average maternal age in England being 30.9 years in 2024. In that same year, nearly two thirds of all births in the county were to people aged over 30. Women over the age of 35 are more likely to experience pregnancy-specific complications, such as gestational diabetes and pre-eclampsia, which increase the risk of adverse maternal and neonatal outcomes. Therefore, maternity services must adapt to manage more complex pregnancies safely and equitably, with appropriate staffing, training, and infrastructure to support personalised and responsive care.

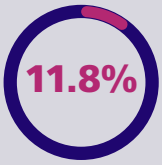
Data modelling based on Johns Hopkins algorithm forecasts that **both low-complexity pregnancies and high-complexity pregnancies will increase by 2040 in Gloucestershire**: **low complexity by 5.11%, and high complexity by 6.68%**[4]. The birth rate is also forecast to increase by then. However, these figures show that high-complexity pregnancies are projected to increase slightly more than low-complexity pregnancies.

More women are now entering pregnancy with multiple long-term conditions and will require consultant care, and this trend is projected to continue. These births are likely to be both more complex and require more medical input, including anaesthetics.

Inequalities in access and uptake of antenatal education

Although there has been some online antenatal education introduced by the NHS in Gloucestershire, this is not universally accessed. Women from more deprived communities are less likely to take up the online offer (those from areas in the highest 30% for deprivation (Indices of Multiple Deprivation deciles 1-3) account for 40% of the county's births but only 12.2% of NHS-provided online antenatal education users). 2.3% of users accessed the course in a language other than English.

40% of county births in 2023/24 were to women in deprivation deciles 1-3.

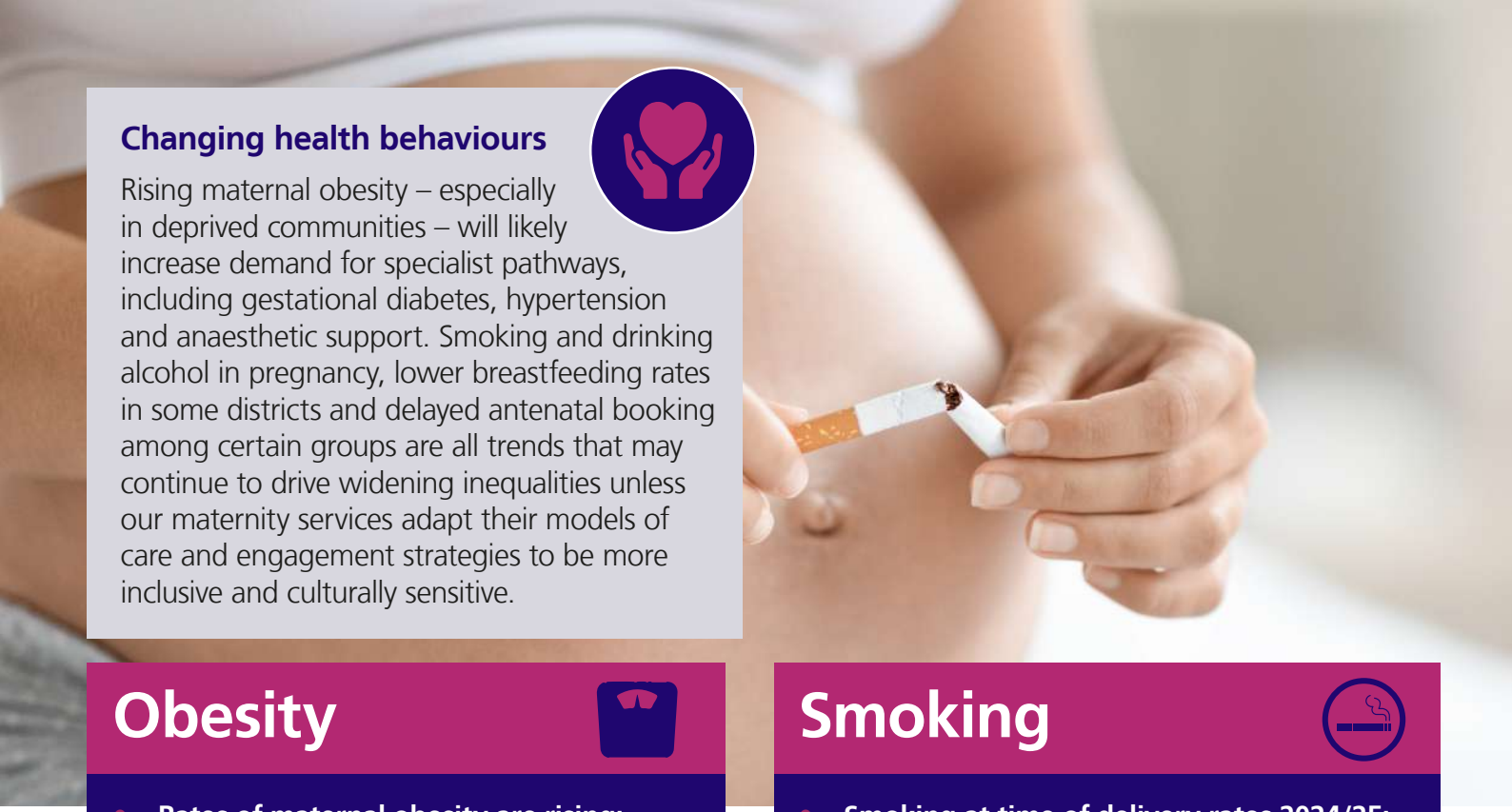


11.8% of women who birthed in Gloucestershire in 2024/25 did not speak English as their first language.

Only 2.3% of users accessed the course in a language other than English.

There is very limited NHS-led, face-to-face antenatal education, and feedback from some women indicates that having a face-to-face option available would be beneficial. This identifies the importance of understanding the needs within the diverse populations, and to coproduce potential solutions with women and the multi-disciplinary team in the maternity service. It is important to align the antenatal education offer with the Family Hubs model of care to ensure that groups are localised for families and support joint multi-professional working.

[4]Note – currently the data does not include confidence intervals, so it is not known if these differences are significant. The variance will be reviewed in further work to see if there is a statistically significant difference

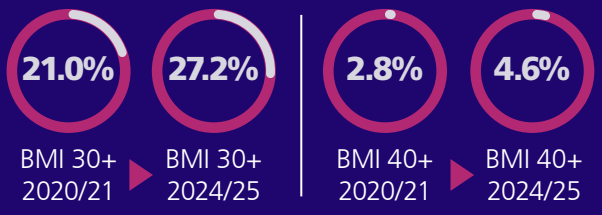


Changing health behaviours

Rising maternal obesity – especially in deprived communities – will likely increase demand for specialist pathways, including gestational diabetes, hypertension and anaesthetic support. Smoking and drinking alcohol in pregnancy, lower breastfeeding rates in some districts and delayed antenatal booking among certain groups are all trends that may continue to drive widening inequalities unless our maternity services adapt their models of care and engagement strategies to be more inclusive and culturally sensitive.

Obesity

- **Rates of maternal obesity are rising:**



- **Particularly prevalent in areas of higher deprivation**
- **Higher risk of maternal complications (gestational diabetes, hypertensive disorders, prolonged labour, caesarean section) and adverse neonatal outcomes (stillbirth, premature birth, childhood obesity).**

Smoking

- **Smoking at time of delivery rates 2024/25:**

- **Although higher than the national average, the local rate has been steadily declining in line with the national average**
- **Rates are highest in the most deprived areas**
- **Increases risk of complications such as low birth weight, premature birth and stillbirth, and long-term consequences for child development.**

Breastfeeding

- **Rates are lowest in Gloucester and the Forest of Dean, and among white British women.**

Alcohol

- **Heavy or regular drinking can cause fetal alcohol spectrum disorder (FASD), and the most serious type of harm called fetal alcohol syndrome (FAS). Children with FASD can have learning difficulties, problems with behaviour, physical disabilities and mental health problems, while those with FAS usually have severe mental and physical disabilities. While there is no local data available about the prevalence of FASD or FAS, studies show that Britain has one of the highest prevalences of FAS in the world.**

Inequalities in outcomes

As we have seen, these demographics and health behaviours feed directly into adverse maternal and neonatal outcomes such as higher rates of stillbirth, neonatal and maternal mortality, full-term neonatal admissions, preterm birth and maternal morbidity – patterns unlikely to reverse without significant targeted intervention. As the maternity population in Gloucestershire continues to diversify and age, the complexity of pregnancies is expected to increase, placing greater pressure on obstetric, fetal medicine and anaesthetic services.

Support for women who experience health inequalities in maternal and neonatal outcomes will need to focus on proactive and preventative measures, and support into early childhood, through interagency collaboration between maternity services, other healthcare services, Family Hubs and voluntary and community organisations.

Importance of preconception care

Preconception care is essential for improving outcomes for both mother and baby, particularly through proactive interventions for those with pre-existing health conditions and/or experiencing health inequalities. However, access to high-quality preconception care is inconsistent, making it vital to consider how it can be delivered more equitably.

Strengthening preconception care should involve integrated, preventative approaches that support individuals before pregnancy, especially those at higher risk of poor outcomes. This period offers a crucial opportunity to identify and address factors that can influence pregnancy and birth outcomes, many of which – such as obesity, smoking, managed and unmanaged chronic conditions, poor mental health, and exposure to domestic abuse – are already present before conception.

Increased demand for ultrasound in pregnancy

There has been an increase in demand for ultrasound scanning in pregnancy, driven by policy changes, which has resulted in demand outstripping current capacity. There is a plan in place to address this, and further work is needed to ensure equitable access. This trend is likely to continue as screening expectations evolve, and as maternal complexity increases.

More consultant-led care

Gloucestershire has seen a shift away from midwifery led births towards consultant-led births since 2019. Despite the temporary closure of Cheltenham birth unit in 2022, this trend mirrors the national picture. More women are giving birth in the consultant unit (an increase from 70.6% of women in 2019 to 82.4% in 2024), and fewer in midwifery-led birth units, as the requirement for consultant-led care has increased.

Caesarean section rates are rising (from 28.5% in 2019/20 to 43.4% in 2024/25), now slightly exceeding spontaneous vaginal births for the first time, and emergency caesarean sections are increasing more rapidly than elective caesareans (10.9% increase in emergency caesarean sections from 2019/20 to 2024/25, compared with 4.0% increase in elective caesarean sections).

The exact reasons for these changes are not fully understood nationally, but are likely to be linked to shifting demographics, including more women giving birth later in life, higher rates of obesity, and a growing prevalence of pre-existing health conditions. This is in addition to change in guidance to ensure women have an informed choice on mode of birth including caesarean section. A growing emphasis on informed choice is likely to influence future patterns

of care further, and a recent review of maternity infrastructure by NHS England suggests that specialist care need will continue to rise (NHS England, 2025).

Induction of labour rates are also rising both locally and nationally. The rate has increased in Gloucestershire from 27.5% in 2021/22 to 33.2% in 2024/25, similar to the national average rates.

Several factors are likely to have contributed to this, including developments in national policy and clinical guidance. These rates are likely to continue to rise as maternal age, obesity and multiple long-term health conditions increase.

Reduction in midwifery-led births

The number of midwifery-led births (birth units and home births) is decreasing, from 28.8% (1669 babies) of all births in the county in 2019 to 16.3% (874 babies) in 2024.

Gloucester birth unit had the most midwifery-led births in the county in 2024, with 13.2% (705 babies) of all births (down from 16.5% (958 babies) in 2019), while Stroud maternity unit had 1.7% (93 babies) (down from 4.2% (242 babies) in 2019), so is now under-utilised. The number of births in Cheltenham birth unit was declining prior to its temporary closure in 2022 (298 in 2019, 233 in 2020, and 141 in 2021), so it is likely that – based on the declining usage of Gloucester and Stroud birth units since 2022 – this decline in Cheltenham would have continued, had it remained open.

Postnatal care

For most midwifery-led birth units, the standard level of care is for women to have a short recovery time (usually within 6 hours) in the room where the birth took place, and then to go home for follow-up support from community midwives. Postnatal beds in Stroud cannot provide the level of specialist care required if a woman needs to stay in hospital following a birth. This is currently provided at the Gloucester site.

Post-operative care for caesarean births is distinct from routine postnatal care and requires additional resources (e.g. increased length of stay) and expertise. Current maternity ward staffing models do not necessarily reflect the complexity of post-operative care. This includes the need for surgical midwifery/nursing skills to manage wounds, monitor complications, and administer an increasing range of medications. With increasingly complex operative births (predominantly as a result of previous caesarean sections and/or maternal comorbidities), a review of postnatal post-operative workforce skills and bed capacity will be required.

Postnatal outcomes and experiences vary significantly by level of deprivation, underscoring the need for consistent, high-quality early postnatal care. Systemwide work has strengthened handovers between maternity, health visiting and general practice, and bereavement support has been expanded to cover 7 days a week. In the future it will remain important to ensure safe and seamless transitions between maternity, health visiting and primary care, especially with changing demographics, and there is a need for better postnatal support for women including around breastfeeding, bereavement and mental health.

Mental health

Around one in four women experience a perinatal mental health condition, and referrals to the Specialist Perinatal Mental Health (PMH) Service continue to grow. However, persistent under-representation of women from deprived and/or ethnic minority groups suggests that improving access and culturally sensitive pathways should remain a priority into the future. As awareness increases and birth trauma recognition expands, demand for specialist perinatal mental health support is expected to rise further.

What women and staff have told us they want from maternity services

Feedback from women

A wide-ranging insight programme involved nearly 900 service users, families, staff and community groups. It also included targeted engagement with Polish, Black and South Asian communities, and a review of Care Quality Commission (CQC) survey results, Patient Advice and Liaison Service (PALS)/Complaints and Friends and Family Test (FFT) survey data.

The insight gathered reveals an inconsistent experience of maternity care in Gloucestershire. Whilst women frequently describe compassionate, skilled care during labour and birth, alongside significant challenges in communication, continuity, and postnatal support, antenatally there are difficulties accessing appointments, inconsistent information, and a lack of continuity of midwifery care. Intrapartum (labour and birth) experiences are often positive – particularly around staff kindness, responsiveness and safety – yet some women report feeling pressured into interventions, receiving insufficient explanation of procedures, and variation in service availability (including birth units and home birth cover). Postnatally, many families rely on partners and private/community services due to inconsistent breastfeeding support, variable ward staffing, and limited mental health follow up. Digital record systems such as Badger Notes are widely criticised for usability and reliability.

Key improvement priorities consistently emerge:

- **Strengthened communication at every stage:**
  improved communication; clearer and consistent information about procedures, delays in care, pain relief, and what to expect through labour, aftercare and postnatally once home; information about support services and resources.
- **More reliable and accessible antenatal and postnatal care:**
  improved access/appointment system; more compassionate care; more regular postnatal checks especially around wound care; better postnatal staffing levels on the wards; better postnatal emotional and mental health support, including birth debriefs; personalised, consistent and compassionate postnatal care.
- **Improved inclusivity, cultural sensitivity and equity of access:**
  better access to support services including antenatal classes, breastfeeding support groups, and mental health support, that is easily accessible to diverse communities and people from all parts of the county.
- **Continuity of care:**
  consistency of midwife and appointments to build trust and provide a sense of familiarity and reassurance.
- **Enhanced breastfeeding support:**
  more support with breastfeeding and identification of tongue-tie.
- **Better digital tools:**
  more accessible and reliable digital tools (due to issues with BadgerNet) that enable improved access to information for women, and improved communication between women and health professionals.

A key consideration going forward is how to maximise the impact of insight, working with the Maternity and Neonatal Voices Partnership (MNVP) to develop future maternity services that are personalised, accessible and equitable.

Feedback from staff

A wide range of ideas and feedback was provided from staff working in maternity as well as from those who work closely with maternity colleagues, such as Family Hubs staff, GPs, those in the perinatal mental health team, and health visitors.

The key points include:

- **Staff wellbeing and support:**
  GHT needs to prioritise staff wellbeing by improving working conditions and reducing stress and workload.
- **Communication and collaboration:**
  Clear dissemination of new information, guidelines and systems, and issues and concerns, is required. Monthly meetings with local health visitors and joint training sessions, where appropriate, would improve collaborative working.
- **Resource allocation and system flow:**
  A review of working practices would ensure effective use of resources and reduce waste. Streamlining processes and reducing paperwork would allow staff to focus on providing quality care for women and babies and enable more efficient flow through services.
- **Care and services:**
  Focus on providing individualised care. Provide improved postnatal care including breastfeeding support and care on the wards.
- **Midwifery-led care:**
  Support midwifery-led services to be more cost effective and deliver good outcomes.
- **Innovation and new ways of working:**
  Encourage innovative ideas and new ways of working, e.g. the HOME pilot for managing hypertension. Reviewing the role of Maternity Care Assistants would enable them to better support midwives.
- **Information sharing:**
  Referral via BadgerNet has been helpful, although there are reports of challenges in terms of reliability, speed of updates and women being able to access their notes, appointments and general information.
- **Continuity:**
  Greater continuity of midwife would support women, particularly the most vulnerable.
- **Birth trauma:**
  More support needed for those who experience traumatic birth.
- **Collaborative working:**
  Opportunities for improved communication, clarity of roles and more collaborative working with health visitors, GPs and voluntary sector/community organisations. Clear appetite from respondents to work more closely with community midwifery teams e.g. in Family Hubs.

From current to future: Challenges we need to address

Based on what we understand about the performance of Gloucestershire's maternity service along with the insight and needs and outcomes of our maternity population, the following key challenges have been identified.

1. Rising levels of complexity

The number of women having consultant-led pregnancies and births, including induction of labour and caesarean births, is increasing.

Several factors are contributing to this rise in consultant-led pregnancies and births:

- **The number of women experiencing clinically complex pregnancies is increasing.** This reflects a range of contributing factors, including an increase in maternal age, higher rates of obesity, a greater prevalence of mental health conditions, and more women living with multiple long-term health conditions. As a result, a growing proportion of women require consultant-led medical care during their pregnancies. This shift has significant implications for maternity services, with more women needing specialist input and oversight throughout their pregnancy and birth.
- **Developments in national policy and clinical guidance** reflect the latest evidence regarding safe and effective care throughout pregnancy and birth. These developments have identified risk factors that could contribute to adverse outcomes for both mothers and babies. As a result, there has been an increase in the number of planned inductions, requiring more specialised care and increasing dependency needs.
- **Shifts in choice and informed decision making are also having an impact.** Coupled with information from new national guidance, changes in the way women are accessing information from a variety of sources to inform their choice has had an impact on women's decision-making regarding birth choices. This has led to greater demand for specific interventions, including inductions and elective caesareans.

It has also resulted in an increasing but still relatively small number nationally and locally of births referred to as 'outside of guidance', i.e. women requesting home or midwifery-led births when this would not usually be recommended by a health professional. This has resulted in an identified need to review local guidance and policies to ensure they follow national guidance and support staff adequately.

Health behaviours and mental health issues can impact on the long-term health of women and the next generation.

Smoking rates and alcohol use in pregnancy, rising levels of obesity, and perinatal mental health issues, are associated with risks of complications for women and babies perinatally as well as long-term health issues. They also have the potential to impact on the health and wellbeing of the next generation. This highlights the importance of embedding prevention through preconception care and optimising opportunities to improve partnership working between maternity services, other healthcare services, social care, Family Hubs and voluntary and community organisations to improve immediate and long-term outcomes. It is particularly crucial for women who experience severe and multiple disadvantage to ensure enhanced and joined-up care.

The NHS 10-Year Plan includes a shift towards wellbeing, ill-health prevention, and maintaining health independence, recognising that improving outcomes for pregnancy and the early years requires proactive measures rather than reactive care. In addition, the Plan highlights giving

every child the best start in life with a focus on the first 1001 days. The local 5-Year Plan engagement response identified supporting parents and families, and health education and prevention in early years, as a priority. To achieve this, maternity services must:

- Explore the provision of preconception care for those women with existing medical conditions or risk factors.
- Work collaboratively with Family Hubs and Neighbourhood Health Services that integrate health, social care, and community support to look for solutions to improve health and wellbeing.

2. Inequalities in access to care, outcomes and experience

Outcomes are poorer for people from ethnic minority and/or deprived communities.

National and local data shows that women from ethnic minorities and/or deprived communities experience poorer outcomes, including increased risks of stillbirth, neonatal mortality, preterm birth, and maternal death, and require culturally sensitive care. These women may experience several practical barriers to accessing care including communication/language, transport, and digital exclusion.

Access to maternity care in Gloucestershire is inequitable, with wide variation depending on where women live and their personal circumstances. For example, some parts of the county have limited availability of maternity services such as routine ultrasound scans. These service inequalities can disproportionately affect those without access to private transport or with complex social needs, ultimately reducing their access to information and therefore their ability to make informed choices about their care.

Wider socioeconomic factors such as unemployment, low educational attainment, domestic abuse, homelessness, digital exclusion, and limited access to transport further hinder engagement with maternity services. These intersecting challenges emphasise the need for targeted enhanced service provision and resources for these women, to support a reduction in health inequalities and disparity inequality of outcomes.

Women from ethnic minority communities, living in areas of deprivation, or experiencing complex social challenges, are less likely to be referred to, or to access, specialist support services like perinatal mental health care. Stigma and mistrust of services may prevent some women from seeking help. As a result, these populations are at higher risk of poorer outcomes.

Some work has been done by the Local Maternity and Neonatal System in Gloucestershire to create an equity action plan focusing on reducing health inequalities and improving outcomes for women from ethnic minority communities and those living in areas of higher deprivation. However, more needs to be done to reduce inequality and ensure that all women have access to the right care and that care is culturally sensitive. Future service design will need to:

- Focus on reducing inequality of outcomes between different demographic groups
- Ensure accessible care

- Demonstrate greater cultural sensitivity, be anti-racist and anti-discriminatory in its design and delivery
- Tackle the systemic factors contributing to poorer maternal outcomes among ethnic minority communities.

Support for women who experience health inequalities in maternal and neonatal outcomes will need to focus on proactive and preventative measures and support into early childhood, through interagency collaboration between maternity services, other healthcare services, Family Hubs and voluntary and community organisations.

People's experience of, and access to, maternity services is inconsistent.

There has been an increasing spotlight on maternity services over recent years, with a number of national investigations and reports giving recommendations on the quality and safety of maternity care. These include the Ockenden Report, Reading the Signals (East Kent), and the National Maternity and Neonatal Investigation that is currently underway (February 2026) – and as part of the latter, Gloucestershire is one of 12 services under review. Gloucestershire Hospitals Trust has had an inadequate CQC rating since 2022 and is working through an improvement journey with the support of the Maternity Services Support Programme, Gloucestershire ICB and NHS England's regional team.

Women in Gloucestershire have shared that their experiences are inconsistent, particularly around communication, postnatal care on the ward, feeding support, and support for mental health issues including birth trauma.

Ensuring a culture of care, inclusion and compassion, appropriate staffing, skills, and expertise in maternity care is crucial for safe, high-quality services and positive experiences for women.

3. Resource constraints

The current workforce model and utilisation of facilities is not designed to meet the changing needs of women. This has increased costs significantly without the same improvement in outcomes.

Workforce

Although there has been some recruitment to consultant posts and Gloucestershire is currently recruited to full establishment for midwives, maternity staffing challenges persist nationally and locally:

- The current Gloucestershire midwifery workforce, with a high number of newly qualified staff, has less experience and specialist skills, for example around home birth and high dependency care.
- The current community midwifery workforce model does not reflect the needs of women, particularly those with more complex health and social needs. The community midwifery caseloads require review so that they are tailored to the level of inequalities and the demographics of different communities across the county. This will ensure equity of provision of maternity care so that improved safety, quality and continuity of care can be provided, reducing staff burnout, dissatisfaction, and workforce loss.
- Increasing complexity of women, changes in national policy and guidelines, and changing choices, means there are not enough permanently recruited obstetricians to meet the rising demand for specialist care and there is also additional demand on theatre staff, including anaesthetists.

Theatre capacity

There is increasing pressure on theatres and post-operative postnatal beds as caesarean section rates rise. Caesarean sections are likely to become more complex as the numbers continue to increase and the surgical challenge and risk of complications increase. Theatre capacity and usage, and post-operative care capacity, should be reviewed.

Birth units

Of the two freestanding midwifery-led birth units in the county (in addition to the alongside midwifery unit in Gloucester), Stroud is open for births, but Cheltenham has been temporarily closed since 2022 to ensure the provision of 1:1 care in labour. For the same reason, Stroud's postnatal beds are temporarily closed.

The number of births in birth units is decreasing – and was reducing even prior to these closures – and current utilisation is low. 14.9% of all births in the county in 2024 were in birth units, down from 25.9% in 2019. In 2024, Stroud maternity unit had 93 births, and the usage of Cheltenham birth unit was declining prior to its temporary closure, with 141 births in 2021. The configuration of staffing and services needs to be considered to meet the changing needs and choices of women, and to reduce inequity in provision.

The table shows the number of live births per district and the districts where birth units and postnatal beds are located.

District	No. of live registered births (2024)	Birth unit	Postnatal beds
Cheltenham	1040	Yes (temporarily closed)	No
Cotswold	637	No	No
Forest of Dean	791	No	No
Gloucester	1421	Yes	Yes
Stroud	939	Yes	Yes (temporarily closed)
Tewkesbury	998	No	No

Financial sustainability

Since 2020, the NHS in Gloucestershire has increased the spend on maternity services from £31 million in 2020/21 to £57 million in 2025/26, an 84% increase despite a reducing number of births. This includes payments to out of county providers of £2.5m in 2020/21 and £4.9m in 2025/26. This significant increase in spend is in response to the changing birth trends and levels of need and complexity amongst women. It is crucial that maternity services deliver high quality, safe and equitable care whilst also providing as much value as possible, and the Government set out a three-year settlement for the NHS in Autumn 2025 which allowed for overall real terms growth of 2.4% per year to 2028/29. Our aim is to ensure that services deliver consistent outcomes and experience whilst keeping within the available resources.

This means looking at opportunities to reshape the way we deliver care to be more productive and provide better value for money, and targeting resources where the health needs of the population are greatest, in order to reduce inequalities in outcomes, in line with the NHS 10-Year Plan.

Whilst we seek to provide health and care closer to where people live, it may be appropriate (clinically and economically) to deliver some services through more central locations in the county and for these to be more streamlined. This may include reviewing how support services are provided as well as how organisations make better use of the estate.

In the public responses to the recent local 5-Year Plan '[Getting ready for the future NOW!]' engagement, approximately 80% of people agreed that services and support that people use most frequently should be available as close to people's own homes as possible and that it is reasonable to travel further for services they don't need as often.

The outcomes that we want

Benefits of developing services that are fit for the future:

Expected Benefits		
Benefit	**Measure**	**Stakeholder**
(What is the benefit?)	*(What is the measure?)*	*(Who benefits?)*
Reduction in inequalities of outcomes between those who experience health inequalities the most and the least. Outcomes include reduction in inequalities in preterm births, stillbirths, small for gestational age, perineal tears, postpartum haemorrhage, neonatal and maternal readmissions, and neonatal and maternal mortality	Metrics on GHT's inequalities dashboard and the national inequalities dashboard comparing differences in these outcomes for those who experience health inequalities	Women and families
Improved and more consistent experience for women	Care Quality Commission annual maternity survey, Maternity and Neonatal Voices Partnership feedback. Targeted engagement to obtain feedback from underserved communities MNVP insight	Women and families
Improved staff satisfaction	Staff survey, vacancy rates, mandatory training completed, staff absence	Staff working in maternity services Women and families
Increase in spend on maternity services limited to the annual net cost uplift factor as issued by NHS England / Department of Health and Social Care	Annual accounts	Wider NHS services and taxpayers

Conclusion and next steps

Ensuring the future sustainability of Gloucestershire's maternity services will require a model that responds to the changing clinical and demographic needs of women, supports informed choice where this can be delivered safely, and delivers equitable, personalised access to high-quality care.

We need to balance the challenges we face of health inequalities, increasing levels of clinical complexity, whilst operating within a finite financial envelope. This means thinking differently about how the maternity service is designed and delivered, and focusing on where we can have the greatest positive impact on experiences and outcomes for women, babies and families.

By designing services that reduce inequalities in outcomes, meet the needs of our diverse communities, are financially sustainable and create the right conditions for staff to provide safe and compassionate care, we can build a maternity system that is both resilient and truly responsive to the women and families it serves.

Further conversations and engagement are now needed with women, clinical staff and wider stakeholders, to share the Case for Change and research about what works elsewhere, and codesign potential solutions for a maternity service fit for the future.

Glossary

Antenatal

The period of pregnancy before birth, including all care and appointments provided to pregnant women during this time.

Antenatal education

Information and classes designed to help women and families prepare for labour, birth, and early parenthood.

BadgerNet / Badger Notes

The digital record system used in maternity services to store pregnancy notes and enable information sharing between women and clinicians. BadgerNet is for staff, and Badger Notes is the app for women.

Birth unit (Midwifery-led unit – MLU)

A unit run by midwives for women with low-risk pregnancies who want a birth with minimal medical intervention.

- **Alongside midwifery-led unit (AMU)**: A midwife-led birth unit located next to a consultant-led unit.
- **Freestanding midwifery-led unit (FMU)**: A birth unit run by midwives that is located away from a consultant-led unit.

Caesarean section

A surgical procedure to deliver a baby through an incision in the abdomen and womb.

- **Elective**: planned in advance.
- **Emergency**: carried out during labour when concerns arise about the health of mother or baby.

Care Quality Commission (CQC)

The national regulator for health and care services in England. It inspects and rates NHS services, including maternity care, for safety and quality.

Complexity (low / high)

A way of categorising pregnancies based on health risks:.

- **Low complexity:** minimal health concerns and typically suitable for midwifery-led care.
- **High complexity:** more health risks, often requiring a consultant-led care and closer monitoring.

Consultant-led care

Medical care provided by consultants and specialist nurses for women with higher risk pregnancies or complications.

Consultant-led unit

A hospital-based unit where care is led by consultant obstetricians, suitable for women with higher-risk pregnancies

Continuity of care

A maternity model in which women see the same midwife or small team of midwives throughout pregnancy, birth, and the postnatal period.

Deprivation (IMD Deciles)
A measure of socioeconomic disadvantage using the national Index of Multiple Deprivation. Areas are ranked from 1 (most deprived) to 10 (least deprived).
Delivery suite
The part of a consultant-led unit where women give birth with medical and specialist support available.
Equity action plan
A local plan setting out actions to improve access, reduce inequalities, and achieve fair outcomes for all women and babies.
Family hubs
Local centres providing joined up support for families, including health, early years, wellbeing and parenting services.
Fetal medicine
A specialist service that supports pregnancies where the baby in the womb has diagnosed or suspected health conditions
Fetal medicine network
A regional network of specialists who support pregnancies where the baby has diagnosed or suspected health conditions.
Friends and Family Test (FFT)
A national survey asking patients whether they would recommend the service they received to friends and family.
Gestational diabetes
A type of diabetes that develops during pregnancy and usually resolves after birth.
Governance
The processes and systems used to ensure safe, high-quality healthcare, including oversight of risks, incidents and improvements.
High dependency care
Specialist monitoring and treatment for women who require a higher level of medical support during pregnancy, labour or after birth.
Home birth
Giving birth at home with support from midwives. Suitable for some low-risk pregnancies.

Induction of labour
A process used to start labour artificially, often due to medical reasons or developing risks in pregnancy.
Integrated Care Board (ICB)
The NHS organisation responsible for planning and funding local health services, including maternity care.
Intrapartum
The period of labour and birth.
Local Neonatal Unit (LNU)
A hospital unit providing specialist care for newborn babies who are premature or unwell.
Maternal Medicine Network
A regional network of specialists who support women with significant pre-existing medical conditions during pregnancy.
Midwifery-led care
Care delivered by midwives for women with uncomplicated pregnancies, focusing on natural labour and birth.
Multiple long-term conditions
When someone has more than one chronic health condition, such as diabetes, hypertension or asthma, which can affect pregnancy.
Neonatal mortality
The number of babies who die within the first 28 days of life.
Ockenden Report
An independent review into maternity services in England, highlighting improvements needed to ensure safe, high-quality care.
Patient Advice and Liaison Service (PALS)
A service that helps resolve concerns, complaints or questions about NHS care.
Perinatal mental health (PMH)
Mental health conditions occurring during pregnancy or within the first year after birth.
Postnatal
The period after birth, usually described as the first six weeks.

Section 29A / Section 31 Warning Notice
Formal notices issued by the CQC when serious concerns are identified in NHS services, requiring urgent improvements.
Severe and multiple disadvantage (SMD)
Multiple challenges such as domestic abuse, homelessness, substance misuse, and mental health issues.
Ultrasound (Maternity Ultrasound)
Scanning in pregnancy that uses sound waves to check the baby's development and wellbeing.

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March 2026

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting held on 14 May 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Audit and Assurance Committee held on 21 April 2026
Board member lead(s)		Shawn Smith, Non-Executive Director (Chair)
Written by		Committee Chair and Trust Secretary
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 Audit & Assurance Committee meeting held on 21 April 2026 (quorate). The Committee meets bi-monthly and is attended by Non-Executive Directors, Executive Directors and senior managers, Internal Audit (BDO), External Audit (Deloitte) and Counter Fraud leads.

The Committee provides assurance on the adequacy and effectiveness of governance, risk management, internal control and financial reporting arrangements.

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.

- Financial sustainability remains a potential Significant Control Weakness, driven by ongoing reliance on non-recurrent savings (c. 50% of savings delivery) (Annual Governance Statement discussions).
- Payroll control weaknesses identified, including c. £482k of outstanding payroll overpayments (79% aged over 121 days) and inconsistent upstream controls. (Internal Audit report -Moderate Assurance. Actions in place)
- Diagnostics waiting times audit identified material weaknesses in data integrity and assurance, including inconsistencies between recovery plans and Board reports and lack of central data validation. (Internal Audit report -Limited design/moderate effectiveness)

- Fire safety remains a high-risk issue with active enforcement notices and a multi-year remediation programme requiring sustained executive and Board oversight (not judged to be a Significant Control Weakness)

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

- Internal Audit delivery remains slightly behind plan due to requested deferrals; continued executive support is required to ensure completion for year-end assurance.
- Risk management actions and policy compliance provide limited assurance, with c.34% of risk actions and c.31% of policies overdue, despite improving trends.
- Counter Fraud investigations are increasing in volume and complexity; clearer reporting of themes, severity and learning has been requested.
- DSPT audit rated 'high risk' due to volume of findings despite high confidence in self-assessment; further assurance required on system recovery testing beyond critical systems.

ASSURE: inform the board where positive assurance has been received

- Head of Internal Audit Opinion: 'Generally satisfactory with improvements required', reflecting improved engagement and responsiveness. (previously defined as a moderate opinion)
- No Internal Audit recommendations are overdue; 12 actions closed since the last meeting.
- External Audit interim work completed on interim audit with no significant misstatements identified to date and confidence in delivery of the year-end timetable.
- Counter Fraud 'failure to prevent fraud' compliance nearing completion and counter-fraud content being integrated into mandatory Code of Conduct training.
- Risk reporting maturity has improved with clearer visibility of Trust-wide risks and refreshed Board Assurance Framework alignment to the Trust Strategy.

APPROVALS: decisions made by the Committee

- Approved the draft Counter Fraud Workplan 2026/27.
- Approved the Audit & Assurance Committee Terms of Reference (subject to explicit reference to annual desktop review in alternate year).
- Determined that, subject to External Audit conclusion, financial sustainability remains the only matter likely to require disclosure as a Significant Control Weakness in the 2025/26 Annual Governance Statement.

Implications

Strategic Aims to which the paper relates (tick as appropriate)	
Patient experience and voice	

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

Board assurance framework

BAF reference	**SR3 (workforce), SR4(finance), SR6&7 (digital) and SR8 (Estates)**

Risks discussed

The Committee considered the full Risk Report and Board Assurance Framework report. Specifically, the Committee discussed the following risks: Financial sustainability and reliance on non-recurrent funding; payroll controls and financial loss; diagnostic waiting times performance and data assurance; cyber security and digital resilience; fire safety and estates compliance; effectiveness of risk action management and policy compliance.

Recommendations

The Board of Directors is asked to TAKE ASSURANCE from the Committee's work and conclusions and NOTE the matters escalated for Board attention, particularly financial sustainability, and payroll controls.
The Board is also asked to SUPPORT continued executive focus on reducing reliance on non-recurrent savings, strengthening payroll upstream controls, improving risk action and policy compliance discipline, and enhancing clarity of learning and control improvement arising from counter-fraud investigations.

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	14 May 2026
Report title	Integrated Governance Report – Legal, Regulatory and Policy Update
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance

For discussion
Content is presented as a constructive learning stimulus, designed to help the Board consider the potential impact of new regulatory requirements and to prompt us to explore whether regulatory breaches or organisational failures experienced elsewhere could reasonably be considered 'true for us'.

Executive Summary

This report provides an update to inform the Board of Directors of recent regulatory, compliance and policy developments issued by bodies such as NHS England, the Care Quality Commission and others, where their publications or actions have a direct or foreseeable impact on the Trust, or where awareness is necessary to support effective Board oversight.

The report is not intended to be exhaustive. Instead, it highlights a selection of current issues for awareness and enquiry, recognising that areas most pertinent to the Trust's business and risk profile will feature across future reports. What is included in this iteration is therefore illustrative, supporting wider Board development/enquiry rather than assurance unless available. An Addendum ('True for Us') is included to surface learning from external failures, inspections or regulatory insight, and to stimulate Board curiosity rather than closure. This supports the Board in testing whether similar conditions or risks might exist locally, without presumption that they do.

Proactive assessment of regulatory and compliance developments is a core component of effective Board governance. It enables early identification of emerging risks, provides an opportunity to stress-test new or evolving expectations, and supports the Board in understanding the cumulative impact of regulatory change on the Trust's overall risk profile, capacity and control environment.

In considering the concept of *'True for Us'*, it is recognised that post-failure regulation often seeks to strengthen accountability, including placing greater clarity and responsibility on directors individually and collectively. Active Board engagement with learning from external failures supports a culture of openness, integrity and continuous improvement, and helps ensure that

internal controls, escalation routes and oversight arrangements remain proportionate, effective and grounded in reality.	
Previously considered by	N/A

Recommendations:

The Board of Directors is invited to:

1. Note and consider the content of this report, and where relevant, satisfy themselves – individually and collectively – through appropriate enquiry, triangulation or follow-up that existing plans, controls and oversight arrangements are sufficient to meet the Trust's obligations and to respond to emerging regulatory expectations.
2. Support Board Committee Chairs and the Corporate Governance Team to ensure the themes and risk areas highlighted are reflected, where appropriate, in Committee agendas, workplans and deep-dive activity, with a particular focus on areas where assurance may benefit from further testing or visibility.

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

Impact on any Strategic Risks?
Strategic misalignment – regulations and 'corporate' failure can clash with existing strategies, requiring difficult trade-offs between national goals (e.g. reducing inequalities/improving safety, delivering sustainability objectives) and local service delivery. Where external regulatory failures highlight gaps between formal assurance and operational reality, Board may need to test whether strategic intent is being consistently translated into practice. Any perception of an organisational learning deficit, or weak grip on emerging risk, can damage public and staff trust and confidence.

Implications on:	
Equality, Diversity and Inclusion	No assessment in the context of this report content but specific items in the report may relate directly
Health Inequalities	No assessment in the context of this report content but specific items in the report may relate directly (e.g. NHS Oversight Framework item)
Finance and Resource	No assessment in the context of this report content, but increased regulatory expectation, remedial action following inspections, or governance improvement requirements may reduce organisational flexibility and capacity, with indirect resource implications over time (e.g. additional assurance activity, revised controls, or workforce impacts.
Regulation/Legal	The intention of the report is specific to the legal and regulatory context.
CQC-Key line of enquiry	The report aligns with the CQC *Well-Led* domain by supporting active Board oversight, learning and curiosity in relation to new regulatory requirements and external failures. It enables the Board to test how effectively strategic risks, regulatory expectations and emerging lessons are translated into local governance, assurance and control arrangements. The *Shared Direction and Culture* domain is particularly relevant, as it assesses how Boards convert national mandates and regulatory learning into a clear local vision and consistent behaviours that staff understand, support and experience in practice.

Green Plan	No assessment in the context of this report content but specific items in the report may relate directly to sustainability

Main Report

A. SITUATION

This report provides an overview of recent legal, regulatory and policy guidance issued by NHS England, the Care Quality Commission and other relevant bodies where their publications or actions have a material or emerging relevance for the Trust, or where early Board awareness supports effective governance and preparedness.

The report is intended to support situational awareness and enquiry, rather than provide full assurance. It highlights selected developments that may give rise to new obligations, changes in regulatory expectation, or learning from external failures, with the aim of helping the Board consider potential implications for strategy, risk, oversight and organisational focus. Content included at this stage is illustrative, recognising that topics most pertinent to the Trust's evolving risk profile will be addressed across future reports.

Where issues arising from the Legal, Regulatory and Policy Update require further consideration, proposals will be considered through the Executive Team. This ensures timely assessment of impact, appropriate engagement with consultations, and readiness to respond to changes in statutory or best-practice frameworks, including where preparatory or mitigating action is required.

Trust Position statements are included to provide clarity on the Trust's current stance, engagement or activity in relation to the topic described. They are intended to explain how the Trust is responding to, preparing for, or considering emerging requirements or learning, and to indicate where further work, oversight or enquiry may sit.

B. BACKGROUND

1. Draft NHS Oversight Framework

Not yet published

The refreshed NHS Oversight Framework (NOF), which remains in draft and has not yet been formally published, sets out a more explicit, data-driven and consequential approach to the oversight of NHS trusts and foundation trusts. A number of Board members received an early briefing on the draft NOF in April. The framework reinforces the direction of travel already evident through CQC *Well-Led* and the Provider Capability Assessment, placing greater weight on

relative performance, organisational capability and demonstrable grip on improvement, rather than improvement intent alone.

Oversight will continue to be based on quarterly segmentation (1–4) informed by nationally defined, scoring metrics across quality, access, people, productivity, finance and population health, alongside an annual assessment of board and organisational capability. Strong performance is not sufficient in the absence of credible quality governance, learning, risk management maturity and system working, and financial performance will continue to act as a gating factor. Overall, the draft NOF does not introduce wholly new requirements, but materially strengthens the consequences of weak assurance, shallow triangulation or over-optimistic self-assessment, reinforcing the expectation that Boards actively use oversight intelligence to drive improvement. The refreshed regulatory and oversight expectations place enhanced weight on health inequalities, with prevention, access and outcomes now carrying more explicit and consequential scrutiny within national frameworks, reinforcing this as a core Board-level priority and a key area for ongoing leadership focus.

Trust position: The Trust is aware that the refreshed NHS Oversight Framework remains in draft and subject to further clarification. To support understanding of the emerging expectations and implications for Board oversight, the Director of Integrated Governance is attending the national webinars and briefings being offered on the framework. Learning from these sessions will be used to inform future updates to the Board, including any implications for assurance, reporting or governance arrangements, once the framework is formally published and implementation expectations are confirmed.

2. **CQC – Transition to Sector Specific Assessment Frameworks**

Published March 2026

The Care Quality Commission has confirmed it is moving away from the Single Assessment Framework and introducing four sector-specific regulatory frameworks covering hospitals, mental health, primary care/community services and adult social care. While the five key questions (safe, effective, caring, responsive, well-led) remain unchanged, the way judgments are reached will change significantly. Scoring will be removed, and clearer rating characteristics will be applied at key question level, with inspection outcomes intended to be more transparent and consistent across sectors. This change is a direct response to criticism of CQC's previous model and is intended to support better quality judgments and provider understanding of regulatory expectations. For acute Trust boards, this reinforces the importance of evidence-based self-assessment, assurance over culture and leadership, and clarity that Board assurance statements accurately reflect operational reality ahead of the phased rollout expected later in 2026.
Link: https://www.cqc.org.uk/news/our-march-update

Trust position: As national expectations and implementation timelines are clarified during 2026, the Trust will consider whether any changes to internal assurance mechanisms or Board reporting are required.

3. **HSSIB – Insulin Safety in Inpatient Settings**

Published March 2026

The Health Services Safety Investigations Body (HSSIB) has published a national investigation into the safe administration of insulin for inpatients with diabetes. The report identifies persistent risks relating to fragmented accountability, inconsistent oversight at Trust and system levels, and incomplete implementation of existing national guidance. Insulin remains one of the highest-risk medicines in acute settings, with harm continuing to occur despite longstanding recommendations.

Of particular relevance for boards is HSSIB's conclusion that assurance for inpatient diabetes safety is often devolved without clear ownership, and that required local oversight mechanisms (such as diabetes safety groups) are inconsistently embedded. The report reinforces the need for Board-level understanding of how national guidance is translated into operational controls, medication safety governance and learning systems, particularly where risks are well known but not fully mitigated.

Link: https://www.hssib.org.uk/patient-safety-investigations/

Trust position: The Trust supports inpatient diabetes self-management where it is safe and appropriate and recognises alignment between local experience and the risks identified in the HSSIB report. While capability-assessment protocols are in place, practical and safety constraints continue to limit consistent implementation, including challenges with secure bedside storage of insulin and duplication of glucose monitoring when sensor-based systems are used alongside EPR requirements. These issues highlight the importance of clear oversight and translation of national guidance into effective operational controls. To strengthen Board-level visibility of high-risk areas in medicines management, the Medical Director will be asked to ensure that inpatient diabetes safety and insulin management is specifically addressed within the Medicines Management Annual Report, now included in the Quality & Performance Committee workplan. This will support focused oversight, learning and any further improvement activity through established governance arrangements.

4. **NHS England Corridor Care Definition Guidance**

Published March 2026

Further to the update to Board in the January Report, NHS England has issued formal guidance clarifying the definition of corridor care and temporary care environments, emphasising that these are not appropriate settings for the ongoing delivery of patient care except in genuinely exceptional circumstances. The guidance recognises significant national variation in how such environments are defined and recorded, contributing to inconsistent Board oversight and assurance.

For Trust boards, this guidance is important in reinforcing the need for clear local definitions, agreed metrics, escalation thresholds and narrative assurance about mitigation of risk when temporary care environments are used. It also underlines the Board's role in challenging whether temporary arrangements are becoming normalised and how patient and staff experience is understood and reported.

Link: https://www.england.nhs.uk/publication/?filter-publication=guidance

Trust position: The Trust recognises the clarity provided by NHS England's guidance and the associated expectations for consistent definition, escalation and oversight. Further to the update provided to the Board in the January report, the issue has been actively considered through existing risk management arrangements. At the Risk Management Group meeting last month, the relevant Division confirmed that a local Standard Operating Procedure is in development to support a clearer and more consistent approach to identifying, recording and managing the use of temporary care environments. The SOP will support improved clarity around definitions, escalation thresholds and mitigation measures, and will help ensure that any use of such environments remains exceptional, visible and subject to appropriate governance and review, rather than becoming normalised.

5. **Neighbourhood Health Framework**

   Published March 2026

The Department of Health and Social Care and NHS England published the *Neighbourhood Health Framework*, setting out national requirements for the development of a neighbourhood health service across England. The framework moves neighbourhood working from guidance to a mandated delivery model, with defined national goals, metrics and a phased implementation timeline from 2026/27 to 2028/29.

The framework places Integrated Care Boards and local authorities, through Health and Wellbeing Boards, as joint system leaders, with NHS providers expected to support delivery through integrated neighbourhood teams, expanded community-based alternatives to hospital care, and new provider and contracting models over time. For provider trusts, the framework has implications for service configuration, partnership working, workforce deployment, and the future organisation of community, outpatient, urgent and specialist services at neighbourhood level. Immediate priorities during 2026/27 focus on consolidation of existing neighbourhood working and preparation for more formal neighbourhood health plans from 2027/28 onwards.

Link: Neighbourhood health framework - GOV.UK

Trust position: The framework places primary leadership responsibility with Integrated Care Boards and local authorities, with NHS providers contributing through partnership working, service redesign and workforce integration at neighbourhood level. The Trust already supports neighbourhood-level working and is actively engaged with system partners on the development of alternatives to hospital-based care. These arrangements provide a strong foundation for future neighbourhood health delivery. During 2026/27, the Trust's focus will be on supporting system-led planning, understanding implications for

services and workforce, and ensuring that any proposed changes maintain patient safety, service quality and financial sustainability. The Trust will work with the ICB and local authority partners to clarify expectations, timelines and assurance arrangements as neighbourhood health plans are developed for 2027/28 onwards. At this stage, no material changes to Trust services are required, and further updates will be provided as system plans and national guidance are clarified.

6. **DHSC/NHSE Financial Directions to NHS England 2026/27**

Published March 2026

The Secretary of State has issued the statutory Financial Directions to NHS England for 2026/27, setting revenue and capital resource limits and reinforcing the direction of travel established in earlier guidance. The Directions confirm tighter controls on resource use and the expectation that NHS trusts deliver breakeven revenue positions, alongside strengthened system accountability arrangements. Although issued to NHS England, the Directions have direct downstream implications for provider boards, particularly in relation to financial planning assurance, risk management, and the interface between Trust and system decision-making. These developments further increase scrutiny of Board assurance statements, financial controls, and the evidence underpinning claims of deliverability in medium-term plans.

Link: https://www.gov.uk/government/publications/2026-to-2027-financial-directions-to-nhs-england

Trust position: The Trust recognises the strengthened expectations they set for financial discipline, system accountability and deliverability of plans. The Trust will continue to consider these implications through existing financial governance and planning arrangements, ensuring that Board assurance statements and medium-term plans are supported by clear evidence, realistic assumptions and transparent articulation of risk and dependency, with appropriate oversight through established Executive and Committee structures.

7. **HSSIB Strategy: Building Investigative Excellence**

Published February 2026

HSSIB has published its new strategy, Building Investigation Excellence, setting out how it intends to strengthen patient safety investigation capability across England. The strategy emphasises systems thinking, investigator competence, and clearer articulation of learning and safety recommendations at organisational and system levels. This has implications for Trust boards in terms of how internal investigations align with national best practice, how learning is embedded and assured, and how Boards satisfy themselves that incident investigation is credible, independent where necessary, and results in sustained improvement rather than repeated recommendations.

Link: https://www.hssib.org.uk/news-events-blog/

Trust position: The Trust recognises the national emphasis on high-quality, systems-based investigations, strong investigator capability, and the delivery of clear, impactful safety recommendations. The Trust has developed a trained cohort of patient

safety investigators, equipped in structured methodologies including Systems Engineering Initiative for Patient Safety (SEIPS), and consistently applying systems-based and human factors approaches. Investigations are undertaken within a restorative and just culture framework, supporting open engagement with patients, families and staff, and enabling a balanced understanding of contributory factors rather than individual blame. This approach aims to strengthen the credibility, consistency and independence of investigations, and supports the development of recommendations that more effectively address underlying system risks.

The Trust continues to invest in capability through training, supervision and peer review, recognising that investigator development is ongoing, particularly in strengthening the translation of learning into measurable and sustained improvement. Through established governance arrangements, the Trust maintains oversight of investigation quality, thematic learning and impact. There is a continued focus on ensuring recurrent themes are systematically addressed and that learning is demonstrably embedded rather than repeated. The Board receives assurance through routine reporting to the Quality and Performance Committee. The Trust will continue to align its approach with emerging national best practice to ensure investigations remain robust, compassionate and focused on delivering meaningful improvements in patient safety.

8. **Prevention of Future Deaths reports – recurring themes**

Publish date April 2026

DAC Beachcroft has published its fifth annual analysis of Prevention of Future Deaths (PFD) reports issued by coroners, drawing together recurring themes from over 300 reports relating to health and social care deaths in 2025. The analysis highlights a striking consistency over five years in the issues that continue to feature most prominently, particularly for acute hospital providers: incident investigation, communication between specialties and recordkeeping. Coroners repeatedly expressed concern not simply about individual errors, but about failures to investigate deaths in a timely or skilled way, superficial or defensive investigations, learning that occurred only once an inquest was underway, and actions arising from reviews that were not embedded or tracked. Across acute, mental health, social care and ambulance services, common threads included fragmented information flow, poor documentation obscuring clinical reasoning, breakdowns in cross organisational communication, and risks associated with patient flow pressures, corridor care and prolonged waits in emergency departments. The report reinforces that PFDs are rarely about the absence of policies or frameworks; rather, they reflect weaknesses in how organisations learn from harm, escalate emerging concerns and translate insight into sustained change. This analysis is included to prompt Board curiosity about how effectively learning from deaths is identified, owned and assured within local governance arrangements, how early warning signs are surfaced before reaching a coroner, and where deeper enquiry may be warranted to test confidence that assurance mechanisms would stand up to external scrutiny. See also the item in the True for Us/Learning section of this report.

Link: https://www.dacbeachcroft.com/en/What-we-think/Prevention-of-future-deaths-reports-in-inquests-recurring-themes-for-health-and-social-care-2026

Trust position: The Trust will continue to respond to any Prevention of Future Deaths (PFD) reports issued directly to it in line with statutory requirements. To strengthen consistency and compliance, a Standard Operating Procedure has been requested to codify responsibilities, processes and timelines associated with PFD responses. In addition, the Integrated Governance Director will review how national learning arising from coroners' reports, including recurring themes identified through external analysis, can be more systematically incorporated into local risk oversight, quality governance and Board-level discussion. This recognises that PFDs frequently indicate wider system and governance risks, rather than isolated events. Further reflection will be supported through future learning and *'True for Us'* mechanisms as national thematic analysis and guidance continue to develop. The next Legal Services Annual Report to the Trust Leadership Team will include a comparative assessment against the themes highlighted in this analysis to support transparency and informed governance scrutiny.

9. **Integrated Health Organisations and outcome based contracting**
   Published March 2026

NHS England has set out early expectations for the development of population health delivery and contracting models, including Integrated Health Organisations (IHOs), signalling a longer-term shift toward outcome-based contracts and integrated provider arrangements. Recent guidance indicates that integrated care boards will be expected to demonstrate how they have begun implementing some outcome-based contracts within three years, with 2026/27 positioned as a "developmental" year focused on building capability, infrastructure and shared understanding rather than formal contract award. The proposed IHO model is intended to support a move away from fragmented and episodic care, enabling organisations to take greater responsibility for population outcomes, resource allocation and the rebalancing of activity from acute to community settings. However, NHS England has also been clear that further consultation and co-development is required, and that detailed guidance on governance, financial flows, accountability and regulatory implications is still evolving. This update is included as horizon intelligence to support Board awareness of the emerging direction of travel, rather than as an indicator of imminent implementation or required action by the Trust at this stage.

Link:https://www.england.nhs.uk/long-read/fit-for-the-future-towards-population-health-delivery-models/

Trust position: **The emerging IHO and outcome based contracting model represents a significant potential change in how services may be commissioned and delivered over the medium term; however, national guidance remains developmental and subject to further consultation. As highlighted in the January update on this same matter, future Board development session will consider the implications of these models for the Trust and the wider system once the policy, governance and contractual framework has been clarified.**

10. **Mental health crisis care in Emergency Departments**

Publish date April 2026

The Health Services Safety Investigations Body (HSSIB) has published an interim investigation report examining the care of people experiencing mental health crisis in emergency departments, identifying a significant and longstanding legal, policy and safety gap. The report sets out how emergency departments are increasingly caring for people in severe mental distress for prolonged periods while they await Mental Health Act assessments or an available inpatient bed, often in environments not designed to provide safe or therapeutic mental health care.

Central to the findings is the absence of clear legal powers to lawfully prevent vulnerable individuals from leaving the emergency department while awaiting assessment or admission, creating a position where staff are frequently forced to choose what they described as "the least harmful way to break the law" in order to try to keep patients safe. The investigation highlights profound tensions between competing human rights duties (including the right to life and the right to liberty), inconsistent application and understanding of legal frameworks across acute and mental health services, and the risk of unlawful deprivation of liberty becoming embedded as "work as done".

The report does not conclude that these risks arise from poor intent or lack of professionalism, but from systemic constraints, workforce shortages, bed capacity pressures and unresolved legislative gaps which have been repeatedly surfaced through coroners' Prevention of Future Death reports and parliamentary scrutiny. This report is included to stimulate Board curiosity about how such national legal and system failures translate locally, how accurately Boards can "see" legal and ethical risk at the front door, and where further enquiry or deep dive may be helpful to test confidence in how these risks are understood, escalated and mitigated in practice.

Link:https://www.hssib.org.uk/patient-safety-investigations/safety-issues-for-people-experiencing-a-mental-health-crisis-who-come-into-contact-with-urgent-and-emergency-care-services/investigation-report-1-of-2/

Trust position: This HSSIB report is highly relevant to the Trust as an acute provider supporting people in mental health crisis within emergency care settings, often in partnership with mental health services. It is included to prompt Board curiosity about how legal ambiguity, system pressures and interface arrangements manifest locally, and how confidently risks to patients, staff and the organisation are understood, escalated and managed in practice. From a Trust mental health service perspective, the themes in the HSSIB interim report resonate strongly with our experience at the acute–mental health interface, particularly within emergency departments. Locally, we continue to see people in mental health crisis remaining in ED for extended periods while awaiting assessment or onward care, often without a clear or consistent legal framework to support proportionate risk management, placing staff in complex ethical and legal positions. These challenges sit alongside differing interpretations of legal responsibility and operational thresholds across agencies, which can contribute to uncertainty at the front door. It is important to note that work is already underway to address some of these system tensions. The Trust has recently opened up constructive discussions with senior police colleagues to reestablish more collaborative working arrangements, and we are currently awaiting dates to progress this further with police and GHC.

C. CONCLUSION

The Board is required to form a collective view that appropriate governance and internal control arrangements are in place to meet statutory, regulatory and policy obligations. This report therefore invites Board members to consider whether they are satisfied, through existing sources of assurance and enquiry, that where relevant, compliance mechanisms remain robust, and that any emerging gaps or uncertainties are being addressed through planned improvement activity, targeted deep dives or Committee oversight where required.

The report is designed to ensure that external regulatory insight and learning from others informs internal reflection and prioritisation, and is appropriately connected to established governance tools, including the Board Assurance Framework and the Trust Risk Register.

Taken together, the illustrative themes highlighted in this report point to the importance of strong Board grip on how regulatory expectations, organisational learning and frontline reality align in practice. Recurring insights from external inspections and failures emphasise the need for effective translation of assurance into delivery, leadership visibility of risk during change, and cultures that support escalation and learning before harm occurs. The forthcoming publication of the Trust's own Amos Maternity Investigation report will represent a significant opportunity to deepen this learning locally, providing a focused and authoritative source of organisational insight. When received, its findings will support the Board in further testing the adequacy of governance, risk management and assurance arrangements, and in shaping targeted improvement activity and Committee focus, ensuring that learning is not only identified but embedded and sustained.

Lead Executive and Author: **Kerry Rogers | Director of Integrated Governance**

Addendum

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

<u>CQC Inspections and updates</u>

CQC publishes report on Royal Bournemouth Hospital – Maternity Services
CQC, report published 27 March 2026
Overall: Requires Improvement Safe: Requires Improvement Well-led: Requires Improvement Effective / Caring / Responsive: Good
The report relates to the first inspection of maternity services following relocation to this Trusts new BEACH building. CQC found that staff were compassionate and patient-centred, and that women felt involved in decisions about their care. Effective multidisciplinary working between midwives and obstetricians was observed, and fetal monitoring standards were met. However,

leaders did not always have a clear understanding of risks and staffing pressures, leading to delays in triage, induction of labour and access to advice. Staffing shortages, sickness absence and gaps in rotas affected timely care, and governance arrangements were not consistently effective, resulting in a breach of Regulation 17. Some controls had not been updated following the move to the new building, including newborn security arrangements, though immediate action was taken after inspection.
https://www.cqc.org.uk/location/R0D02/reports/LAP-02683/maternity

Of interest/relevance:

Digital and AI in healthcare – Clinical Senate system insights
April 2026
The South West Clinical Senate has published recommendations arising from a Council meeting focused on the shift from analogue to digital services and the increasing use of artificial intelligence (AI) in healthcare. The report highlights that while digital and AI enabled tools offer significant potential to improve access, diagnostic accuracy and flow, their rapid adoption is exposing new forms of clinical, governance and equity risk. In particular, the Senate draws attention to variation in digital maturity, reliance on workaround processes at the frontline, unclear accountability for AI supported decision making, and the risk of widening inequalities where digital systems are not designed inclusively. Real world clinical examples underscore how fragmented infrastructure, interoperability gaps and blunt access controls can inadvertently increase workload, obscure risk and reduce patient autonomy. The report is included as system intelligence to prompt Board curiosity about how digital and AI related risks are surfaced, governed and assured locally, and how confidently the organisation could evidence safe, ethical and equitable adoption as these technologies become more embedded in routine care.
https://www.swsenate.nhs.uk/recommendations-from-the-south-west-clinical-senate-council-on-the-shift-from-analog-to-digital-and-the-use-of-artificial-intelligence-ai-in-healthcare/
Trust position: As digital and AI enabled tools become increasingly embedded across clinical pathways, the issues highlighted by the Clinical Senate are relevant to the Trust's governance, safety and equity responsibilities, and are included to prompt Board enquiry. From a digital leadership perspective, our Chief Digital Information office concurs the Clinical Senate's themes resonate strongly, particularly the risk that digital and AI capability advances faster than the underpinning governance, interoperability and clinical ownership needed to assure safety and equity at scale. Many of these themes are not new but exacerbated by the pace of change. As AI digital tools become embedded across pathways, the Board may wish to explore where variation in digital maturity and fragmented system boundaries could obscure risk or access to improved care. The increased use of 'shadow digital' which diffuse accountability and security is an area of particular challenge in ensuring appropriate governance without stunting delivery of value adding tools the benefits they offer. There are also important questions about how confidently the organisation could evidence human oversight and ethical use where AI influences clinical judgement. These considerations suggest a need for continued Board curiosity around readiness, not just adoption, as digital and AI agendas mature.

CQC Beyond Councils of Governors – rethinking public accountability
March 2026
NHS Providers has published event insights and briefings exploring the potential implications of national reform proposals that would remove the statutory requirement for NHS foundation trusts to maintain Councils of Governors, alongside wider changes to patient and public accountability arrangements set out within the 10year health plan and expected to be reflected in forthcoming legislation. The briefings emphasise that, while Councils of Governors have historically provided a quasi democratic mechanism through which the public, staff and partners can hold boards to account, the proposed reforms create uncertainty and risk of an accountability "gap" if alternative routes for community insight and independent challenge are not deliberately designed and embedded. The material highlights the importance of boards thinking beyond structural compliance and asking how legitimacy, responsiveness and patient voice will be sustained in practice, including through clearer mechanisms for lived experience leadership, patient safety partnerships and other forms of participatory governance. NHS Providers also notes that during the period of uncertainty, Councils of Governors retain their legal functions until legislation changes, and that constructive culture, mutual respect and clarity in communications will be important to maintain effective governance and avoid unnecessary destabilisation. This update is included as horizon intelligence to support Board awareness of a potentially significant shift in public accountability expectations for providers.
Links:

- https://nhsproviders.org/resources/event-insights-beyond-councils-of-governors-rethinking-public-accountability
- https://nhsproviders.org/resources/beyond-councils-of-governors-rethinking-public-accountability
- https://nhsproviders.org/resources/navigating-uncertainty-around-councils-of-governors

Trust position: The proposal to remove the statutory requirement for Councils of Governors would represent a material change in the architecture of public accountability for foundation trusts; however, the position remains subject to legislation and further national clarification. In the meantime, the Trust has already begun constructive conversations with its Governors about how the relationship can continue to evolve, with a shared focus on improving services through the eyes of patients and staff, and on how Governors can continue to help ensure those voices are heard and meaningfully influence change. As referenced in the January report to Board, a future Board development session will consider the implications for the Trust's accountability, patient voice and stakeholder assurance arrangements once the legislative timetable and any replacement expectations are clearer, ensuring that any transition strengthens rather than weakens meaningful public and staff insight into Board decision making.

Healthcare provision in prisons – system learning on needs assessment and assurance
April 2026

The Health Services Safety Investigations Body has published the fourth and final report in its series on healthcare provision in prisons, examining how population health needs are assessed and the consequences of mismatched services, particularly for people with disabilities. While focused on secure settings, the findings reinforce wider system learning highly relevant to Board oversight and assurance. The investigation highlights how infrequent and outdated needs assessments can quickly cease to reflect reality in fast changing populations, creating a gap between commissioned services and actual need, with resulting risks to patient safety, dignity and equity. It also illustrates how fragmented accountability, slow change processes and unclear ownership across organisational boundaries can allow known risks to persist, despite established frameworks and good intentions.

Link: https://www.hssib.org.uk/patient-safety-investigations/healthcare-provision-in-prisons/fourth-investigation-report/

Trust position: While this HSSIB report relates specifically to healthcare provision in prisons and does not imply direct responsibility for the Trust, the themes it identifies are relevant to Board level assurance and oversight more generally. The report is included to prompt curiosity about how reliance on static needs assessments, fragmented accountability and slow system response can create a gap between changing need and commissioned provision, and how confidently similar risks would be visible through the Trust's own assurance arrangements.

Mental Health Act 2025 – provisions coming into force April 2026

April 2026

Provisions of the Mental Health Act 2025 came into force in April 2026, amending the existing Mental Health Act 1983 rather than replacing it. Notably, these changes extend the application of the Human Rights Act to certain private providers delivering NHS arranged mental health care, including informal and aftercare patients, addressing a previously recognised accountability gap. The changes also signal closer scrutiny of admissions pathways and aftercare arrangements, particularly where care is commissioned across organisational boundaries. While wider reform will follow in later phases, this early commencement highlights the continuing evolution of the legal and ethical framework governing mental health care delivery and oversight. This item is included for Board awareness of emerging statutory expectations rather than immediate operational impact.

Link: https://www.hilldickinson.com/our-view/articles/mental-health-act-updates-in-force-from-6-april-2026/

Information Governance guidance on inquiries, investigations and courts

March 2026

NHS England has published updated guidance on information sharing in the context of public inquiries, investigations, reviews and court proceedings. The guidance clarifies how and when confidential health information may lawfully be disclosed, emphasising proportionality, legal basis and the preference for anonymised data where possible. It also reinforces organisational responsibilities when responding to statutory inquiries and reviews, particularly where information

is required to prevent serious harm or support learning. This guidance is included to provide context to the increasing scrutiny faced by NHS bodies and to support Board awareness of expectations around lawful, timely and transparent information handling.
Link: https://transform.england.nhs.uk/information-governance/guidance/inquiries-reviews-investigations-and-court-orders-in-health-and-social-care-services/

THIS Institute evaluation of the Maternity Incentive Scheme (Year 8)
April 2026
The Health Improvement Studies (THIS) Institute has published an evaluation of NHS Resolution's Maternity Incentive Scheme, informing the eighth year of the programme launched in March 2026. The evaluation concludes that financial incentivisation can be a powerful lever for organisational behaviour, while also warning of administrative burden and the risk of prioritising compliance over meaningful improvement. Recommendations include clarifying the purpose of the scheme, simplifying safety actions, and strengthening accountability for how incentive funding is used. This report is included to prompt Board reflection on the effectiveness and limitations of incentive-based approaches to safety and improvement, particularly in complex, pressured clinical environments. Implementation is effective from 1st April 2026 and there is some significant changes this year which the Chief Nurse and Maternity Team are reviewing and collating a plan for full implementation.
Link: https://www.lexology.com/library/detail.aspx?g=d9fb2c01-42f3-440d-b603-1eaddb012e4e

Hospital Deaths and Prevention of Future Deaths Reports (PFDs)
As referenced in the DAC Beachcroft article earlier in this report, recent national reporting highlights the scale and seriousness of deaths in hospital settings where coroners have issued Prevention of Future Deaths (PFD / Regulation 28) reports, identifying that action was required to avert similar outcomes elsewhere. National media investigations and professional commentary point to repeated PFDs raising concerns about hospital overcrowding, corridor care, delayed escalation, staffing pressures, communication failures and documentation gaps, with evidence that similar themes recur across multiple organisations over time.

A consistent national finding is that while PFDs are intended as a learning mechanism rather than blame, they often reveal systemic issues rather than isolated failures, including capacity constraints and weaknesses in how risk is escalated and managed at pressure points in the system. Professional analysis suggests that the learning from PFDs is not always translated into sustained organisational or system-wide change, with variable response quality and limited aggregation of themes at national or regional level. For this Trust, these national insights prompt reflection on the extent to which we:

- treat coroners' reports (to us or to others) as strategic intelligence, rather than as one-off responses;
- have clear sight of emerging cross-cutting risks such as overcrowding, patient flow, escalation and record-keeping; and

- ensure that learning from deaths is aggregated, tracked and revisited through governance structures, particularly where pressures are enduring rather than transient.

Further development is required to ensure that lessons from national PFDs are explicitly tested against our own operating context. This is particularly relevant as national scrutiny of avoidable hospital deaths, crowding and capacity pressures continues to intensify.
Link: Preventable Deaths Tracker – A vigilance platform to learn lessons following preventable deaths

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HIGH PROFILE FAILINGS – LEARNING/'TRUE FOR US'

High profile corporate governance failures and/or weaknesses continually litter the headlines and the events that damage such organisations do not just happen. They are commonly linked to boards being blind to the underlying risks that threaten their organisations and to the effectiveness of governance systems. Whilst these are predominantly headline news items with some containing allegations to be investigated – they will be routinely presented to the Board in this report to stimulate consideration of the importance of corporate governance (and of perceptions on reputation through trust and confidence) and to give due regard to there being any risk of it being 'true for us'.

The ambition is to develop a Framework to ensure that in a planned way we assess where any of these significant failings could happen at the Trust in order to learn and improve control environments accordingly, but regardless, each member of the Board should consider their individual responsibilities to 'be assured' and as such consider requirements to support attaining that position and consider as necessary what it might mean for GHFT. In the last Board report the Edenfield failings were presented to Board to understand what went wrong, how and when order to illustrate the future intended purpose of this section of the Report. The remaining narrative below aims to achieve the same thing with some recent/well known areas of governance failure.

Industry failure and learning drift – national maternity services
Recent findings from the National Maternity and Neonatal Investigation provide a stark reminder of how large-scale organisational failure can persist in plain sight, even in services subject to extensive scrutiny and repeated review. The investigation describes a system in which many of the same failings identified in earlier maternity scandals — failure to listen to families, defensive responses when concerns are raised, poor documentation, and reluctance to acknowledge error — have continued across multiple organisations and over many years.

Of note is that these failures were not attributed to an absence of policy, guidance or regulatory oversight. Instead, the investigation highlights how learning was repeatedly identified but not embedded, how signals from patients and staff were discounted or normalised, and how boards and leadership teams were not always able to see the gap between formal assurance and lived

reality. In some cases, families only obtained transparency once external scrutiny or legal processes had begun.

This mirrors learning from other industry failures, including in non-NHS settings, where organisational confidence in governance processes masked deeper cultural and behavioural risks. The relevance for Board lies not solely in the clinical domain itself, but in understanding how assurance can become detached from practice, how familiarity can blunt curiosity, and how warning signals can be rationalised away when pressures are sustained. The inclusion of this national learning is not to draw comparisons with local services, but to prompt reflection on how we might ensure that assurance remains grounded in reality; how patient and staff voices are heard when they challenge prevailing narratives; and how we guard against repeating patterns that have already been named, investigated and ostensibly "addressed" elsewhere.

The Thirlwall Inquiry / Countess of Chester – failure of escalation and governance

This is a clear NHS industry failure with relevance to the Board, with the final report pending. The Thirlwall Inquiry is explicitly examining whether NHS governance, culture and escalation systems contributed to the failure to protect babies at Countess of Chester Hospital, despite repeated concerns raised by clinicians. Evidence to the Inquiry and expert commentary emphasise themes of silenced staff voice, over-reliance on professional reassurance, and failure of governance structures to respond to credible early warnings . The relevance is again the insight this provides into how learning drift occurs, how culture shapes escalation, and how boards detect when assurance no longer matches reality. **bmj.com, Thirlwall....inquiry.uk**

Institute of Directors (IoD) policy paper – explicitly about governance lessons for boards

The IoD published a focused paper "The Post Office Scandal – A failure of governance" drawing specifically on the Inquiry's governance evidence and translating it into director-level lessons. It argues that although the scandal is often labelled "an IT scandal", the root causes were human decision-making, culture and ethics, with the board ultimately accountable for prolonged failure to scrutinise management and key business activities. It highlights themes that map very directly to NHS board risk: lack of professional curiosity and critical challenge, undue reliance on management/legal reassurance, groupthink, failure to "lift the rock" on culture, and a board focus pulled toward reputation and finance at the expense of underlying technology/legal risk.

Link: ***https://www.iod.com/app/uploads/2024/10/IoD-The-Post-Office-Scandal-%E2%80%93-A-Failure-of-Governance-3a831350ff1204afaabb59adb973590e.pdf***

Post Office Horizon IT Inquiry – Volume 1 is published; further volumes are in progress

The Inquiry's Chair, Sir Wyn Williams, has published Volume 1 of the Final Report (human impact and redress), and the Inquiry website confirms that work continues on the remaining volumes, including Maxwellisation (the process of giving those criticised a right of reply) before publication of further findings.
While Volume 1 is not the main governance volume, the Inquiry's own "rapid read" summary confirms that the Inquiry has examined knowledge and governance, organisational culture, and government oversight as part of its overall work programme. This example is included to prompt Board curiosity about how we test assurance in high-stakes areas, how we respond to repeated

"weak signals", and how we create conditions where staff, patients and partners can surface concerns early without defensiveness or suppression. **Link:** ***https://www.postofficehorizoninquiry.org.uk/*** **Link:** ***Rapid Read (summary)*** ***https://www.postofficehorizoninquiry.org.uk/sites/default/files/2025-07/Post_Office_Horizon_Inquiry_Volume_1_Rapid_Read.pdf*** There is an official Government response to Volume 1 (updated February 2026), and an active GOV.UK collection continues to be updated (as recently as March 2026). While this focuses on redress, it is part of the broader accountability environment and will likely evolve as governance volumes are published. **Link: Government response to Inquiry report (Vol 1) (updated Feb 2026)** **https://www.gov.uk/government/publications/government-response-to-the-post-office-horizon-it-inquiry-report-volume-1** **Link: GOV.UK collection – Post Office Horizon IT Inquiry (updated Mar 2026)** **https://www.gov.uk/government/collections/post-office-horizon-it-inquiry**
Enclosures: None
FOI: Public

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	14 May 2026
Report title	Risk Management Assurance and Board Assurance Framework Report
Sponsoring Director/Author	Kerry Rogers, Director of Integrated Governance Lee Troake, Head of Risk H&S Sarah Favell, Trust Secretary

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

Executive Summary

This report provides the Board with assurance on the effectiveness of the Trust's risk management arrangements and the current organisational risk profile.

Overall, the Trust continues to demonstrate good risk management maturity, with risks being consistently identified, articulated, reviewed and escalated across operational, divisional and corporate levels. The Board can take reasonable assurance that the principal risks to the delivery of the Trust's strategic objectives are visible, understood and actively managed, despite a persistently challenging operating environment.

During the reporting period, overall risk exposure has reduced modestly, with a net reduction of seven active risks (from 564 to 557). This reflects both sustained mitigation activity and a more proportionate application of the revised Trust risk appetite framework, improving clarity around which risks require Trust-wide oversight and which are appropriately managed at Divisional level.

The Trust Risk Register (TRR) continues to be dominated by systemic risks, particularly those relating to patient safety and operational delivery, workforce sustainability, estates safety and statutory compliance, and digital resilience. Six risks are currently scored at the highest level (20), including fire safety, cyber security and IT infrastructure resilience, Emergency Department overcrowding, interventional radiology workforce shortages and corridor care. These risks represent the most significant threats to patient and staff safety, service continuity and regulatory compliance and remain subject to enhanced executive and Board scrutiny.

Risk quality indicators remain strong, with 100% of active risks having controls, mitigations and actions recorded, providing assurance that risks are being managed in accordance with Trust standards. The number of overdue risk reviews continues to reduce, and while action delivery

remains an area for continued focus, particularly at Divisional level, the reduction in long-overdue actions demonstrates improving grip and trajectory rather than unmanaged risk.
De-escalations from the TRR reflect disciplined and evidence-based governance, resulting either from the recalibration of Trust risk appetite (November 2025) or from demonstrable reduction in risk exposure following delivery of mitigation actions. This confirms that de-escalation decisions are not tolerance-led but based on assurance.

In summary, the Trust's risk management framework is effective and embedded, supporting informed decision-making and Board oversight. However, the overall risk profile remains highly pressured, driven by sustained demand, workforce shortages and ageing infrastructure. Continued executive focus, investment and system-level collaboration will be required to achieve further material and sustained risk reduction.

In relation to the Board Assurance Framework (Section 7), the Framework has been refreshed and aligned to the Trust's strategic objectives, with 10 principal strategic risks clearly articulated and subject to defined executive ownership and committee oversight. The Board Assurance Framework is now operating as a live strategic tool, strengthening the line of sight between strategic aims, principal risks, controls and sources of assurance. The Board can take reasonable assurance that strategic risks are appropriately identified and managed, with improving maturity in the assessment of control effectiveness and assurance gaps. Notwithstanding this progress, the strategic risk environment remains highly pressured, particularly in relation to financial sustainability, estates, digital resilience and workforce, and continued development of assurance quality, including clearer articulation of gaps and further embedding of the three lines of defence, remains a priority.

Previously considered by	Risk Management Group, Audit and Assurance Committee

Recommendations:

Board is invited to:

- Note the current risk profile and assure itself that this reflects the organisational risk, indicating the recently refreshed Risk Appetite is suitable and sufficient
- Note the current level of assurance and areas of improvement
- Support continued executive focus on strengthening accountability and assurance depth, particularly in the management of overdue actions, persistent high risks, and policy compliance
- Review and agree the current position of the Board Assurance Framework, including the articulation of principal strategic risks, and support the continued strengthening of assurance arrangements.

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

Digital first	

Impact on any Strategic Risks?
All

Implications on:	
Equality, Diversity and Inclusion	N/a
Health Inequalities	N/a
Finance and Resource	N/a
Regulation/Legal	N/a
CQC-Key line of enquiry	Risk Management under well-led
Green Plan	N/a

INTEGRATED RISK ASSURANCE REPORT

BOARD OF DIRECTORS

MAY 2026

1. Overall Assessment

The Trust's approach to risk management continues to demonstrate good organisational maturity, with risks being consistently identified, captured and reviewed across all levels. The current position provides the Board with reasonable assurance that principal risks to delivery of the Trust's objectives are being recognised, escalated appropriately and actively managed, despite a highly challenged operational environment.

The overall risk exposure has reduced during the reporting period, with a net reduction of 7 risks (from 564 to 557), equating to a 1.3% decrease in risk exposure. This reflects sustained management action alongside more proportionate application of the Trust's revised risk appetite.

2. Current Risk Profile

The Trust and GMS combined hold over 500 active risks across all risk registers. The Trust-wide profile is broad, mature and systemic, reflecting sustained pressures rather than isolated control failures. Risks span clinical, operational, workforce, estates, digital, financial and statutory compliance domains.

Overall, the profile demonstrates good organisational risk awareness, with risks being routinely identified, articulated and reviewed across operational, divisional and corporate levels.

2.1 Dominant Risk Themes

Safety, Quality and Delivery

Safety, quality and delivery represent the single largest and most significant risk theme, cutting across all Divisions. Risks predominately reflect systemic operational pressures, rather than absence of controls, including:

- Delayed diagnosis and treatment
- Patient deterioration linked to flow, capacity and staffing
- ED overcrowding and corridor care
- Medication safety pressures
- Infection prevention and control
- Safeguarding capacity and resilience

These risks often arise from demand–capacity mismatch, constrained workforce supply and ageing infrastructure, and therefore require system-wide and multi-year solutions, rather than short-term mitigation.

Workforce

Workforce risks remain a core risk cluster, particularly within:

- Interventional Radiology
- Critical Care
- Oncology
- Maternity
- Selected nursing and AHP groups

These risks reflect national workforce shortages, extended time to competence and fragility in specialist rotas. Although improved staff retention rates signal greater stability, workforce gaps continue to expose the Trust to quality, safety and sustainability risks.

Estates and Infrastructure

An increasing proportion of high-scoring risks are estates-related, notably:

- Water safety
- Fire safety compliance
- Ventilation and air handling
- Unsuitable or sub-optimal clinical spaces

These represent chronic exposures linked to an ageing estate and require capital investment to materially reduce residual risk.

Digital

Digital risks, while not always the highest scoring, have become more prominent and visible, particularly in relation to:

- Cyber security
- Data integrity
- Interoperability
- Infrastructure resilience

These risks reflect growing reliance on digital systems as part of the Trust's transformation programme and are recognised as critical enablers with high impact failure consequences.

2.2 Risk Maturity at Operational Level

The large volume of lower-scoring (green and yellow) risks indicates:

- Strong local risk identification and capture
- Appropriate use of risk registers at operational level
- Visibility of service pressures even where mitigations are in place

This supports assurance that risk management is embedded beyond the corporate register.

3. High Scoring Operational Risks

There are six risks on the Trust Risk Register scoring 20. These include three newly escalated risks - fire safety contraventions, cyber security and IT infrastructure failure, as well as three risks that have continued to persist since March 2025 - overcrowding in minors, a shortage of Interventional Radiologists and corridor care.

There are a further sixteen risks on the Trust Risk Register that score 16, which relate to systemic pressures rather than isolated hazards. Many of these have also persisted from the previous reporting period and are cross-cutting between services and divisions, including, but are not limited to, hospital flow, specialist workforce capacity (particularly in areas of national skills shortage and hard-to-recruit specialities), clinical quality and effectiveness principally in relation to older people, cancer and time-sensitive interventions, estates backlogs, ventilation and bed base. Addressing these risks typically requires multi-year plans, capital and workforce investment and system partner collaboration.

4. Risks Impact on the Achievement of Objectives

The Trust Risk Register shows a high concentration of current, active risks scoring 15–20, predominantly clustered around:

- Patient safety and experience (particularly urgent, maternity and cancer pathways)
- Workforce sustainability and capacity
- Ageing estate, fire safety and statutory compliance
- Digital resilience, cyber security and infrastructure

These risks if unmitigated have the potential to directly threaten delivery of all four strategic aims, with the greatest cumulative impact on Quality, Safety and Delivery and People, Culture and Leadership, while also undermining Digital First ambitions and, indirectly, Patient Experience and Voice.

4.1 Strategic Impact by Objective

Quality, Safety and Delivery

This objective carries the highest exposure, with risks relating to:

- Fire safety, evacuation, asbestos and environmental hazards
- ED flow, crowding and delayed treatment
- Clinical effectiveness in cancer, maternity and pharmacy services
- Estates constraints affecting theatres and critical care

These risks if unmitigated would directly threaten patient safety outcomes and compliance with statutory duties, national standards (RTT, ED 4-hour target, maternity and cancer standards) and equity of access and outcomes. Without mitigation, these risks constrain the Trust's ability to shift from reactive risk management to proactive quality improvement, a key strategic expectation. This strategic aim is the most immediately exposed were the control mitigations ineffective.

People, Culture and Leadership

Workforce sustainability remains challenging with multiple specialist shortages including in interventional radiology, anaesthetics, oncology, critical care and obstetrics. Although improvement in our staff retention rate reflects an overall increased stability in the workforce.

Mitigations to address risks to unsafe environments relating to fire safety, asbestos, evacuation, and falls from height would if ineffective be likely to negatively impact the Trust's ability to improve

staff experience and morale and to achieve top-quartile NHS Staff Survey outcomes. Staffing pressures fuel burn-out, creating a negative feedback loop that reinforces workforce risk. Workforce shortages and fatigue can over time erode staff capacity to consistently deliver compassionate, attentive care.

Digital First

Risks to cyber security, digital infrastructure and digital workforce capacity would if mitigations are ineffective undermine confidence in:

- EPR and core systems
- Digital pathways and patient portals
- Data quality and availability

A significant cyber or infrastructure incident would impact all strategic aims.

Patient Experience and Voice

Persistent ED overcrowding, corridor care, delays in diagnosis and maternity capacity issues directly affect dignity, trust and patient feedback, which if ineffectively mitigated, affect the Trust's ability to demonstrate that care is shaped by patient voice.

4.2 Impact on the Four Enablers - Health Inequalities, Brilliant Basics, Continuous Improvement and Sustainability

Some risks, if unmanaged, will undermine our ability to narrow health inequalities, disproportionately affecting vulnerable and disadvantaged patients. For example,

- ED overcrowding corridor care and delays may mean that people from deprived communities who are more likely to access care via ED, experience poorer access, dignity and outcomes
- Delays in cancer diagnostics, screening and specialist care could widen outcome gaps, as delayed diagnosis has a greater impact on deprived populations
- Maternity service risks could particularly affect women and babies at higher clinical or social risk
- Cyber and infrastructure vulnerabilities could lead to digital exclusion, limiting equitable access to digital-first models of care

Unsafe or deteriorating environments also conflict brilliant basics expectations of clean, calm and welcoming care settings. Many risks represent vulnerabilities of the basics e.g., Fire safety, evacuation, asbestos, window safety, ageing theatres, critical care unit and air handling systems.

Current risks constrain the Trust's improvement capability including, persistent high operational pressure risks, workforce instability, digital fragility and backlog in estates reinforce short-term firefighting responses. Ageing, inefficient estates and infrastructure by definition, drive higher energy use, increased maintenance, and reactive repairs which raise carbon impact.

5. Risk Mitigation

Review of risks de-escalated from the Trust Risk Register shows two distinct and intentional drivers, reflecting different aspects of risk governance:

- Risks de-escalated in November 2025 were primarily the result of the implementation of a revised Trust risk appetite, rather than a change in the underlying risk exposure.
- All other de-escalations occurred as a result of demonstrable risk reduction, evidenced by improved controls, mitigations, or delivery of actions leading to a reduced risk score.

This distinction is important, as it demonstrates both improved clarity and confidence in the Trust's appetite for risk, and tangible operational and clinical improvement resulting in lower residual risk.

5.1 Risk Appetite De-escalations

A significant number of risks were de-escalated in November 2025, following the introduction of a revised Trust risk appetite framework. These de-escalations represent a governance recalibration, not a relaxation of, or material change in controls. The Trust clarified the level of risk it is prepared to tolerate at Trust level, and which risks were deemed appropriate to manage at Divisional level.

While still present, the risks sat within the agreed appetite and reflected a realignment of risks to address over-escalation as a result of a previous misaligned risk appetite, which had diluted the Board's focus and effective oversight.

5.2 Risk Reduction De-escalations

Outside November 2025, all recorded de-escalations were the result of measurable risk reduction, which typically followed delivery of agreed action plans, workforce stabilisation, improved clinical processes or compliance, estates interventions or service redesign and evidence of improved outcomes, performance or assurance.

Examples include risks relating to:

- Midwifery staffing
- Boarding patients on wards
- Pharmacy manufacturing capacity
- End-of-life discharge pathways
- Haematology, dermatology and breast screening capacity
- Radiology and vascular workforce capability

These de-escalations demonstrate progress against Quality, Safety and Delivery priorities, alignment with Continuous Improvement ambitions and evidence that mitigation actions are translating into real reduction in harm or exposure.

A summary of the TRR is provided in Appendix 1.

6. Quality of Risk Management – KPIs

Risk quality indicators provide strong assurance that:

- 100% of active risks have controls recorded
- No risks lack mitigations (excluding newly raised draft risks)
- No established risks are without actions in place

This demonstrates consistent compliance with the Trust's risk management standards and effective support to services in articulating and mitigating risk.

6.1 Reviews and Timeliness

The number of risks overdue for review continues to reduce, with 86 risks (15%) currently overdue. All risks with review dates prior to July 2025 have now been updated, and only a small number remain overdue at Trust Risk Register level, with clear accountability identified.

Automated reminders and divisional oversight arrangements remain in place and are contributing to improving review compliance.

6.2 Actions and Delivery

Action delivery remains an area requiring continued management focus:

- A proportion of actions on risks and incidents remain overdue, particularly within divisional risk registers
- The number of very long-overdue actions has reduced, indicating progress against legacy issues
- Oversight of overdue actions is embedded through Risk Management Group and Divisional governance structures

While the presence of overdue actions reflects operational pressure, the trend demonstrates improving grip and trajectory of improvement, rather than unmanaged risk.

7. Board Assurance Framework (BAF) – Strategic Risk Overview

7.1 Overall Position

The Board Assurance Framework (BAF) has been refreshed and realigned to the Trust's Strategy (November 2025), strengthening the line of sight between strategic objectives, principal risks and the controls and assurances in place to manage them.

The current position provides the Board with reasonable assurance that the principal strategic risks to delivery of the Trust's objectives are:

- Clearly articulated and aligned to the four strategic aims
- Subject to defined executive ownership and oversight
- Supported by an increasingly robust framework of controls and assurances

The Board Assurance Framework is operating as a live strategic tool, complementing the Trust Risk Register by focusing specifically on risks to strategy delivery rather than operational pressures alone.

7.2 Strategic Risk Profile

The BAF currently comprises 10 principal strategic risks, spanning:

- Quality, safety and operational delivery
- Workforce sustainability and organisational culture
- Financial sustainability
- Estates and infrastructure
- Digital resilience and transformation
- Patient and stakeholder engagement

The strategic risk profile reflects a highly challenged operating environment, consistent with themes identified within the Trust Risk Register, and demonstrates strong alignment between operational risk exposure and strategic risk positioning.

7.3 Key Strategic Risks and Themes

Financial Sustainability

The most significant strategic risk remains financial sustainability (SR4), which continues to score at the highest level. This reflects:

- System-level financial pressures
- The requirement to deliver efficiency programmes at scale
- The need to balance financial recovery with service quality and access

This risk underpins and interacts with several other strategic risks, including workforce, estates and service delivery. This risk is regularly reviewed at Finance and Resource Committee, although note there was no committee meeting in April 2026.

Quality, Safety and Access

Strategic risks relating to quality, safety and access remain prominent, including:

- Delivery of safe and effective services in line with statutory and regulatory requirements (SR1)
- Timely access to services (SR5), reflecting national priorities on waiting times and flow.

These risks are directly linked to the operational pressures described elsewhere in this report, particularly demand–capacity mismatch, workforce constraints and estate limitations. These risks are being consistently reviewed at full meetings of the Quality and Performance Committee.

Workforce Sustainability and Culture

Workforce risks (SR2 and SR3) remain material, reflecting:

- Ongoing challenges in recruitment and retention
- Fragility in specialist workforce areas
- The importance of organisational culture, staff experience and development

These risks have a direct impact on quality of care, productivity and the Trust's ability to deliver sustainable improvement. They are regularly monitored at People & Organisational Development Committee

Estates and Infrastructure

The strategic risk relating to estates (SR8) reflects:

- Ageing infrastructure and backlog maintenance
- Compliance risks (including fire and water safety)
- Limitations in estate suitability to support modern models of care

This aligns with the increasing prominence of estates-related risks on the Trust Risk Register and represents a structural constraint on service delivery. These risks are reviewed at Estate focused meetings of the Finance and Resource Committee. Compliance issues are also reviewed at Group Health & Safety Committee, as appropriate.

Digital
Digital risks have increased in prominence, with two distinct but related risks:
- Digital infrastructure and cyber resilience (SR6)
- Digital transformation and culture (SR7)

These risks recognise that digital is both a critical enabler of transformation and a high-impact vulnerability where failure could affect all strategic aims. These risks are regularly reviewed at Finance and Resource Committee.

Health and Safety Governance
A new strategic risk (SR9) was established in 2025 to reflect:
- The need for a robust and clearly defined health and safety governance framework
- Increased focus on statutory compliance and Board oversight.

This represents a strengthening of strategic visibility over an area of significant regulatory importance. This risk is regularly reviewed by the Health & Safety Committee with reports to Trust Leadership Team and an annual report to Audit and Assurance Committee.

Patient and Stakeholder Engagement
The risk relating to patient and stakeholder engagement (SR10) is currently low scoring; however further consideration is being given to whether patient voice and health inequalities require stronger representation within the Board Assurance Framework. This area will continue to evolve during 2026-2027, as part of the Trust's strategic development.

7.4 Assurance and Control Framework
The Trust is strengthening its approach to strategic risk assurance through:
- Greater emphasis on control effectiveness, rather than control presence
- Application of the three lines of defence model
- Improved identification and management of assurance gaps

Executive ownership of risks has been reinforced, supported by:
- Regular executive-level review (from May 2026)
- Ongoing scrutiny by Board Assurance Committees
- Reporting through committee assurance mechanisms

7.5 Committee Oversight and Review
All strategic risks have been subject to recent review by the relevant Board Assurance Committees (February to April 2026), with:
- No material changes in overall risk scores

- Confirmation that controls and mitigating actions remain appropriate
- Continued focus on strengthening assurance and delivery.

The Audit and Assurance Committee retains oversight of the overall BAF and assurance framework, with the last review in April 2026.

7.6 Forward Look

Further development of the Board Assurance Framework will focus on:

- Establishing a sustainability / Green Plan strategic risk. The Green Plan is being presented at Finance and Resource Committee in May, and this will be considered in the context of that annual plan.
- Reviewing the need for a strategic risk regarding research and innovation activity. This was previously identified in the 2025 Board Assurance Framework as SR14, but it was recognised that this needed a comprehensive review against the Trust's refreshed strategic priorities. This will be considered at the Finance and Resource Committee meeting (May)
- Clarifying the positioning of patient voice and health inequalities as a Strategic Risk – it is expected that this risk will evolve from the ongoing work relating to service delivery of the strategic aims.
- Continuing to strengthen assurance quality and evidence through robust executive review of the effectiveness of controls (3x annually) and board committee review
- Continuing to embed the realigned Board Assurance Framework as a central component of Board strategic oversight, with the Framework being subject to Board review three times annually)

7.7 Conclusion

The refreshed Board Assurance Framework demonstrates a maturing and increasingly robust approach to strategic risk management.
The Board can take reasonable assurance that:

- Strategic risks are appropriately identified, aligned and owned
- Governance and oversight arrangements are effective
- There is increasing focus on the effectiveness of controls and depth of assurance

However, consistent with the Trust Risk Register, the overall strategic risk environment remains highly pressured, requiring sustained executive focus, investment and system collaboration to achieve material and sustained risk reduction.

8 Recommendations

The Board is invited to:

- Note the current risk profile and assure itself that this reflects the organisational risk, indicating the recently refreshed Risk Appetite is suitable and sufficient
- Note the current level of assurance and areas of improvement
- Support continued executive focus on strengthening accountability and assurance depth, particularly in the management of overdue actions, persistent high risks, and policy compliance

- Review and agree the current position of the Board Assurance Framework, including the articulation of principal strategic risks, and support the continued strengthening of assurance arrangements.

Appendix 1: Trust Risk Register

Risk ID		Division	Type	Subtype	Current likely-hood	Current conse-quence	Current rating	Target rating
	2610 The risk of not adhering to numerous pieces of NICE guidance through the inadequate resourcing of specialist psychology services for cancer and palliative care patients.	Diagnostics and Specialties	Quality, Safety & Delivery	Clinical Effectiveness	5	3	15	1
374	3930 The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Corporate	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	3	5	15	4
674	2719 The risk of harm affecting patient and staff safety due to the inefficient evacuation of a hospital building in the event of fire due to poor uptake in evacuation drills and training and a clear evacuation plan.	Corporate	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	3	5	15	6
1012	The risk of critical disruption to operational and clinical services ,	Corporate	Digital First	Infrastructure & Stability	5	3	15	2

	due to decreased sustainability and delays in development of digital services, systems and infrastructure caused by strategic and tactical workforce constraints.							
1042	Risk of a fall from height from a Tower Block window in Gloucestershire Royal Hospital leading to serious or fatal harm to patients, in particular those without capacity or with mental health conditions	Corporate	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	3	5	15	5
1097	The risk of insufficient cyber resilience, disaster recovery and business continuity causing prolonged loss of critical systems after a Cyber incident, leading to service disruption, patient harm, financial, regulatory and reputational consequences.	Corporate	Digital First	Data Integrity, Quality & Cyber Security	3	5	15	6
266	3682 The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient	Medical	Quality, Safety & Delivery	Operational Models	4	4	16	6

	flow in the Emergency Department.							
293	3879 The inability to provide a Pharmacy Manufacturing Service due to the closure of the department.	Diagnostics and Specialties	Quality, Safety & Delivery	Experience	4	4	16	3
333	3968 Risk of a delay to follow-up appointments leading to significant reduction of vision within the Glaucoma sub-specialty due to insufficient workforce resources.	Surgical	People, Culture and Leadership	Workforce Sustainability	4	4	16	6
368	3751 The risk of harm as a result of a failure to manage asbestos in our buildings in line with the Control of Asbestos Regulations 2012.	Corporate	Brilliant Basics	Compliance	4	4	16	5
425	2424 The risk of increased financial impact on theatres and the trust due to ageing and ineffective air handling units	Surgical	Estates and Facilities	Facilities Management Operational Delivery	4	4	16	6
458	3326 The risk to quality from an inadequate bed base, estate and facilities within the Department of Critical Care in Gloucestershire	Surgical	Estates and Facilities	Estates Modernisation and Capital Development	4	4	16	1

	Royal Hospital (DCCG)							
490	3685 The risk of harm to pregnant women and babies due to delayed review, identification and treatment when attending triage.	Women's and Children's	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	4	4	16	6
722	4006 The risk that the Trust is unable to retain members of the substantive workforce.	Corporate	People, Culture and Leadership	Workforce Sustainability	4	4	16	8
746	The risk of failure to provide a safe and high-quality maternity service due to inadequate number of Consultant Obstetricians.	Women's and Children's	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	4	4	16	5
751	The risk of failure to provide a safe and high quality maternity ultrasound service due to a lack of current dedicated maternity scanning service	Women's and Children's	Quality, Safety & Delivery	Clinical Effectiveness	4	4	16	3
764	S2045 The risk of reduced quality of care in the fractured neck of femur (NOF) pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck	Surgical	Quality, Safety & Delivery	Clinical Effectiveness	4	4	16	8

	of femur at Gloucestershire Roy							
850	The risk of increased workplace stress in Oncology due to an imbalance of consultant workforce across Oncology against workload	Diagnostics and Specialties	People, Culture and Leadership	Workforce Sustainability	4	4	16	2
911	The risk of significantly reduced quality of patient care and management caused by insufficient general anaesthetic workforce to manage the clinical demands upon service	Surgical	Quality, Safety & Delivery	Experience	4	4	16	4
1001	The risk to the quality of breast services within Gloucestershire Hospitals due to the breast screening service being unable to meet key performance indicators	Surgical	Quality, Safety & Delivery	Clinical Effectiveness	4	4	16	1
1016	The risk of reduced quality of service provision caused by insufficient Critical Care consultant workforce to manage the clinical demands upon service.	Surgical	Quality, Safety & Delivery	Experience	4	4	16	4

1060	The risk of poor outcomes and harm to women and babies as a result of the current diabetes management and guidelines during pregnancy, labour and post-birth	Women's and Children's	Quality, Safety & Delivery	Safety (Patient Safety, Staff Safety)	4	4	16	4
363	3371 The risk of statutory intervention due to non-compliant fire safety infrastructure including an obsolete fire alarm at GRH, poor compartmentation / fire doors and insufficient break-glass points; leading to harm to patients, visitors and staff.	Corporate	Brilliant Basics	Compliance	4	5	20	6
401	The risk of core IT infrastructure equipment failure and loss of access to business critical data as a result of environmental hazards, e.g. loss of essential service; power / AC, heatwave, floods water leaks and ingress etc.	Corporate	Digital First	Infrastructure & Stability	4	5	20	3
426	2268 The risk to patients within the Minors Area of the Emergency Department due to overcrowding and staffing	Medical	Quality, Safety & Delivery	Operational Models	5	4	20	4

841	The risk of being unable to deliver acute and cancer patient care due to a critical shortage of Interventional Radiologists	Diagnostics and Specialties	People, Culture and Leadership	Workforce Sustainability	5	4	20	6
1096	The risk of the Trust's digital environment being compromised by cyber threats exploiting vulnerabilities (e.g. unsupported systems, poor patching, unmanaged devices, weak controls and asset management), leading to loss of data or system integrity,	Corporate	Digital First	Infrastructure & Stability	4	5	20	6
1202	The risk to patient safety of compromised clinical care due to being placed in a corridor within the emergency department at GRH	Medical	Quality, Safety & Delivery	Experience	5	4	20	4
28								

APPENDIX 2 – BOARD ASSURANCE FRAMEWORK SUMMARY (April 2026)

Strategic aim	Risk title and description	Initial Score	Current Score	Target Score	Risk Owner	Committee
SR 1 Quality, safety & delivery	**Inability to deliver safe and effective services against regulatory and statutory requirements**	20 5x4	12 4x3	6 3x2	CN/MD	QPC
SR2 People, culture & leadership	**Inability to attract and sustain a skilled, diverse and adaptable workforce may lead to skills shortages, reduced service quality, reduced operational productivity, and increased costs.**	20 4x5	16 4x4	12 3x4	CPO	PODC
SR 3 People, culture & leadership	**Inability to retain a skilled, compassionate and diverse workforce that reflects the communities we serve because of a poor cultural environment and lack of development opportunities, impacting overall staff experience**	20 4x5	16 4x4	12 3x4	CPO	PODC
SR 4 Quality, safety & delivery	**Failure to meet statutory and regulatory requirements to manage financial resources.**	25 5x5	25 5x5	Mar 26 5x4=20 Mar 27 5x3=15	DoF	FRC

				Mar 28 5x2=10 Mar 29 5x1=5		
SR 5  Quality, safety & delivery	**Failure to provide timely access to services for patients.**	n/a New risk - wider than old SR1	16 4x4	12 4x3	COO	QPC
SR 6  Digital First	**Infrastructure & Cyber – Reliable Digital Foundations** There is a risk that the Trust's digital infrastructure and cyber security arrangements may not be sufficiently robust, resilient, connected, or up-to-date to support safe, effective, and continuous service delivery – including a solid platform for digital transformation.	15 3x5	20 4 x5	12 3x4	CDIO	FRC
SR7  Digital First	**Strategic Digital Risk: Digital Transformation & Culture** There is a risk that the Trust may not develop or sustain a digital culture, operating models, software architecture, skills, and leadership skills necessary to deliver digital transformation at scale and pace.	n/a	4x5 20	10 2x5	CDIO	FRC

SR 8  Quality, safety & delivery	**State of the Estates** Risk of sub-standard asset condition and estate compliance position impacting safety and experience (staff and patients).	4x5 20	4x5 20	4x4 16	COO	FRC
SR 9  Quality, safety & delivery	**Health and Safety risk**	4x5 20	4x4 16	3x2 6	DoIG	AAC
SR 10  Patient experience & voice	**Failure to engage and involve patients, carers and communities in shaping services and experience.**	2x2 4	2x2 4	1x3 3	DoID	QPC

Note: Scores are presented on a likelihood x consequence format, consistent with the Trust risk methodology

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	14 May 2026
Report title	NHS Provider Licence -Annual Self-Certification of Compliance (2025/2026)
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

NHS Foundation Trusts are required to self-certify annually that they comply with the conditions of the NHS Provider Licence. This report sets out the Trust's assessment of compliance with the relevant licence conditions for the period 2025/26, supported by evidence from internal control systems, Board oversight mechanisms, and independent assurance.

For the period under review, the Trust has undertaken an assessment of compliance against the applicable conditions:

- Condition G3 – Fit and Proper Persons
- Condition G5 – Systems for Compliance
- Conditions NHS1 and NHS2 – Availability of Information and Governance
- Condition CoS7 – Availability of Resources.

Based on triangulated assurance from internal audit, external audit, Board Assurance Framework (BAF), committee oversight, and statutory reporting (including the Annual Governance Statement), the Trust considers that there is a reasonable and evidence-based basis to confirm compliance with all applicable Provider Licence conditions.

Areas requiring continued strengthening have been identified, particularly:

- Embedding consistency in assurance as to controls and mitigations across the Board Assurance Framework and operational risk registers
- Ongoing response to external regulatory actions (e.g. CQC) and associated governance oversight.

Condition	Narrative	Status
Condition G3	Fit and Proper persons regulations compliance	Compliant
Condition G5	Systems for compliance	Compliant

Conditions NHS1 and NHS2	Publication of statutory documents Maintenance of effective governance arrangements	Compliant
Condition CoS7	Availability of resources	Compliant

Previously considered by	

Recommendations:

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

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?

All

Implications on:	
Equality, Diversity and Inclusion	N/A
Health Inequalities	N/A
Finance and Resource	N/A
Regulation/Legal	Compliance with the requirement of the Provider Licence, received on authorisation, as revised in 2023

CQC-Key line of enquiry	Well-Led. The Trust is required to meet the terms of its licence and this report proposes the evidence available to support the Board's assessment
Green Plan	N/A

Main Report

1. Introduction

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

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

1.3. The Trust is required to self-certify its compliance with the following conditions after the financial year end (2025/2026):

1.3.1. Condition G3: Fit and Proper Persons as Governors and Directors

1.3.2. Condition G5: Systems for Compliance with Provider Licence conditions.

1.3.3. NHS 1 & 2: Good governance arrangements

1.3.4. Condition CoS7: Provider has reasonable expectation that required resources will be available to deliver the designated services.

2. **Condition G3 – Fit and Proper Persons requirement**.

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

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

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

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

of qualifications and education. This has been actioned across the Board of Directors.

2.5. In February 2026, the Trust's Fit and Proper processes were subject to audit as part of the Care Quality Commission's Well-led inspection. Whilst the final written report has not been received by the Trust as at the date of writing this report, verbal feedback from the Inspection team was positive.

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

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

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

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

3.2.1. Board Assurance Framework.
3.2.2. Integrated Performance Report (quality, finance, workforce, operational performance)
3.2.3. Regulatory compliance assurance reports to Board Assurance Committees and Board
3.2.4. Reservation of Powers, Schemes of Delegation, and Standing Financial Instructions Reviews
3.2.5. Board Committee Effectiveness and Terms of Reference Reviews (report to Board due in July 2026)
3.2.6. Committee Chair reports (4As) to Board detailing risks and issues that required escalation; and
3.2.7. An enhanced Integrated Performance Report, delivering a consolidated summary of critical metrics across quality, safety, people, performance, and finance, further aiding Board Oversight.
3.2.8. Other specific reports on high-risk areas.
3.2.9. Trust Risk Register

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

3.4. The Trust's Internal Auditors (currently BDO) undertake several specific risk-based internal controls audits each year. Head of Internal Audit Opinion for 2024/2025 was Moderate. The draft Head of Internal Audit Opinion for 2025-2026, provided to the Audit and Assurance Committee (April meeting) was the Trust's risk management, control and governance processes are generally satisfactory with improvements required in some areas. This is similar to the assurance rating of moderate we provided to the Trust in 2024/25. It is not anticipated this opinion will alter when the final Annual Report is provided to the Audit and Assurance Committee in June 2026.

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

3.6. Areas of strength include:
  3.6.1. A mature committee framework, with clear escalation via 4A reports to Board;
  3.6.2. Sustained improvement in Internal Audit opinion, demonstrating a strengthening control environment.

3.7. Areas for continuing development are:
  3.7.1. Continued alignment of the Trust Risk Register and Board Assurance Framework against the revised Risk Appetite Statement (November 2025).
  3.7.2. Further integration and appropriate review of assurance sources.

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

4. Good Governance conditions – NHS1 and NHS2.

4.1. Condition NHS1 requires Trusts to make available written and electronic copies of its Constitution and most recent annual accounts/report of Auditor and annual report. The Trust does so by publishing those items on its website.

4.2. Condition NHS2 outlines the governance arrangements that the Trust must adhere to, including Board capability, oversight of quality, financial stewardship, and sustainability obligations.

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

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

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

  Each Committee has undertaken a review of its effectiveness and Terms of Reference during 2025-2026, with the report scheduled to be presented to the Board of Directors (July 2026)

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

4.6. Each Committee provides regular Assurance Reports (KIAR/4As) that are reviewed by the Board. These reports focus on issues requiring escalation and offer assurance on actions that aim to improve governance.

4.7. The Trust Risk Register is regularly reviewed at relevant Assurance Committees and Board of Directors meetings.

4.8. The Board Assurance Framework (BAF) serves as a structured tool to identify and manage strategic risks, helping ensure committees' activities align with the Trust's strategic goals. In November 2025, the Board Assurance Framework was refreshed to ensure alignment with the Trust's Strategy for 2025-2030.

4.9. Effective clinical governance processes are evidenced through:

4.9.1. Incident management processes and procedures (Patient Safety Incident Response Framework)
4.9.2. Raising concerns processes.
4.9.3. Duty of Candour processes.
4.9.4. Care Quality Commission inspection processes and outcomes.

4.10. The Trust's Annual Report, incorporating the Annual Governance Statement (currently in draft but approved by the Audit and Assurance Committee in April 2026) includes commentary on committee performance and any gaps identified in effectiveness, promoting transparency in governance. The Trust's annual report sets out several key areas where evidence of compliance with regulatory requirements and internal governance standards is presented:

4.10.1. Care Quality Commission (CQC) Compliance:

The Trust is broadly compliant with CQC registration standards; however Maternity Services are subject to a s31 enforcement notice. This Notice led to targeted quality improvement actions, with oversight by the Integrated Care Board, aimed at enhancing safety and service quality. During the relevant period, regular progress reports were provided to both Board and Care Quality Commission. The Trust has self-certified that improvements against the Conditions imposed have been achieved and embedded.

4.10.2. Workforce compliance:

Regular reporting on workforce metrics, including vacancy rates, staff turnover, and mandatory training completion, is overseen by the People and Organisational Development Committee and included in the Integrated Performance Report to Board

4.10.3. Internal Audit and Governance

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

4.10.4. Board Assurance Framework

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

4.11 The Trust's pans for achieving net zero carbon emissions are detailed in the Green Pan and relevant sections of the Annual Report, targeting a net-zero footprint by 2040 for emissions under

their direct control. The Trust has implemented various initiatives, including infrastructure upgrades, green space initiatives, operational changes, and sustainable waste management.

4.12 It is our assessment that governance systems are well established and functioning, though the improvements identified within the Trust commissioned well-led review by Aqua, are the process of an ongoing implementation plan. It is proposed that the Trust confirms its compliance with this requirement.

5. CoS7: Availability of Resources

The Trust must, as a provider designated as providing Commissioner Requested Services, not later than two months from the end of each Financial Year, self-certify as to the availability of the Required Resources for the period of 12 months, in one of the following forms:

> (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
>
> (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services."
>
> (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

5.1. The Trust is required to confirm that it has the required resources to continue to provide those services, management, workforce, financial and facilities and resources. Commissioner Requested Services are services that:

5.2. The evidence to support this self-certification includes:

5.2.1. Going concerns assessment process, considered by the Audit and Assurance Committee (April 2026).

5.2.2. External Audit Opinion (initial indication presented at Audit and Assurance Committee in April 2026, following completion of the interim audit, was positive. Full audit report will be presented to Audit and Assurance Committee in June 2026.

5.2.3. Trust patient services contracts.

5.2.4. Financial reports and updates provided to the Finance and Resource Committee and Board.

5.2.5. Medium-term business plans submitted to NHS England (March 2026).

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

6. Conclusion

The Trust has undertaken a comprehensive and evidence-based assessment of compliance with the NHS Provider Licence.

Across all applicable conditions:

- Governance systems are embedded and operating effectively.
- Assurance is triangulated across multiple independent sources.
- There is a clear trajectory of improvement, particularly in internal control maturity.

While no breaches of licence conditions are identified, the Board should note:

- The importance of sustained focus on governance maturity
- Continued regulatory scrutiny in specific service areas.
- The need to maintain robustness of assurance processes.

The Trust can self-certify compliance as “Confirmed” for all applicable Provider Licence conditions.

7. Recommendations

(i)Receive ASSURANCE that the Trust is compliant with the NHS Provider Licence and confirm support for the source, robustness, and an appropriate degree of independence of the assurance.

(ii)To APPROVE the self-certification of ‘confirmed’ for each of the applicable Provider Licence Conditions and approve publication as appropriate.

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting

Title		ADVISE, ALERT and ASSURE Report of the meeting of the QPC Committee held on 26 March 2026
Board member lead(s)		NED Chair – Sam Foster and Exec leads CNO/CMO/COO and Deputy CEO
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	X
	Discussion	X
	Note	X

Purpose of report

To present an update to the Board of Directors from the meeting of the QPC Committee held on 26 March 2026. 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.

Surgery Division – Never Events

- Five Never Events in the past 12 months, including wrong-site ophthalmology procedures and surgical implant issues.
- Ongoing concern regarding how learning is embedded and shared across specialties.
- Inspection readiness highlighted as a significant risk (theatres governance, CSSD, SAU).

Central Sterile Services Department (CSSD)

- Operational risks including short-notice cancellations linked to estates and CSSD capacity.

Surgical Assessment Unit (SAU) Pressures

- Rising demand and long waits.
- Medical decision-making capacity lagging behind nursing and ACP staffing increases.
- Pathway, flow and workforce redesign required.

Maternity Workforce and Training Capacity

- Training capacity limiting ability to release staff in line with national expectations.
- Continued regulatory oversight remains in place.

Manual Validation of Quality Data (Surgery Division)

- Ongoing reliance on manual validation of quality data poses organisational risk, particularly for external inspection readiness.

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

Strategic Risk 10 – Reframing

- Further development needed to mature and reframe the risk around patient experience, patient voice and health inequalities.
- Need to integrate currently separate strategies (patient experience, engagement, health inequalities).

Maternity Reporting Improvements

- Need for more concise, assurance-focused Board reporting.
- Requirement for clearer trajectories, visibility of equality trends, and improved cultural reporting.

IPR Watch Metrics – Escalation and Presentation

- Need to include absolute numbers alongside percentages for clarity and meaningful assurance.
- Continue strengthening escalations when red metrics persist.

Surgery Division – Embedding Learning

- Need for strengthened assurance on consistency of learning from Never Events across services and external providers.
- Improved trend analysis and early complaint resolution processes.

Workforce, Culture and Leadership

- Continued focus required on leadership visibility, human factors work and staff resilience in theatres, CSSD and SAU.

ASSURE: inform the board where positive assurance has been received

IPR Watch Metrics – Effective Oversight

- Watch metrics functioning as an early-warning system.
- Escalation processes working and issues moved into main IPR where needed.

- Clear alignment with wider governance structures.

Surgery Division – Positive Quality and Performance Trends
Reductions in falls and pressure ulcers.
Improved patient placement.
Strong Friends & Family Test performance.
Significant reduction in 52-week RTT breaches.
Improved cancer pathways and elective productivity.
Improved complaint response rates (now >60%).

APPROVALS: decisions made by the Committee, & Applaud Positive Achievements, Examples of Excellence, or Noteworthy Progress

Maternity Improvement Work
Notable breadth of improvement activity underway.

Strong Operational Delivery in Surgery
Nationally strong RTT position.
Improved cancer performance and elective productivity.

Falls and Pressure Ulcer Reductions
Tangible impact from targeted nursing investment.

Divisional Transparency and Engagement
Surgery Division commended for openness in presenting achievements and challenges.

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	**SR10**

Risks discussed

The Committee discussed the following risks: The Committee discussed a range of risks that enabled triangulation with the BAF

Recommendations

The Board of Directors is asked to take **assurance** from the report and **note** the areas detailed in the report to be advised and areas for applauding.

Gloucestershire Hospitals
NHS Foundation Trust

Alert, Advise and Assure Report to the Board of Directors Meeting

Title		ADVISE, ALERT and ASSURE Report of the meeting of the QPC Committee held on 23 April 2026
Board member lead(s)		NED Chair – Sam Foster and Exec leads CNO/CMO/COO and Deputy CEO
Written by		Committee Chair
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	X
	Discussion	X
	Note	X

Purpose of report

To present an update to the Board of Directors from the meeting of the QPC Committee held on 23/4/26 This committee meets monthly and is attended by members of the Board and senior managers.

Chair's summary

The Quality and Performance Committee met at a time of relative operational stability and continues to see evidence of improving grip and maturity across several areas of quality, safety, and workforce. The Committee took assurance from stronger nursing staffing, effective winter delivery, and the benefits of acute medical centralisation. However, the Committee continues to have oversight on a small number of persistent risks that warrant continued Board visibility. Maternity workforce resilience and elements of diagnostic sustainability require sustained executive focus to ensure improvements are embedded and risks are reduced rather than managed through short-term mitigation.

The Committee discussed these matters openly and with appropriate candour, mindful of public confidence and the Trust's commitment to transparency, learning, and improvement. Overall, the Committee is satisfied that known risks are understood, appropriately governed, and actively managed, and that progress is being made where further improvement is required.

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 workforce resilience and service sustainability

- The Committee remains concerned regarding ongoing workforce fragility within maternity services, evidenced by high sickness absence and reduced appraisal completion. While leadership and governance are improving, the continued suspension of home births and delays in external reviews underline the need for sustained focus on workforce resilience, learning, and service sustainability.

Diagnostics sustainability (DM01)

- The Committee is not yet assured that diagnostic recovery is fully sustainable. Short term capacity solutions remain in place for endoscopy, and echocardiography recovery continues to lack credible trajectories and consistent divisional grip.

Patient flow and corridor care

- The Committee noted some need for corridor care during peak pressure, particularly affecting frail, and older patients. Mitigations are in place and strong executive oversight.

Complaints Handling

- The Committee remains concerned that current complaints managing arrangements do not yet provide consistent assurance on timeliness, quality of responses or demonstrable learning. Given the importance of complaints as a source of patient insight and reputational trust, the Committee considers this issue to warrant ongoing Board attention.

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

Maternity quality governance

- Strengthening leadership and governance arrangements are beginning to show benefit. The Committee advises continued monitoring of workforce wellbeing, culture, and delivery of outstanding actions, including assurance on translation and interpreting services.

Urgent and Emergency Care and system flow

- Performance has improved but remains fragile, particularly within non admitted pathways and overnight flow. The Committee advises continued system wide focus on discharge readiness and escalation ahead of future pressure periods.

Cancer and elective performance

- Overall elective performance remains strong, though some speciality specific and tumour site challenges persist. The Committee advises continued targeted scrutiny until recovery is demonstrably sustained.

Patient experience and health inequalities

- Complaints and PALS activity continues to highlight access and communication challenges. The Committee advises further clarity on how patient experience and health inequality intelligence are translating into measurable service improvement.

ASSURE: inform the board where positive assurance has been received

Nursing workforce and safer staffing

- The Committee took strong assurance regarding improvements in nurse recruitment, retention, and sickness, with associated reductions in agency use and positive impact on quality indicators.

Winter delivery and ambulance handovers

- The Committee was assured that winter was managed without escalation to critical incident, supported by improved planning, coordination, and stable ambulance handover performance.

Acute medical centralisation

- Clear clinical and operational benefits have been realised, with no evidence of unintended harm. Appropriate monitoring and governance arrangements remain in place.

Child Protection Medical Assessments and radiation safety

- The Committee was assured that risks in these areas are well controlled through established governance, with no current need for escalation.

APPROVALS: decisions made by the Committee, & Applaud Positive Achievements, Examples of Excellence, or Noteworthy Progress

The Committee applaud:

- Stabilisation of senior maternity leadership and strengthening of governance arrangements.
- Delivery of a more resilient and coordinated winter response.
- Sustained improvement in nursing workforce stability through a data-driven approach.
- Strong devolved accountability and compliance in radiation safety arrangements.
- Improved triangulation and use of patient experience intelligence.

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	**SR10**

Risks discussed

The Committee discussed the following risks: The Committee discussed a range of risks that enabled triangulation with the BAF

Recommendations

The Board of Directors is asked to take **assurance** from the report and **note** the areas detailed in the report to be advised and areas for applauding.

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Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Date of Meeting	14 May 2026
Report title	Integrated Performance Report (IPR)
Sponsoring Director/Author	Al SHEWARD – Chief Operating Officer Matt HOLDAWAY – Chief Nursing Officer Mark PIETRONI – Medical Director Karen JOHNSON – Director of Finance Dave TAYLOR (Director of Operations Hospital Flow) Alex MATTHEWS (Deputy COO – Planned Care) Suzie CRO (Director of Quality Governance) Steve PERKINS (Director of Operational Finance) Debbie TUNNELL (Deputy Director for People & OD)

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

Executive Summary

Urgent and Emergency Care (UEC)

UEC performance continued to show gradual improvement into late March, with four-hour performance improving to 64.6% in March from 62.8% in February, marking the third consecutive month of improvement despite a significant increase in attendances. Admitted pathway performance has strengthened further, while non-admitted performance remains more volatile, particularly overnight, reflecting ongoing congestion and staffing challenge. Performance remains below the operational standard, but the improving trajectory is encouraging going into April.

Operational pressures continue to be driven primarily by high emergency admissions and patient complexity, compounded by a reduced bed base. Same Day Emergency Care (SDEC) and admission avoidance pathways remain effective, but rising acuity and slower discharge have limited the pace of improvement, particularly at the start of the week. Weekend discharge performance continues to lag weekday flow, contributing to early-week congestion. Focused Quality Improvement work following March sprint activity is now being embedded, with particular emphasis on time to first clinician, minors flow and overnight staffing resilience.

Ambulance handover performance remains well controlled, with average handover times reducing to 20 minutes in March, continuing a downward trend and remaining comfortably within

escalation thresholds. Corridor nursing and enhanced escalation SOPs have supported this position, alongside improved use of assessment space. Priorities for April include embedding learning from sprint work, maintaining senior clinical oversight, progressing workforce recruitment, and finalising revised SOPs to support sustained improvement across both admitted and non-admitted pathways

PLANNED CARE

Planned Care performance continues to stabilise going into April, with RTT 18-week performance improving to 74.3% in March (up from 71.7% in February) and exceeding the operational target for the month. This improvement has been driven by sustained focus on long-waiter recovery, although overall performance remains below the national standard and is sensitive to capacity, productivity and workforce constraints.

The total incomplete RTT waiting list increased marginally, driven entirely by growth in patients waiting under 18 weeks, reflecting sustained demand and a temporary re-prioritisation of validation towards long waiters. The number of patients waiting over 18 weeks reduced by 1,691 in-month, demonstrating effective recovery action. RTT EDI groups remain under close oversight: the Armed Forces pathway has sustained elimination of 52-week waits, while Learning Disability patients continue to be reviewed weekly, with a small cohort of long waiters subject to targeted booking and escalation.

Significant progress has been made on 45-week waits, with breaches reducing from 638 to 471 (-167). Dermatology and ENT delivered the largest improvements, with ENT now compliant; Orthopaedics has also reduced for the first time in several months. However, Spinal Surgery deteriorated in-month and remains a material risk, alongside ongoing challenges in Neurology, Orthopaedics and Paediatrics. Planned Care therefore remains under enhanced executive oversight, with sustained improvement dependent on recurrent capacity solutions and diagnostic throughput.

DIAGNOSTICS (DM01)

Diagnostic performance (DM01) remained broadly flat between February and March, holding at approximately 18.97% breaching which is within the tolerance set in the 2026-27 operating plan (less than 20% breaching performance target). While several modalities demonstrated improvement, overall recovery remains fragile and offset by deterioration in key services, reflecting continued demand pressure and reliance on short-term recovery actions.

Notable in-month improvements were seen in Cystoscopy (-93 breaches), Colonoscopy (-43) and CT (-13), with CT expected to continue improving and DEXA anticipated to return to compliance. However, Non-Obstetric Ultrasound deteriorated further (+66 breaches) and Echocardiography performance fell sharply in-month, with the largest breach volume increase across diagnostics, despite a reduction in overall waiting list size.

Overall, the diagnostic waiting list increased by 296 patients with breaches rising by 159, indicating that capacity remains insufficient to meet demand. Recovery continues to rely heavily on non-recurrent measures, particularly in Endoscopy, NOUS and ECHO. A sustainability business case for Endoscopy is progressing through Trust governance.

CANCER

Cancer performance in April 2026 remains fragile and is expected to be slightly weaker than

March, reflecting known capacity and pathway constraints. In March, 62-day performance was 71.7% (unvalidated), above internal trajectory but below the national standard, with a clear risk flagged of short-term deterioration as longer-wait patients were prioritised and surgical capacity remained constrained. Early April data shows the 62-day backlog at 207 patients, with continued improvement in some pathways, but persistent pressure in Lower GI and Urology, compounded by diagnostic and surgical bottlenecks.

The 28-day Faster Diagnosis Standard improved materially in March to 75.9% (unvalidated), driven primarily by Breast recovery, however performance is expected to remain below the 80% ambition in April while recovery actions embed. Overall, April performance continues to present a delivery risk against national standards, with sustained improvement dependent on stabilising diagnostic flow and releasing additional treatment capacity.

QUALITY

ALERT – Key Quality Risks

- **ED Patient Experience:** FFT positive responses are 92.9% satisfied or very satisfied, with a widening gap between CGH (strong) and GRH (weaker) and Delivery Suite (strong) and Maternity Ward (weaker)
- **Infection Prevention:** *C. difficile* cases have reduced to 21 per 100,000 bed days, a 50% drop from the spike last month. There remains a focus on cleaning equipment and the environment, antimicrobial stewardship, timeliness of stool sampling, prompt isolation of symptomatic patients and optimising management of patients with *C. difficile.*
- **Falls:** 5 falls per 1,000 bed days this month, the downward trajectory continues. Falls with harm being taken through Patient Safety Incident Response Framework (PSIRF) processes to decide the learning response for each case.
- **Workforce Gaps in Complaints**: Gaps for Head of Complaints and Complaints managers in W&C, D&S and Corporate posts are impacting performance across the Trust, currently 26% compliant. Robust workforce recruitment has been actioned and should impact next month.

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.
- **Press Ulcers:** Two patients sustained hospital acquired Cat 3 pressure ulcers. Improvement work has enhanced monitoring with the new BI Pressure Ulcer dashboard.
- **Stabilise PALS and Complaints teams**, addressing workforce gaps to ensure timely responses and maintain public confidence. Currently closing 84% of concerns within 5 days.
- **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 >92.9% and above our average benchmark.

- **PALS** continues to exceed the 75% closure standard, maintaining ~84% within 5 days despite higher volumes.
- **Mixed-Sex Breaches** remain minimal and rare, 22 this month, 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 to 0.911.
- **PSIRF Timeliness** 2 x Never Events, 4 x Multiprofessional Reviews,2 x After Event Review and 4 s Patient Safety Incident Investigations in March. Trustwide, PSIRF training compliance has risen to 79%

APPLAUD – Notable Achievements.

- **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.
- **Risk Management Performance**: A reduction in overdue actions on risks and incidents continues to be noted in the following Divisions and Trust Wide: Corporate, Medical, Surgical, D&S and GMS.

FINANCE

The financial position at the end of March2026 shows that the Trust has reported a year-to-date surplus of c£5m which is c£5m favourable to plan. £4.9m of this improvement from the planned breakeven position is due to national adjustments.

Nationally NHSE included funding within its planned position for identified pressures within plans for specific organisations – our Trust was not one of those. Subsequently some of those organisations have not met the criteria to access this funding and so NHSE plan to re-distribute this funding and our Trust will receive a share of this which will see an improvement in the reported financial position.

As previously reported delivery of financial sustainability continues to be a challenge in this financial year with a knock-on impact into 2026/27 due to lower recurrent (ongoing) delivery compared to what was planned for.

Capital had a year-to-date expenditure plan of c£55.6m and has full year confirmed expenditure of c£54.5m. The underutilisation is linked to a range of reduced scheme values on nationally funded programmes.

Our cash position shows that we are currently holding 20 days operating cash.

WORKFORCE

The workforce section reflects where there has been a deterioration in performance across the standard people metrics, or where performance requires ongoing close monitoring. Focus is seen this month on appraisal compliance, sickness absence and Bank use. The supportive narrative reflects the areas/services which are contributing to this position, together with the recovery actions in train to realise an improvement against target.

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

Previously considered by	

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	

Impact on any Strategic Risks?
SR1, SR2&3, SR4, SR5

Implications on:	
Equality, Diversity and Inclusion	
Health Inequalities	
Finance and Resource	Month by month financial performance update
Regulation/Legal	NHSE mandated performance report
CQC-Key line of enquiry	All domains
Green Plan	

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

FOI: Publc

Integrated Performance Report (IPR)

March 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	Feb-26	Mar-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%	22.0%	17.0%
		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%	10.4%	9.4%
	Elective Care	Total elective activity undertaken compared with 2019/20 baseline		111%	107%	112%	110%	107%	118%	108%	107%	118%	102%	106%	133%
		Total diagnostic activity undertaken compared with 2019/20 baseline		146%	142%	157%	140%	147%	149%	137%	142%	148%	137%	138%	175%
	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	172	138
		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%	6.98%	5.76%
		Proportion of patients meeting the faster cancer diagnosis standard	*75%*	82%	83%	86%	84%	80%	78%	77%	76%	70%	57%	68%	76%
		Total patients treated for cancer compared with the same point in 2019/20	*No Target*	357	362	344	334	343	406	304	280	311	313	284	301
	Outpatient	Outpatient follow-up activity levels compared with 2019/20 baseline		109.92%	104.97%	109.42%	110.14%	106.43%	120.21%	109.32%	107.68%	118.60%	102.80%	104.16%	123.71%
	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%	97.31%	97.49%	97.55%	97.64%
	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	0.944	0.927
		Summary Hospital -level Mortality Indicator Limits		Within	Within	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	38.4	21
		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	23	21

Watch Measures

			Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Watch Measures	Urgent Care	ED Armed Forces 4 hour breaches (TRAK flag)	0	5	8	4	5	2	2	9	3	1	2	4	4
		ED Learning Disabilities 4 hour breaches	0	63	101	81	92	65	70	76	66	84	80	53	71
	Elective Care	52ww RTT	0	94	75	47	40	37	36	29	31	30	21	13	6
		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%	11.3%	9.5%
		Same Day Non-Clinical Cancellations		57	38	59	84	69	104	74	68	38	51	45	54
		Cancellations not rebooked within 28 days	0	7	12	14	9	25	11	28	16	14	9	13	5
		Angiogram Waiting List Position		293	288	274	280	265	231	220	216	232	250	255	237
		Histopathology 10-day reporting	90%	56%	56%	49%	63%	63%	58%	52%	41%	38%	50%	47%	31%
	Flow	G&A Occupancy - CGH	92%	88%	89%	88%	86%	85%	87%	87%	86%	89%	91%	90%	92%
		G&A Occupancy - GRH	92%	95%	94%	92%	94%	94%	94%	95%	95%	94%	97%	97%	96%
		Daily Average of boarded patients	0	4	3	1	4	2	3	3	3	3	3	3	2
	Safe Care	VTE Assessment within 14 hours (%)	95%	91%	90%	91%	85%	89%	87%	87%	88%	88%	86%	86%	86%
		VTE assessment completed - excluding short stay (%)	95%	96%	95%	95%	91%	94%	93%	93%	94%	93%	93%	92%	93%
		Number of Category 2 pressure ulcers acquired as inpatient		15	19	11	11	21	11	24	11	15	15	6	12
		Smoking Status Compliance (%)	95%	97.11%	97.16%	97.09%	97.12%	97.54%	98.40%	98.56%	98.16%	98.04%	97.95%	97.54%	98.25%
		Severe Harm from Patient Medication Errors	0	2	1	0	0	1	0	0	0	0	1	0	0

UEC: Performance

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

Highlights

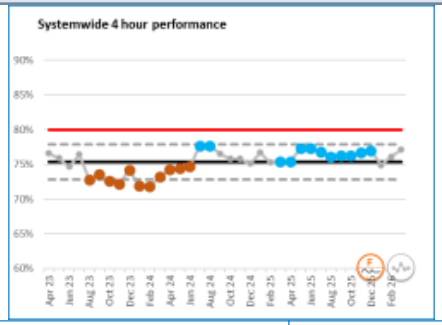
- 4-hour performance improved to 64.6% in March compared to 62.8% in Feb, following targeted 'sprint' activity.
- 12-hour performance also improved by 1%.

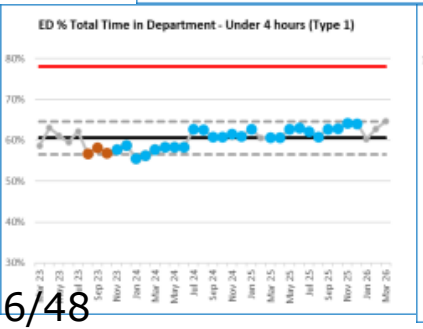
Areas of Concern

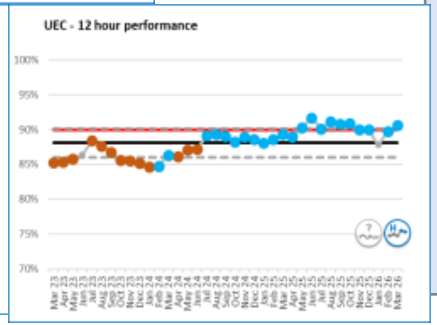
Performance remains below the operational standard.
Time to clinician remains a key area for improvement

Looking Forward

- Focus on learning that can be taken forward following March Sprint events
- Significant upcoming recruitment (nursing and medical)







Technical Analysis

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 improving the 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

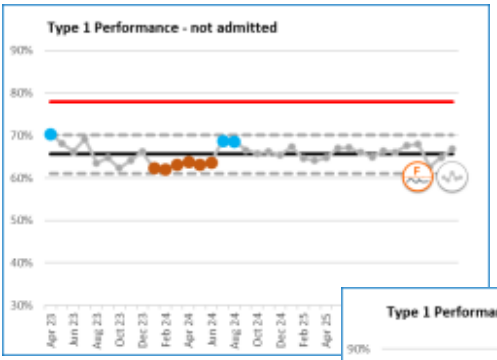
- Admitted performance continues to improve, but there has been little change in non-admitted performance.

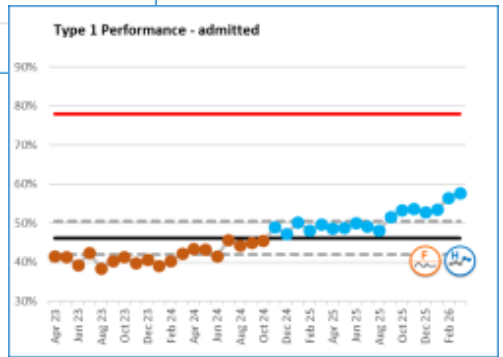
Areas of Concern

- Overall attendance levels remain consistent with recent months, sustaining pressure on ED flow.
- Non-admitted performance remains volatile and below trajectory, particularly overnight.

Looking Forward

- Focus on learning that can be taken forward following March Sprint events





Technical Analysis

Non-admitted 4-hour performance improved to 67% from 65% in Feb.
Admitted performance has continued to improve, reaching 58% in Mar-26, this was 50% in March-25.

Planned Actions

- Continued learning from March Sprint targeted at Minors flow and overnight waiting, with specific focus on reducing time to first clinician.
- Continued additional Matron presence at CGH, maintaining non-admitted performance above 90% and supporting further improvement
- Sustained improvement will depend on embedding fast-track triage, maintaining senior clinical oversight, and stabilising overnight staffing.
- Additional staffing agreed to support fast-track triage adjacent to the ED front door.

UEC: Performance

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

Highlight

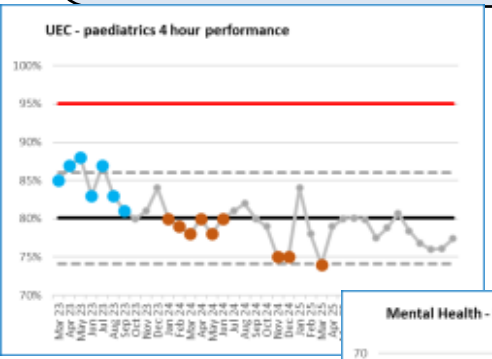
Despite a significant rise in overall attendance from 12,300 in Feb to 14,346 in March (+2,016). 3rd Month in a row of improved 4hr performance.

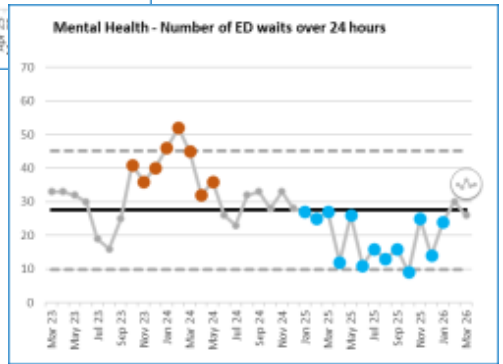
Areas of Concern

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

Looking Forward

Interviewing for 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 March 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

- Recruit to ED Paeds Consultant.
- Seeking to establish a dialogue across the System through the ICB regarding management of MH patients.
- New PAU/ED SOP in draft awaiting approval, needs to go through Div Boards and UEC Board.

UEC: Average Handover Time

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

Highlights

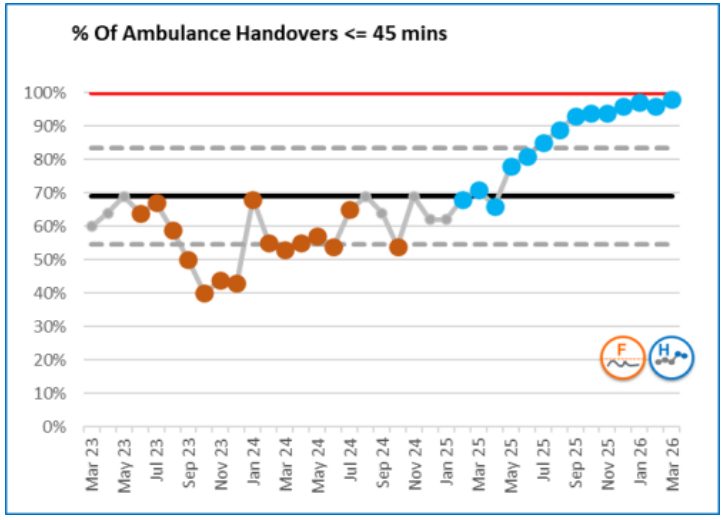
Average ambulance handover times have decreased from 21mins in January & Feb to 20mins in March. This is a continued downward trend.

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, still seeing average handover times will below the half-hour.

Planned Actions

- Review RATA process and review of space utilisation within RATA and old resus.
- 24hr Ambulance reception cover to be in place from May to reduce digital time for booking in.

% 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 improved from 71.67% in February to 74.30% in March (+2.6%). However, the total incomplete waiting list has increased from 67,826 to 68,175 (+349), all under 18 weeks.

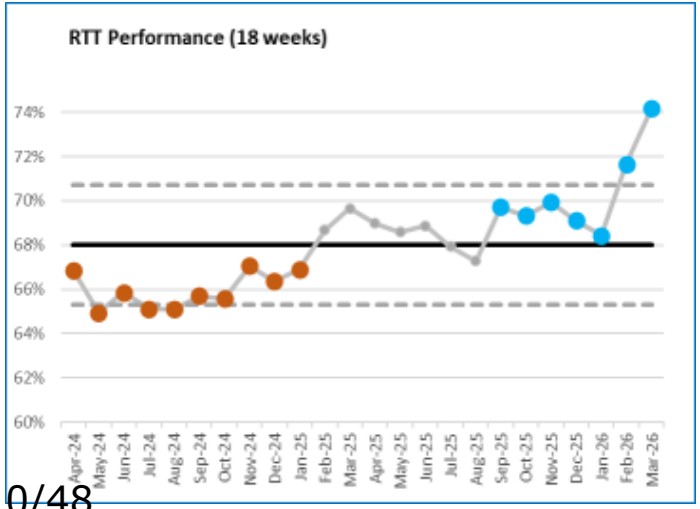
Technical Analysis

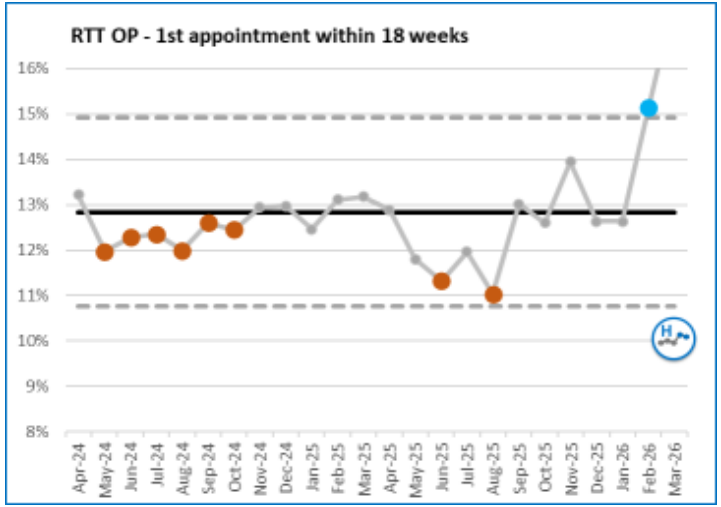
The swing in performance relates primarily to the temporary cessation of validation below 18 weeks and additional focus +18 weeks performance. The total number of patients over 18 weeks has decreased from 19,214 to 17,523 (-1691).

Planned Actions

Maintain a clear focus on 45 weeks+ elimination by all RTT specialties submitting a recovery plan to either:

a.) Move from 45 to 35 weeks in Q1 (if already at 45 weeks)
b.) Move from 52 to 45 weeks in Q1 (and stabilise)





As of 10/04/26 Gloucestershire is at 74.3% of patients waiting for their first activity within 18 weeks, against a target of 73.1%, The top 5 specialties furthest below the Nov 24 baseline of 68.1%:

#1 Neurology (40%)
#2 Ortho (41.8%)
#3 Spines (42.4%)
#4 Oral (45.7%)
#5 Paediatrics (50%)

RTT EDI groups

RTT waiters with learning disabilities and armed forces CCG (13Q)

Highlights

The Armed Forces national sprint has been fully achieved (0 patients waiting >52 weeks).

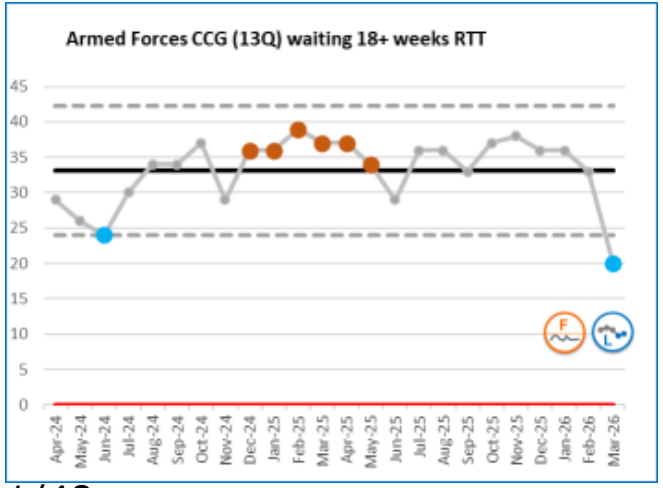
Technical Analysis

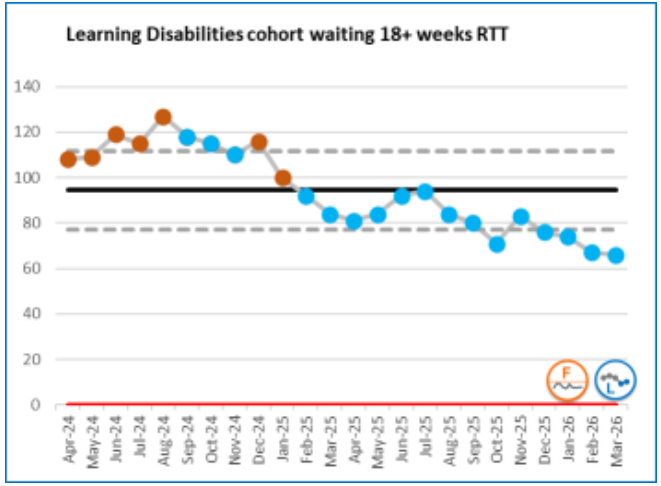
Armed Forces – 88 patients total on the RTT waiting list of which 22 patients are currently over 18 weeks. 5 patients are over 40 weeks with three unbooked (2 Derm, 1 Neuro).

Learning Difficulties – 231 patients total on the RTT waiting list of which 76 patients are current over 18 weeks. 17 patients are over 40 weeks with 7 unbooked (2 Cardio Investigations, 1 Gastro, 1 Ortho, 2 UGI, 1 Urology).

Planned Actions

- **Armed Forces** – Continue to review 13Q RTT waiting list by specialty to book patients >18 weeks in Q1 26-27.
- **Learning Difficulties** – Review all patients over 40 weeks at the Long Waiters Oversight weekly meeting.





Armed Forces – 75% of patients treated <18 weeks in March 2026. Oral Surgery and Dermatology have the largest volume of patients over 18 weeks.

Learning Difficulties – 67.10% of patients treated <18 weeks in March 2026. Oral Surgery and Neurology have the largest volume of patients over 18 weeks.

Elective: 45 Week Wait

Highlights

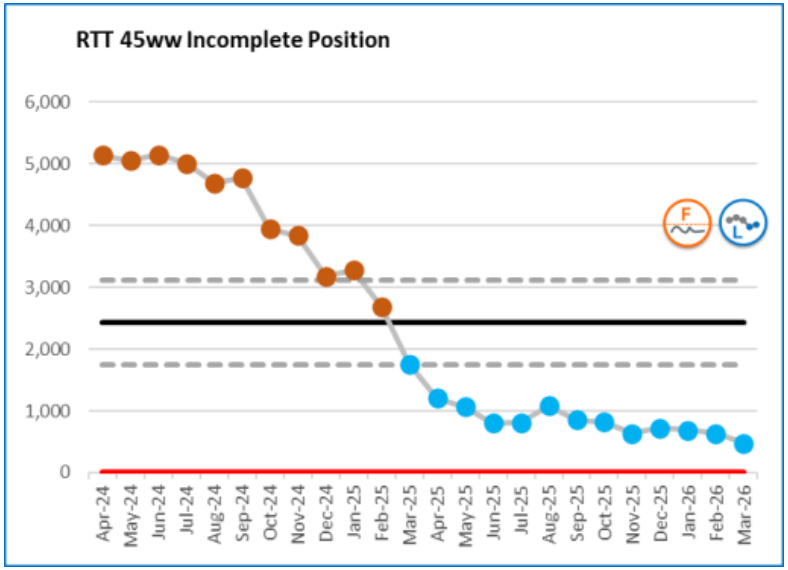
The number of 45 weeks has again decreased since last month, from 638 in February to 471 in March 2026. Two specialties have made significant progress: Derm (-129) and ENT (-27).

Areas of concern

Continue to be Dermatology, Orthopaedics and Upper GI services due to volume. Orthopaedics has decreased for the first time in months from 157 in February to 135 in March.

Looking forward

Challenges will continue to exist with the 3 referenced services due to volume. All other specialties are required to submit a formal RTT recovery plan to reduce below 45 weeks.



Technical Analysis

- The finalised March month-end position confirmed a total of 471 x 45 week breaches (a reduction of 167 on last month).
- ENT has now become compliant with 45 weeks RTT following the most challenged waiting list position post COVID19.
- Spines has deteriorated in month (+12 patients) and is a significant performance risk.

Planned Actions

- Robust recovery plans for each specialty that will be required to assess national benchmarking opportunities as a means to convert core capacity into new patient slots.
- A tabletop deep dive for Spinal Surgery will take place w/c 13th April 2026.
- A formal case for investment for GI surgery is anticipated to be received end of April 2026.

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

Standard: 85%

Highlights

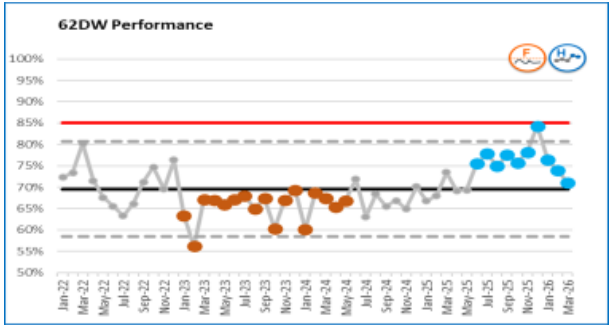
Achievement of 85% by Skin in March-2026.

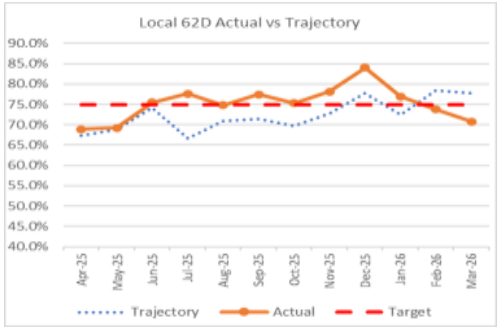
Areas of concern

Validated 62 Day standard for February is at 73.9% and so we will miss the national target and the minimum requirement of 75% for 62 day
Ongoing concerns continue to be linked to late diagnosis and limited surgical capacity for first treatments
March-26 unvalidated is showing 71.7% performance

Looking forward

Due to surgical capacity constraints, we continue to see a decline in Lower GI 62-Day position, this is despite the 2 new consultants that started at the end of last year.
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 February is currently at 68.5% but we expect March to be above 75%
This is in part due to the much improved position of breast performance rising to 72.5% from 40%

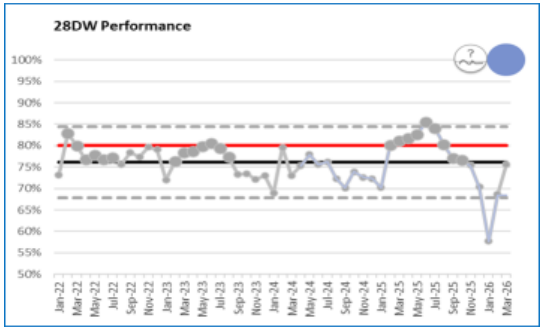
Areas of concern

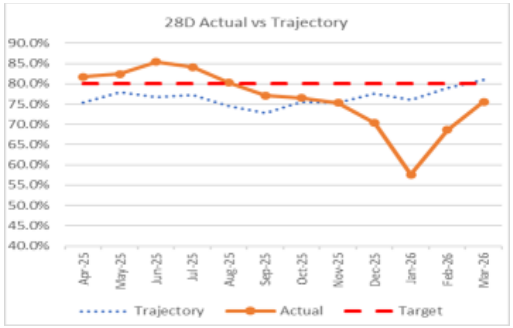
First OPA capacity for H&N, Derm, Urology (Haematuria) and Colorectal capacity long term.

Breast capacity continues to improve and are now booking to day 20.

Looking forward

Breast and Skin to present recovery plans and timeline trajectory of compliance at Cancer Delivery Group





Technical Analysis

Unvalidated 28 Day standard for March 2026 is currently at 75.9% 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

- 207 on backlog as of 12/4
- Improved compliance in LGI and Urology which continues its downward trend

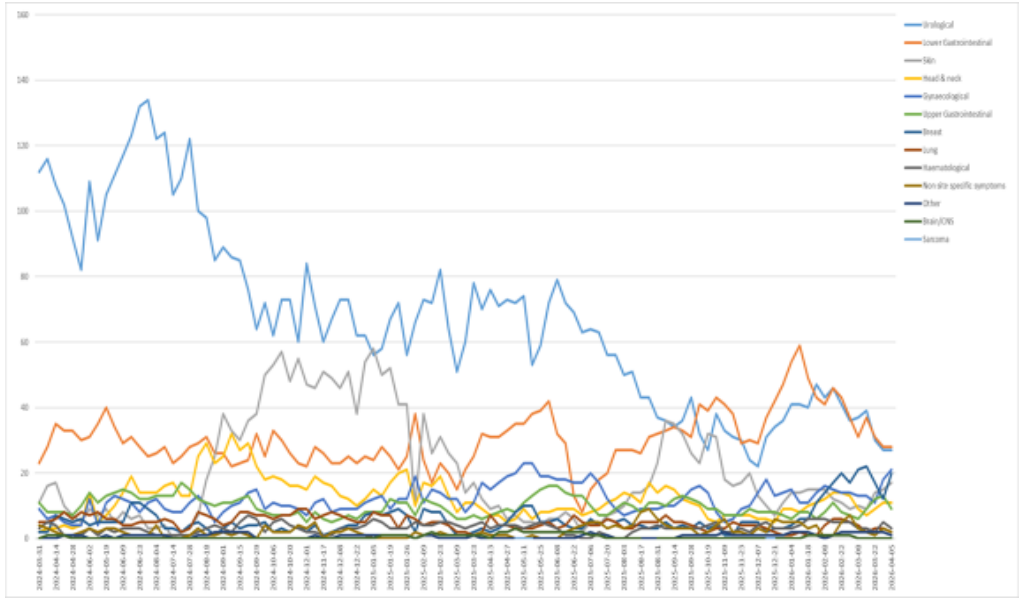
Areas of concern

- 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 position 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 decreased 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 – March 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		
	Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26	Jan-26	Feb-26	Mar-26
Acute leukaemia												
Brain/CNS	100.0%	100.0%	100.0%	71.4%	50.0%	100.0%	100.0%	100.0%				
Breast	6.2%	6.0%	17.8%	23.6%	40.0%	72.5%	94.3%	98.9%	86.6%	81.6%	54.5%	65.4%
Gynaecological	90.6%	95.6%	86.3%	63.6%	74.8%	63.9%	88.1%	83.3%	84.1%	42.4%	86.7%	34.6%
Haematological	94.4%	87.0%	86.7%	35.0%	43.8%	30.4%	98.4%	100.0%	100.0%	90.9%	81.8%	67.8%
Head & neck	92.1%	92.8%	91.6%	74.5%	77.8%	76.6%	91.7%	95.0%	88.9%	84.6%	69.2%	81.5%
Lower GI	94.2%	96.7%	96.7%	69.5%	83.7%	79.4%	78.9%	93.3%	87.5%	47.3%	75.8%	63.6%
Lung	95.5%	100.0%	100.0%	92.6%	100.0%	91.3%	90.2%	95.6%	92.6%	63.2%	69.2%	57.1%
Other				0.0%			100.0%	100.0%	100.0%	100.0%	50.0%	85.7%
Sarcomas							100.0%	100.0%	0.0%	0.0%		0.0%
Skin	70.8%	84.4%	60.1%	76.9%	85.8%	84.0%	96.6%	95.3%	100.0%	94.5%	84.1%	91.2%
Non site specific symptoms	0.0%	0.0%	6.1%	13.3%	22.2%	7.0%						
Testicular	100.0%	91.7%	100.0%	80.0%	92.9%	100.0%				100.0%		100.0%
Upper GI	99.0%	98.3%	93.8%	89.7%	94.1%	90.5%	98.3%	100.0%	100.0%	77.0%	87.8%	82.6%
Urological	94.3%	96.0%	97.7%	54.7%	67.2%	64.3%	93.1%	91.2%	77.0%	79.7%	68.4%	73.2%
Trust Total	68.0%	69.7%	69.2%	58.9%	68.6%	75.0%	92.8%	95.0%	87.3%	76.4%	73.9%	71.0%

Screening Programmes: Breast Screening

Highlights

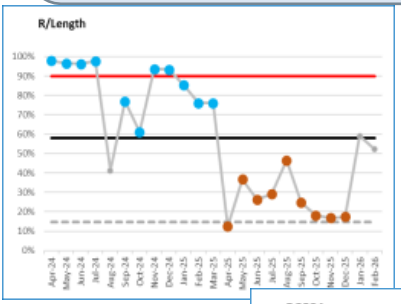
- Reduction of backlog to 2,100 at start of April from a peak of 10,016 at the start of November 2025. Additional capacity of 650 planned in April.
- Successful implementation of new perpetual DNA process to avoid wasted slots.

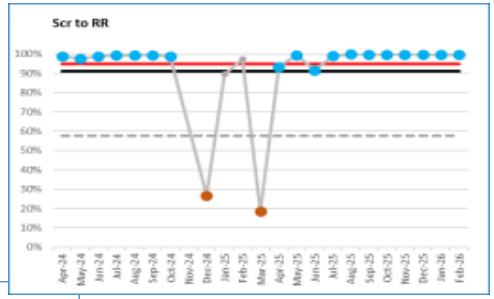
Areas of concern

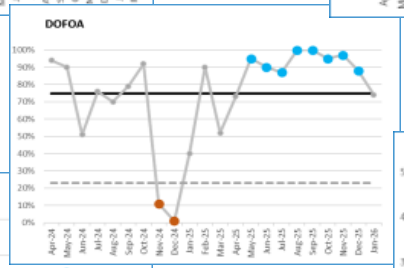
- Further equipment failures are impacting screening capacity in Thirlestaine. Replacement parts are on order but delivery date is to be confirmed.
- Assessment capacity – DOFOA likely to fall due to increased screening numbers.

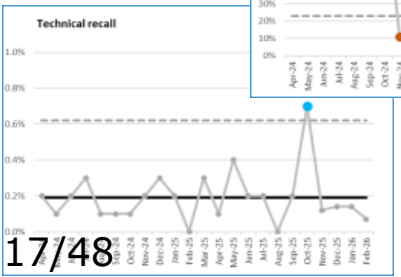
Looking forward

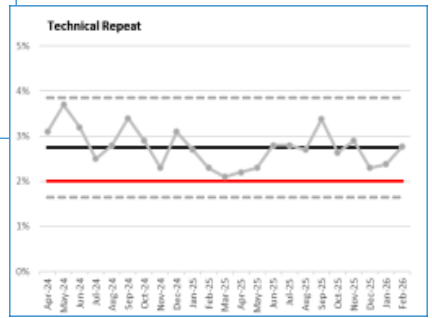
- B6 Mammographer recruited and started on 1st April
- Final review by NHSE of the long-term sustainability business case. Proposed to be signed off by April 2026 so that recruitment can commence. Informal feedback indicates the business case was approved on 7/4











Technical Analysis

- Current backlog is 2,100, which is a reduction of 1,385 from last month. This is despite significant down time on Robin due to failures on the van. Current round-length has increased slightly to 36months + 26 weeks, but should drop again in April
- Recovery is projected by July 2026, though based on current performance may be delivered before.
- Failure to sign off the sustainability business case would see a return to a backlog from December 2026 which would peak back to almost 8,000 by April 2028

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. GHC have indicated that there will be a 6month period between approval of funding and the room being operational.
- Continuing a 7-day service with Cancer Alliance / NHSE funded Sunday clinics, which have supported with accelerated recovery of the backlog.
- Invitation of other practices who are behind to TBC where there is no backlog

Diagnostics: Performance Trend

Highlights

Maintained position February to March (0.69% difference). The waiting list has increased by 296 patients and breaches increased by 159.

Areas of concern

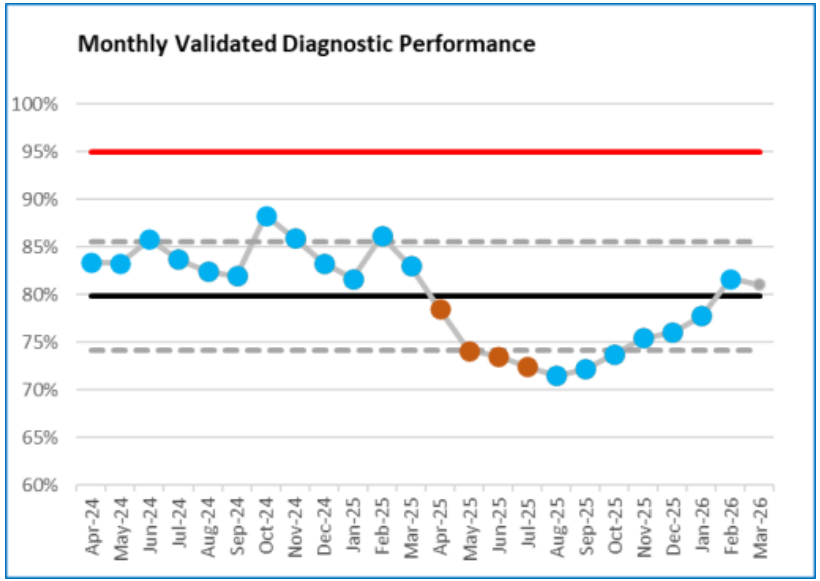
Three modalities have deteriorated in month DEXA, NOUS and ECHO), ECHO deteriorated by 13.7% in month

Echo continues to have the largest number of breaches (an increase of 132 compared to the previous month) although a total reduction of the waiting list by 284.

Looking forward

Total diagnostic waiting list likely to remain flat or increase further Monthly breaches likely to remain high, potentially similar to March levels.

- CT performance will continue to improve.
- DEXA will move back to a compliant position
- Endoscopy will continue with marginal % improvement.



Technical Analysis

The most notable improvements in breaches, were Cystoscopy (-93), Colonoscopy (-43) and CT (-13);
Non-Obstetric Ultrasound experienced an increase in breaches of 66.

Planned Actions

- **Neurophysiology** has held the position; recovery remains slow.
- **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 has been 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 implemented however recovery remains unstable.

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	2026-02-01	2026-03-01
Audiology - Audiology Assessments	99.38%	98.98%	99.22%	99.22%	98.27%	99.76%	99.66%	99.65%	99.88%	100.00%	99.80%	99.60%
Barium Enema	83.55%	99.08%	100.00%	100.00%	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%	41.82%	28.15%
Colonoscopy	67.16%	72.55%	64.09%	51.96%	45.87%	48.34%	51.27%	50.60%	48.91%	50.00%	53.16%	53.35%
Computed Tomography	92.83%	91.28%	90.81%	89.75%	86.15%	88.47%	89.11%	87.28%	87.07%	88.64%	92.64%	93.44%
Cystoscopy	45.18%	38.97%	33.40%	28.29%	36.31%	28.36%	32.75%	36.93%	39.83%	41.96%	46.20%	58.65%
DEXA Scan	100.00%	100.00%	100.00%	99.77%	100.00%	100.00%	100.00%	99.82%	100.00%	100.00%	100.00%	94.79%
Flexi sigmoidoscopy	74.47%	61.40%	51.05%	45.05%	40.29%	42.34%	41.69%	38.54%	37.40%	47.55%	52.76%	52.18%
Gastroscopy	86.10%	80.38%	75.00%	77.54%	74.81%	73.63%	71.75%	73.81%	73.77%	82.48%	82.23%	84.31%
Magnetic Resonance Imaging	77.59%	76.09%	85.26%	91.42%	99.17%	98.90%	99.10%	97.84%	99.11%	99.02%	99.45%	99.03%
Neurophysiology - peripheral neurophysiology	40.88%	43.82%	35.68%	53.05%	56.86%	60.87%	62.28%	75.14%	59.76%	69.67%	75.80%	75.16%
Non-obstetric ultrasound	99.68%	99.93%	99.49%	99.18%	99.40%	99.47%	99.64%	99.91%	99.63%	99.36%	98.21%	96.67%
Respiratory physiology - sleep studies	98.26%	90.38%	96.73%	96.43%	97.90%	94.22%	96.27%	99.22%	91.69%	82.23%	96.30%	93.01%
Urodynamics - pressures & flows	76.09%	100.00%	75.81%	87.50%	100.00%	100.00%	100.00%	100.00%	91.67%	100.00%	100.00%	100.00%

Flow Summary

Highlights

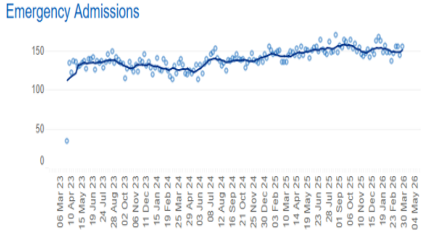
Admission avoidance and SDEC pathways continue to play an important role in moderating system pressure, although overall flow has become more complex.
Demand remains sustained at a higher baseline, with performance broadly in line with recent seasonal expectations.
Discharge performance remains variable, with improvements in some pathways offset by increased downstream complexity and care dependency.

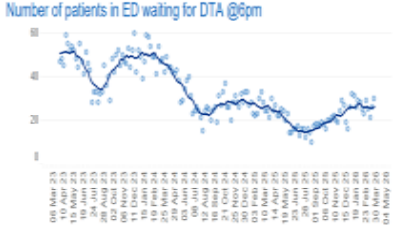
Areas of concern

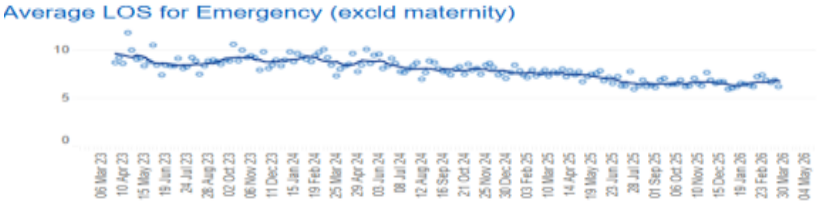
Emergency demand remains the principal driver of pressure, with ED attendances and conveyances at elevated levels.
The system continues to experience early-week congestion, reflecting cumulative weekend discharge constraints and demand variation.
Patient complexity, acuity and discharge dependency are increasingly constraining flow, limiting the system's ability to recover quickly from demand surges.

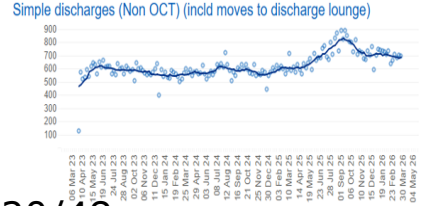
Looking forward

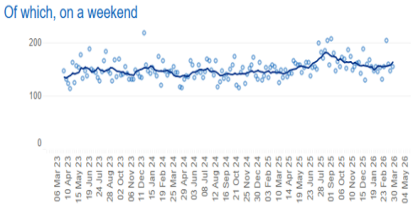
With demand expected to remain high, sustained improvement will rely on system-wide discharge performance, rather than further short-term escalations.
Ongoing work to optimise clinical and discharge decision-making, seven-day services, and pathway clarity will be critical to maintaining resilience.
Continued focus on reducing discharge delays and smoothing week-to-week variation will be key to mitigating ED congestion and operational risk.











Technical Analysis

- Time-series data continue to show a sustained high-demand trajectory, reflecting both seasonal pressures and longer-term growth in emergency presentations.
- While elements of the internal hospital pathway have stabilised, net flow is increasingly determined by discharge readiness and external capacity rather than in-ED or ward processes alone.
- Reductions in length of stay have plateaued, indicating diminishing returns from internal efficiency measures without parallel discharge capacity improvements externally.

Planned Actions

- Continued focus through CVOF-led reviews to understand changes in acuity, dependency and discharge profiles.
- Further embedding of Clinical Led Discharge (CLD) across services to support earlier, safer decision-making.
- Ongoing review of seven-day clinical and discharge services to reduce early-week congestion and improve flow stability.

Discharge Ready Summary

Highlights

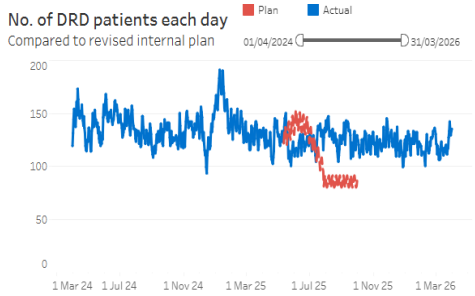
The increase in DRD over the winter period has been significantly less pronounced than in previous winters, however most recent performance heading into Easter shows significant deterioration both in terms of DRD numbers and delays.

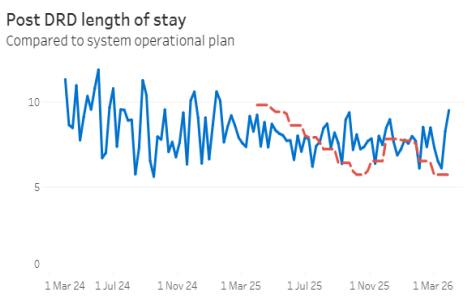
Areas of concern

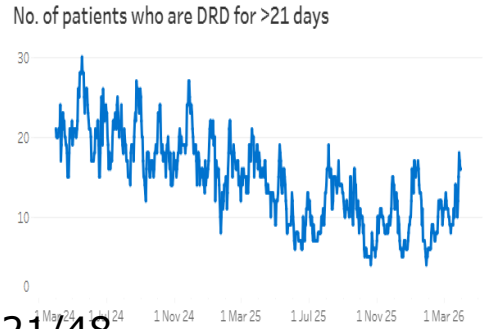
Deterioration in DRD performance related to Easter and restrictions within P1 & 2 related to wider system change programmes.

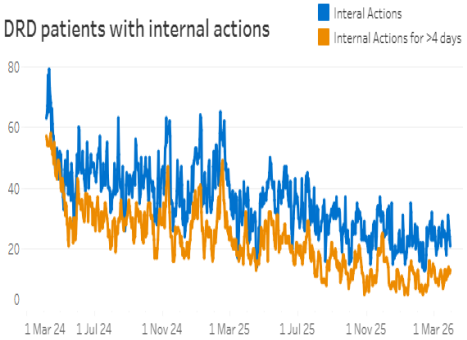
Looking forward

With demand expected to remain high, further reductions in DRD will depend on improved consistency and reliability of pathway 1–3 capacity.
Continued refinement of system-level DRD targets will be informed by performance monitoring and pathway-specific learning









Technical Analysis

- Chart trends show DRD changes broadly consistent with expected seasonal variation, without the sharp escalation seen in previous winters until the end of February into March.
- DRD has gone from 98 up to around 120 with a further spike into April.
- This is mirrored in associated days DRD, indicating significant issues within the wider system pathways in terms of flow.

Planned Actions

- Continued system-wide focus on DRD improvement workstreams to further reduce delays and length of stay.
- Targeted improvement on pathway 1–3 discharges over weekends and early weekdays where performance remains weakest.
- Delivery of the system-agreed pathway 1 capacity, including increased weekly starts, to support sustained reduction in delays.

Delay Related Harm Summary

Highlights

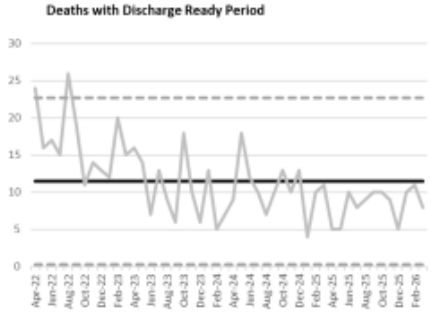
Levels of delay-related harm remain within expected seasonal variation and are improved compared with previous winters.
Deterioration seen in previous years between demand and harm has not been replicated, reflecting improved system resilience.
Increased but transient winter pressure was observed, with harm levels stabilising as pathway performance improved.

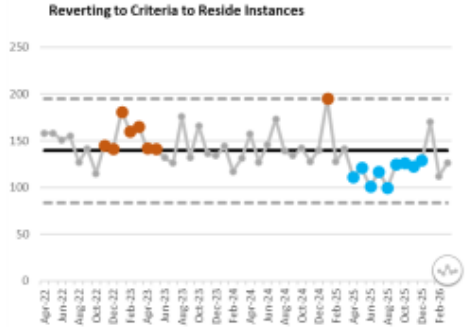
Areas of concern

Delays within discharge pathways continue to present a risk of delay-related harm, particularly for patients in pathway 1 and 2 placements.
Average DRD days for pathway 1 remain a key driver of harm, indicating a strong link between prolonged discharge delays and adverse outcomes.
Workforce and care capacity constraints continue to limit the pace at which system mitigations can be embedded.

Looking forward

Further reductions in delay-related harm will require sustained focus on reducing pathway 1 length of stay and improving onward flow.
The successful mobilisation of new pathway 2 capacity will be critical to reducing harm risk for complex patients.
Continued system-level oversight remains essential to prevent harm escalation as demand pressures persist





Technical Analysis

- Charted trends demonstrate no disproportionate escalation in harm relative to demand, suggesting effective mitigation during peak pressure.
- Harm continues to correlate most strongly with prolonged DRD, particularly in pathways 1 and 2, rather than with acute flow issues.
- The current pathway 2 bed base remains misaligned to increasing patient dependency and acuity, increasing the risk of extended delays.

Planned Actions

- Commissioning a revised pathway 2 bed base, better aligned to patient dependency and acuity.
- Continued cross-system work to improve discharge process reliability and deliver agreed capacity trajectories.

Quality Metrics

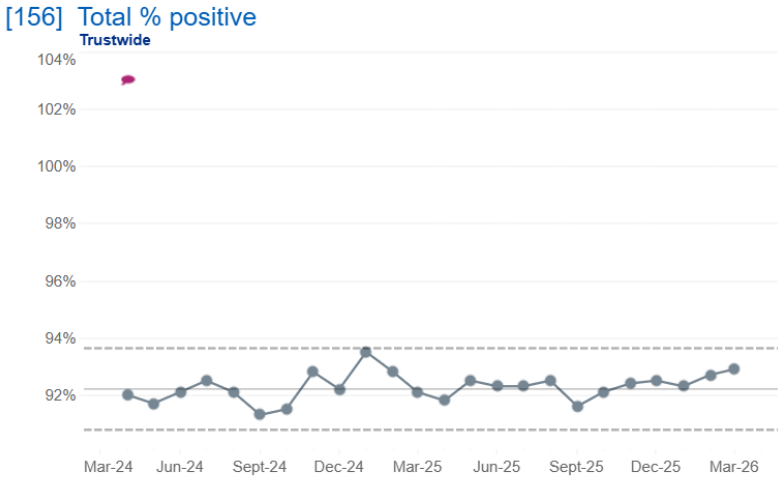
(Safety, experience and effectiveness)

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
Increasing, significant difference in score between our ED's (CGH and GRH) Slight decrease for day case and a significant difference between Delivery Suite and Maternity Ward.

Looking forward
Would expect overall position to remain fairly static into April while flow remains relatively challenged



Technical Analysis

The overall Friends and Family Test (FFT) score has remained relatively static albeit with a very slight increase at 92.9% in March and remains above average. Slight increases across both ED impacting 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. New divisional reports are now in circulation.

PALS

Highlights

Closure rate maintained above target (75%) at 86%. Position remains positive.

Areas of concern

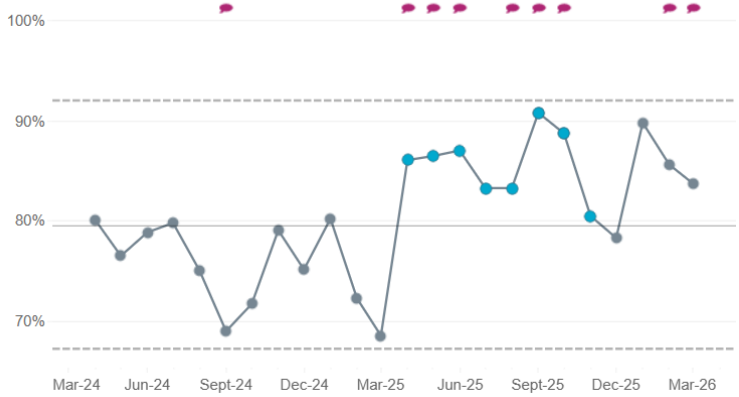
Volume of cases remains high. Long term sickness continues and compounded by annual leave, high case numbers and increased complexity.

Looking forward

Anticipate remaining in line with KPI with further adjustment to processes to support team wellbeing.

[569] % of PALS concerns closed in 5 days

Trustwide



Technical Analysis

The PALS team have closed 86% 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. Quality concerns relating to ongoing pressure has been added to risk register reference number 1128. Review underway of the concerns relating to reduced administration provision to support future decision making.

Patient Care: Mixed Sex Breaches

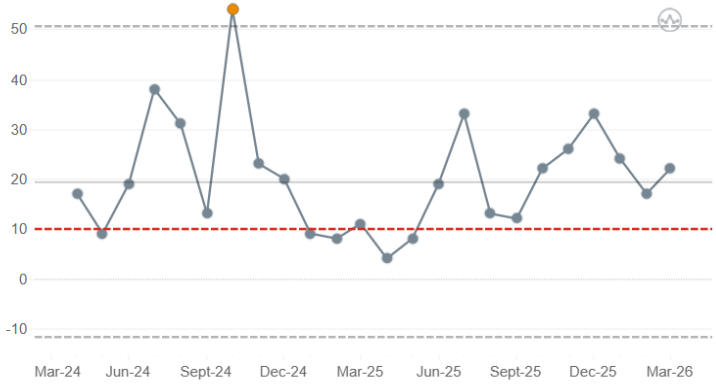
Highlights
Mixed sex accommodation breaches remain low and are an exception

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

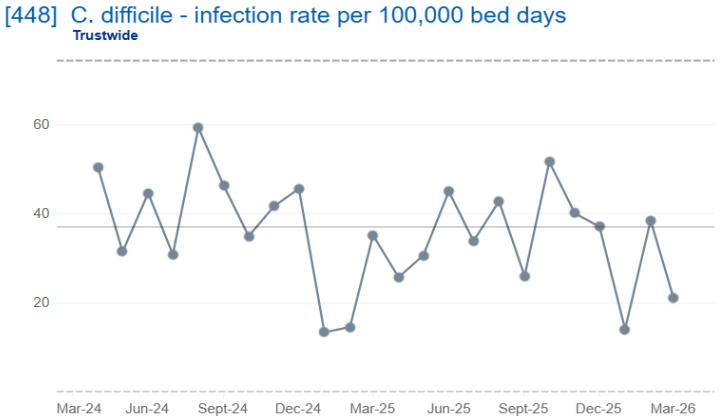
The annual CDI threshold for 2025-2026 has been set at 97; we have had 95 cases April 2025- March 2026; we have therefore finished the year below trajectory

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; this has been achieved. We are waiting for the 2026/27 thresholds



Technical Analysis

For 2025-26 we have had 95 trust apportioned cases of *C. difficile;* we finished the year below trajectory. Model hospital data benchmarking ICBs for rates of CDI per 100,000 age-sex weighted populations (12 months rolling to quarter ends) shows 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 and will be updated for 2026/27 during April 2026. 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 continue with IPC and estates and progressing the cleanliness improvement summit planned for 15/5/2026.

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.

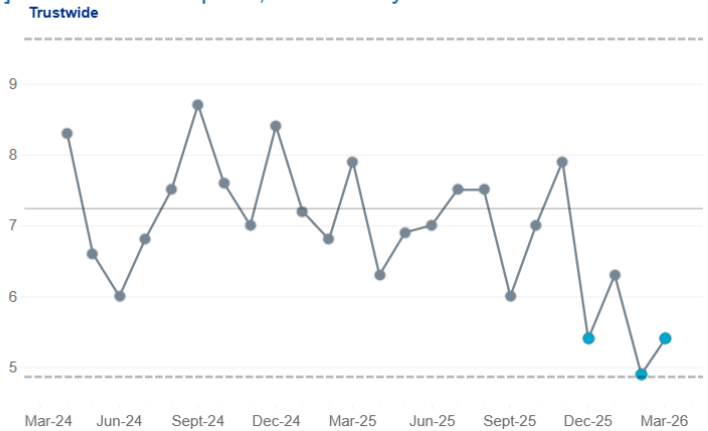
Areas of concern

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



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 – sporadic use, education to continue to nursing and medical staff

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

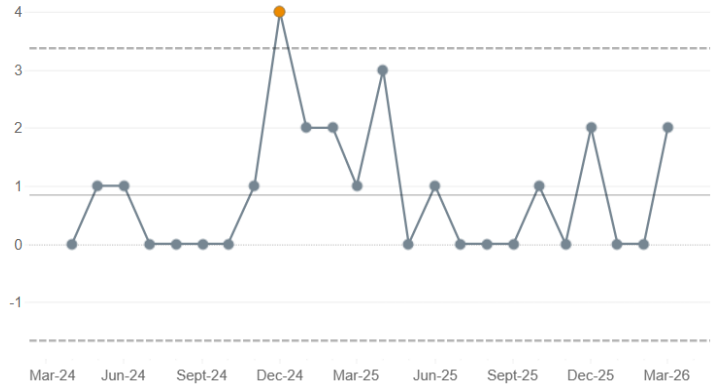
Numbers are low and we continue to learn from each case reported.

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

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.

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.

Mortality – SHMI National Data

Highlights

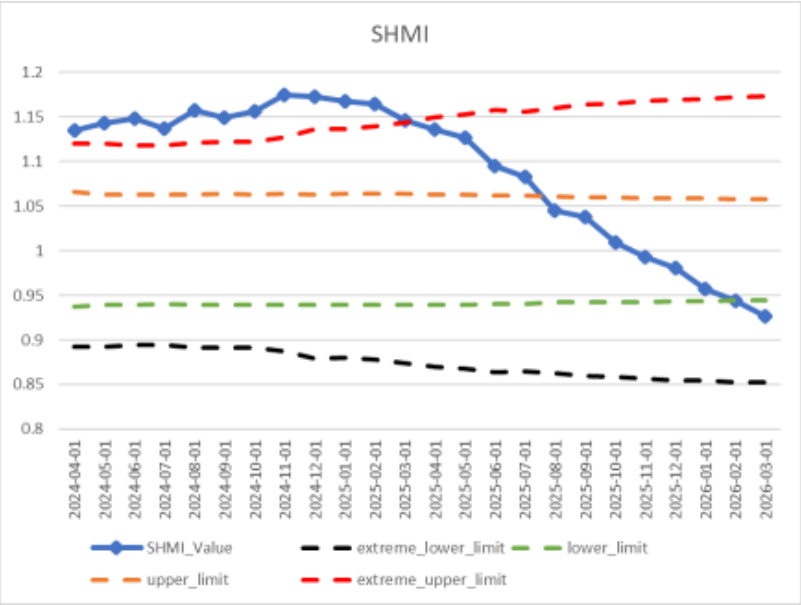
SHMI (NHS Digital) published 9/4/26 = 0.911 (data Dec 24- Nov 25)

Areas of concern

Ongoing monitoring of SHMI without remedial coding
Clinical audits guided by mortality alerts (BAU)

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

EPR changes completed Feb 26

New coding policy for Dementia to increase coding accuracy in place

PSIRF (Patient Safety Incident Response Framework) Learning Responses

Highlights

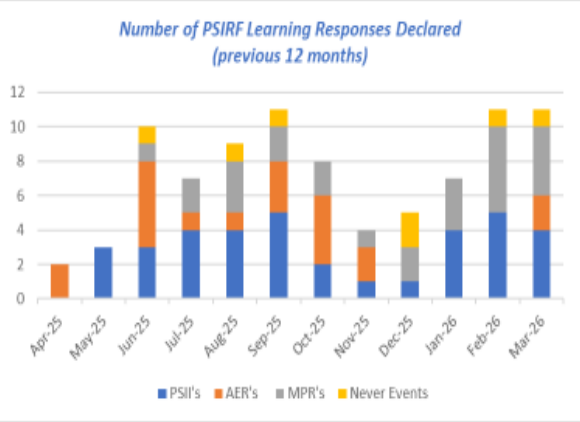
88 Patient Safety Incidents have required review through PSII, AER, or MPR in the last 12 months; an average of 7.3 per month.

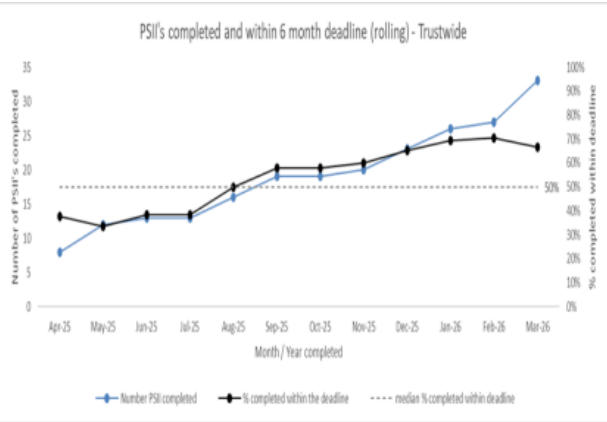
Areas of concern

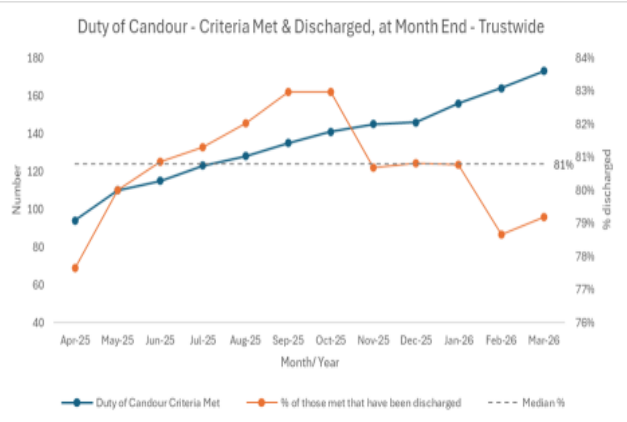
Timeframes within which learning responses are completed. Median on time for PSII's remained at 50%, for AER's remained at 63% and MPR's remained at 71%.

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: Thematic Analysis completed and shared with Trust Board. Learning Responses are prioritised and being completed within required timeframes

Complaint Performance 2025/2026 (March)

Highlights

Timeliness declined since Nov 2025, following sustained recovery earlier in the year. 26% in March 2026 (red), driven by capacity pressures rather than loss of focus. Executive oversight maintained throughout

Areas of concern

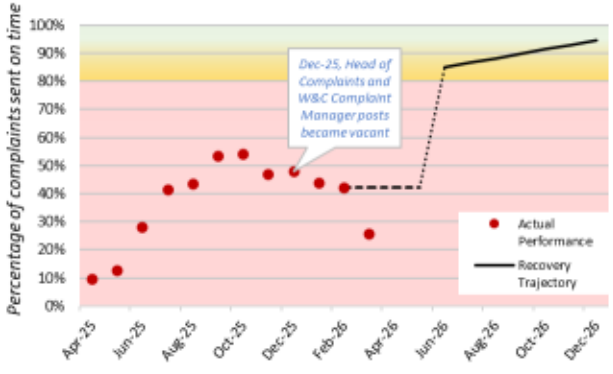
Workforce and leadership gaps: Head of Complaints vacancy. Complaint Manager losses (Dec 2025) Increased volumes in Q4 and paused Complaint Improvement Programme. Backlogs in drafting and Divisional sign-off, Oldest complaints (>6 months) remain a delivery risk

Looking forward:

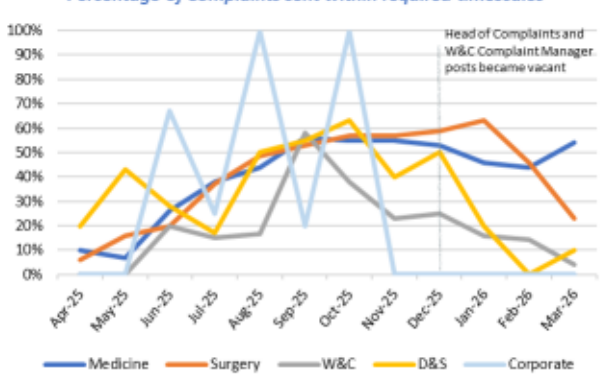
Performance expected to remain constrained short-term. Recovery dependent on: Workforce stabilisation (Head of Complaints / Complaint Manager) Targeted backlog clearance (oldest & highest risk) and Trust-wide adoption of New

Complaint Framework, including Early Resolution. Full implementation removes central drafting as rate-limiting step and supports return to 95% timeliness

Complaints Performance - IPR recovery Trajectory to 95%



Percentage of Complaints sent within required timescales



Number of complaints received and responses sent

Division	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Corporate						
Received	3		1	9	4	6
Closed/Sent	2	7	4			
Diagnostics and Specialties						
Received	10	3	8	7	5	5
Closed/Sent	12	6	6		7	3
Gloucestershire Managed Services						
Received	1				3	
Closed/Sent	3	2	2			
Medical						
Received	43	36	33	41	46	41
Closed/Sent	52	40	30	28	30	47
Surgical						
Received	47	36	31	55	43	56
Closed/Sent	41	44	35	43	35	42
Virtual Ward Hub						
Received		1				
Closed/Sent	3					1
Women's and Children's						
Received	28	27	19	20	22	20
Closed/Sent	22	19	15	12	7	10
Total Received	132	103	92	132	123	128
Total Closed/Sent	135	118	92	83	79	103

Technical Analysis and Planned Actions:

March position: 26%, below standard.
Mitigations in place: overtime, bank support (imminent), temporary Head of Complaints recruitment
Recovery actions: Stabilise workforce. Reinstate targeted backlog plan. Restart Complaint Improvement Programme
Progress monitored via executive oversight with monthly reporting

Risk Management Performance

Highlights

- High degree of compliance in relation to all live risks having identified controls and risk reduction actions
- D&S Division and GMS achieved compliance with timeliness of risk reviews. Corporate division was only 1% over the compliance threshold

Areas of concern

- Timeliness and effectiveness of risk reviews improved this month from 21% previously to 17%
- W&C remain at 39% not reviewed over consecutive months
- Overdue actions on risks are at 34 % and at 62% on incidents - remain an area of significant and persistent non-compliance

Looking forward

- RMG has called for divisional leaders to contact teams and individuals to identify any barrier to improving performance
- Risk that have met they target to be closed on the risk register and managed as BAU

- Overdue actions on risks

	No. overdue	Total open	% overdue	Change since last month
Corporate	40	147	27%	↑
Medical	63	124	51%	↓
Surgical	53	148	36%	↑
D&S	18	149	12%	↓
W&C	56	107	52%	↑
GMS	28	91`	31%	↑
Trust	258	766	34%	↔

- Overdue actions on incidents

	No. overdue	Total open	% overdue	Change since last month
Corporate	18	45	40%	↓
Medical	63	72	87%	↑
Surgical	50	68	73%	↑
D&S	22	46	43%	↑
W&C	168	242	70%	↑
GMS	9	9	100%	↔
Trust	330	482	62%	↑

Technical Analysis

- Risk exposure reduced this month by 4.2% with 38 risks closed
- The graph (left) shows the number of risks reported each month as overdue. The Trust remains in the amber RAG area for the KPI.
- The tables (centre and right) demonstrate performance against the actions KPI. Compliance is higher (76%) on risk actions, than on incident actions (37% compliant)

Actions

- RMG has called for divisional leaders to contact teams and key individuals to identify any barrier to improving performance
- Teams to review whether actions are smart and correctly assigned
- Actions overdue from 2024 to be resolved by divisions

Use of Resources Metrics

Financial Metrics

Highlights

Revenue is £4.9m favourable to planned breakeven position. Further detail is on the following slide. Agency spend is £2m higher than NHSE target (full year).Bank spend is £8m higher than NHSE target (full year). FSP is £7.3m adverse to plan. Capital spend is £1.1m lower than plan.

Areas of concern

The 25/26 position is supported by £5.9m year end GICB support. Without this, GHFT would be £5.8m deficit against breakeven plan.

Looking forward

Recurrent delivery of FSP continues to be the main area of concern. The recurrent shortfall in 25/26 is £9.8m which impacts the underlying deficit of the Trust as we exit the financial year.
The FSP challenge for 26/27 is £52.3m.

NHS England Oversight Metrics

Metric	Month 12 (Full Year) Plan	Actual	Var
Revenue (deficit)/surplus	0	4,993	4,993
Agency spend against NHSE target	-7,960	-10,469	-2,509
FSP	41,775	34,474	-7,301
Capital vs budget plan	55,638	54,507	-1,131
Nos days operating cash	5	20	15
BPP - nos invoices paid in 30 days	95%	97%	2%
Bank spend against NHSE target	-37,306	-45,968	-8,662

Risks

The Trust financial position as we move into 2026/27 is facing significant risks including:

- FSP delivery.
- Non delivery of the financial position and intervention by NHS England.

M12 Revenue Position

Internal Reporting

The Trust is reporting internally that we have delivered a £78k surplus at the end of March. Our plan was to breakeven so we have delivered better than plan.

We achieved this by managing our finances within the Trust and with some external support from Gloucestershire ICB. If we had not received this, we would be been £5.8m overspent.

External Reporting

NHS England has given GHFT an additional £4.9m funding as part of allocating out some of their unused funds. We aren't able to spend this funding but it does help us with our cash position. This means that we are reporting externally that we delivered a surplus of £4.9m.

Summary I&E Position (Trust only)	YTD Budget £000	YTD Actual £000	YTD Variance £000
(Surplus)/Deficit before yr end funding	**0**	**5,845**	**5,845**
Additional GICB funding	0	(5,923)	(5,923)
Adjusted (surplus)/deficit	**(0)**	**(78)**	**(78)**
Additional NHSE allocation (DSF)	(0)	(4,915)	(4,915)
Reported (surplus)/deficit	**(0)**	**(4,993)**	**(4,993)**

M12 Pay

Highlights

Pay is overspent by £2.1m after excluding £35m pension adjustment which is matched by notional income.
This includes £2.5m unfunded maternity cover and £0.7m year end annual leave accrual.

Areas of concern

Non delivery of recurrent FSP continues to be a significant pressure. The 25/26 gap is £2m but this includes £3m non-cash releasing savings. If these are excluded, the pressure is £5m.

Looking forward

On the face of it, all workforce groups except medical, are underspent if maternity cover is removed. However, there remains a £5m FSP pressure which has not been met. The approach to managing pay FSP in 26/27 needs to incorporate plans across workforce groups to improve delivery.

Summary Pay Position (Trust Only) Excl £35m pension	M12 YTD Plan £000s	M12 YTD Actuals £000s	M12 YTD Variance £000s
Infastructure	81,578	79,339	(2,239)
Medical & Dental	160,837	163,750	2,913
Nursing	200,052	198,492	(1,561)
Other Clinical Staff	76,350	73,440	(2,910)
Total (excl reserves)	**518,817**	**515,020**	**(3,797)**
Reserves (FSP & Other Staff)	**(1,112)**	**(84)**	**1,028**
Divisions (FSP target & vacancy factor)	(4,504)	376	4,881
Adjusted (Surplus)/Deficit	513,201	515,313	2,112

Summary Pay Variance Trust Only)	Corporate	D&S L4	Med L4	Reserves	Surg L4	W&C L4	Total
Infrastructure	(3,514)	303	254	398	187	133	(2,239)
Medical & Dental	61	895	1,578	441	(381)	319	2,913
Nursing	274	(165)	3,835	(3,757)	(484)	(1,263)	(1,561)
Other Clinical Staff	35	(2,522)	(254)	(65)	(137)	32	(2,910)
Other Staff Sub	70	1,110	1,856	1,028	879	966	5,909
YTD Variance	(3,074)	(380)	7,269	(1,954)	64	186	2,112

Technical Analysis (further info on following slides)

Nursing underspend of £1.56m of which £1.2m is unfunded maternity leave cover.
This position includes one off year end adjustments of £0.46m (benefits).
Medical staffing overspend of £2.9m of which £0.7m is unfunded maternity cover. It also includes £0.8m year end adjustment for annual leave accrual.

NHSE set 25/26 targets for bank spend to reduce by 15% (£7m) and agency to reduce by 40% (£5.4m). During the year, the Group has increased bank spend (£1m higher than 24/25) and reduced agency spend by 20% (£3m). This means that neither target has been met.

Planned Actions

A joint Finance and People & OD workshop will take place in April shape an emerging approach to workforce deployment and financial control.

M12 Nursing Pay

Highlights

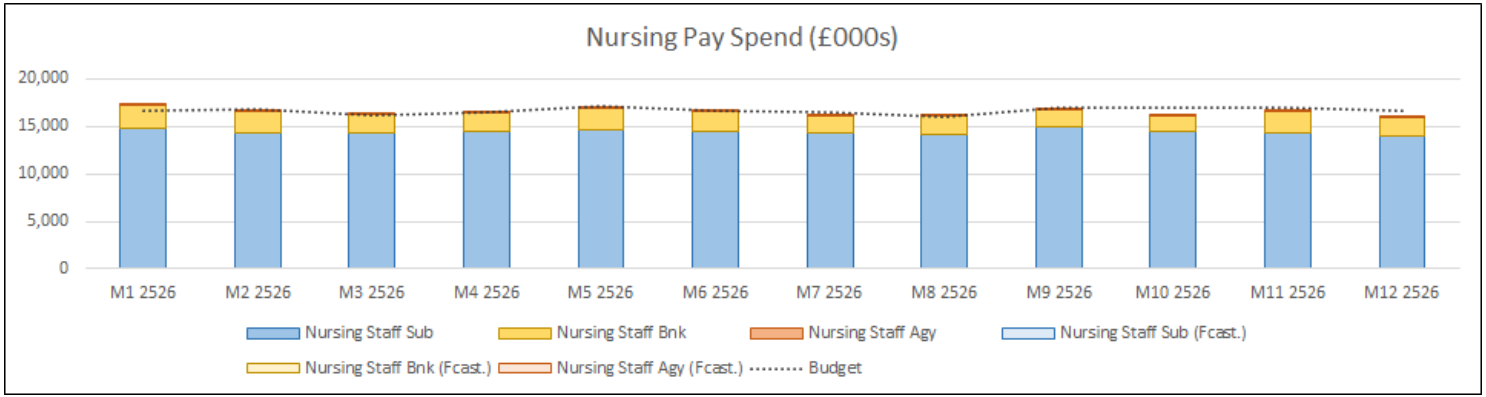
The Month 12 YTD nursing position is £1.56m underspent of which £1.2m is unfunded maternity leave cover.
This position includes one off year end adjustments of £0.46m (benefits).

Areas of concern

Agency has increased in M12 at £85k which is higher than the M1-M11 average of £70k per month. The increase is within Medicine.
Bank has reduced by £225k and is broadly in line with average run rate.

Looking forward

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.

M12 Medical Pay

Highlights

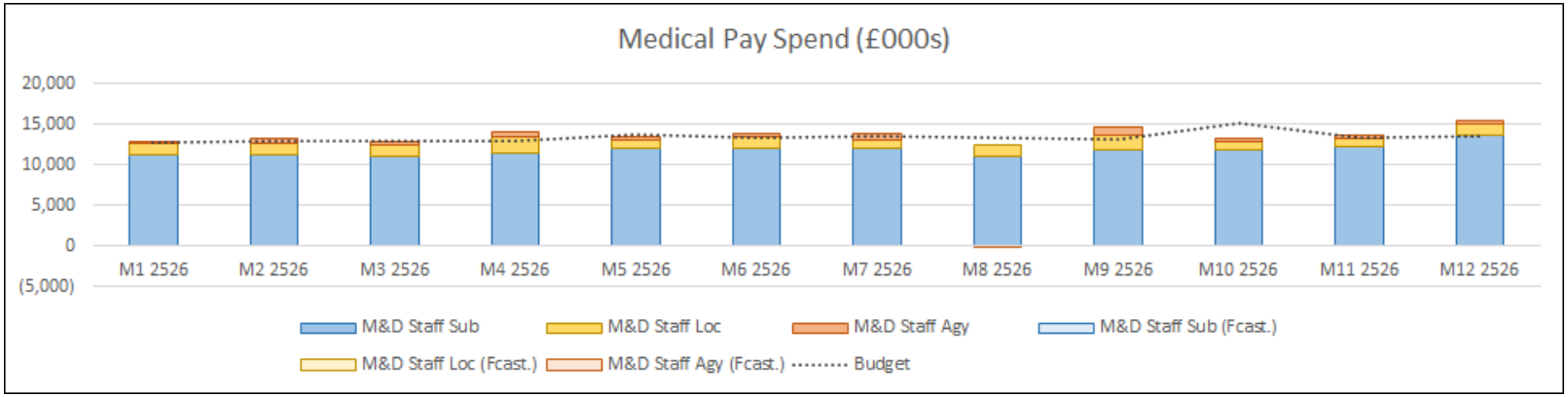
Medical staffing overspend of £2.9m of which £0.7m is unfunded maternity cover. It also includes £0.8m year end adjustment for annual leave accrual.

Areas of concern

Agency and locum have increased this month primarily due to year end accruals. This includes unscheduled care pilot sprint schemes and endoscopy service recovery.

Looking forward

Medical pay is £1.4m overspent after excluding maternity leave and annual leave accrual. Action is needed to reduce this run rate to avoid overspends in 26/27.



Technical Analysis & Actions

M8 position was particularly low spend due to annual leave accrual being released from the balance sheet.
M12 spend is high due to year end adjustments for annual leave accrual.
Medical Grip & Control meetings chaired by the Medical Director meet on a monthly basis. Divisions provide explanations and recovery plans for high earners, locum spend and WLI.

M12 Non Pay

Highlights

The non pay position is £37m overspent, reducing to £14m overspend after excluding passthrough drugs and IFRIC12 & donated assets.

Areas of concern

FSP gap of £7M 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 which will increase as we start 2026/27.

Non Pay	YTD Variance			
	Divisions	Corporate	Reserves/ Central	YTD Variance
YTD Variance	25,083	1,133	11,035	**37,251**
Drivers of variance				
IFRIC12 & donated assets		11,431		**11,431**
Pass through drugs and devices	11,719		253	**11,972**
System wide savings not being delivered			7,761	**7,761**
FSP gap	4,445		2,993	**7,438**
Clinical supplies in divisions	2,953			**2,953**
Release of 3% productivity reserve			-511	**-511**
Non Passthrough drugs	2,727	75	-78	**2,724**
Reserves slippage			-930	**-930**
Increase water legal case provision			400	**400**
Notional Apprentice Levy matched by income			1,321	**1,321**
Linen contract leakage - accrued benefit			-174	**-174**
SABA bad debt provision release		-3,500		**-3,500**
Interest Receivable & Payable + finance costs		-3,338		**-3,338**
Car parking (offset by income)		-3,410		**-3,410**
Other	3,239	-126		**3,113**
Total YTD Variance	25,083	1,133	11,035	**37,251**

Technical Analysis

Pass through drugs are driving a pressure, although partly offset by £6.4m 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 (£2.8m) and clinical supplies in divisions (£2.9m). The pressures have been mitigated by releasing balance sheet items and accelerating balance sheet releases but these are non recurrent.

Planned Actions

Medical Grip & Control meetings take place every fortnight to discuss drugs spend.

M12 Capital Position

Highlights

At the end of March (M12), the Trust had goods delivered, works done or services received totalling £54.5m including £26.4m in March. Planned spend for the year was £55.6m, equating to a variance of £1.1m behind plan. However, the overall CDEL position is only £59k less than allocation.

in £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Allocation	Forecast	Variance
DIGITAL	9,721	12,360	(2,639)	13,550	12,360	1,191
DIGITAL - IFRS16	101	1	100	101	1	100
MEDICAL EQUIPMENT	5,318	7,505	(2,187)	9,408	7,505	1,903
MED EQUIP - IFRS16	2,268	1,009	1,259	1,398	1,009	389
ESTATES	19,416	19,040	376	24,158	19,040	5,118
ESTATES - IFRS16	499	139	360	402	139	263
SLIPPAGE RESERVE	730	0	730	(8,909)	0	(8,909)
NBV OF ASSET DISPOSALS	0	(48)	48	(44)	(48)	5
Total Charge against Capital Allocation (incl. IFRS 16)	**38,053**	**40,005**	**(1,952)**	**40,064**	**40,005**	**59**
NAT PROG: CIR FUNDING	9,710	9,710	0	9,710	9,710	0
NAT PROG: CDC PATHWAY OPTIMISATION	0	42	(42)	42	42	0
NAT PROG: CONST STANDARDS FUNDING - DIAGNOSTIC	4,270	674	3,596	674	674	0
NAT PROG: DIGITAL DIAGNOSTICS	336	807	(471)	807	807	0
NAT PROG: CANCER FUNDING	2,916	2,916	0	2,916	2,916	0
IFRIC 12	533	533	0	533	533	0
DONATIONS VIA CHARITABLE FUNDS	1,274	248	1,026	248	248	0
Total Expenditure against Additional Funding	**19,039**	**14,930**	**4,109**	**14,930**	**14,930**	**1**
Gross Capital Spend Total	**57,092**	**54,935**	**2,157**	**54,994**	**54,935**	**60**
Less Donations and Grants Received	(1,274)	(248)	(1,026)	(248)	(248)	(0)
Less PFI Capital (IFRIC12)	(533)	(533)	0	(533)	(533)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	353	353	0	353	353	0
Total Capital Departmental Expenditure Limit (CDEL)	**55,638**	**54,508**	**1,131**	**54,567**	**54,507**	**59**

Technical Analysis

The Trust submitted a gross capital expenditure plan for the 25/26 financial year totalling £57.1m. During the course of the year, the Trust received additional System Capital of £2.0m (held at the System level), whilst there was a net £3.1m reduction in National Programme funds and a £1.0m deferral of agreed charity funding to 26/27. The resultant final gross capital allocation for the year was therefore £55.0m.

Spend on System Capital funded projects totalled £40.0m versus a final allocation of £40.1m, a variance of £0.1m behind the allocation.

Spend on additional funded projects totalled £14.9m in line with the allocation.

Planned Actions

An exercise is now required to review where slippage has occurred within the 25/26 programme to assess the impact on the 26/27 plan.

Whilst it is usual for the capital programme to be notably back ended, the spend achieved in the latter part of the year to deliver the 25/26 programme was significantly above the previous year, with £34.8m spent in February and March, 63% of the total £54.9m spend in year (compared to £20.7m in last two months of 24/25, 46% of the total spend in year).

Work has now started across programme areas to prepare business cases to commence delivery of the 26-27 Capital plan

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.

Workforce

Workforce Performance Indicators

Highlights

- Sickness absence has risen slightly
- Temporary staffing (agency and bank) has risen for two consecutive months for bank, and is higher for agency than it was in December

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
- Spending caps for temporary staffing have been set as part of the multiyear plan, entailing significant reductions each year

KPI (Trust)	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Turnover	11%	8.71%	8.54%	8.40%	8.34%	8.64%	8.13%	8.03%	8.73%	8.48%	8.47%	8.57%	7.88%
Vacancy	8%	7.30%	7.34%	7.48%	7.45%	7.99%	6.85%	6.87%	6.96%	7.29%	7.09%	7.37%	7.95%
Sickness	4%	4.37%	4.37%	4.62%	4.39%	4.39%	4.40%	4.41%	4.43%	4.47%	4.47%	4.54%	
Appraisal	90%	82%	82%	83%	84%	84%	84%	83%	82%	83%	82%	82%	84%
Essential Training	90%	90%	90%	90%	91%	91%	91%	90%	90%	91%	91%	91%	91%
Agency FTE	-	94.46	90.35	84.28	85.37	67.04	71.40	57.46	59.46	61.62	61.00	67.91	66.54
Agency % of Establishment	2%	1.05%	1.00%	0.93%	0.96%	0.75%	0.80%	0.64%	0.67%	0.69%	0.69%	0.77%	0.75%
Bank FTE	-	650.32	572.59	568.92	577.05	609.63	565.42	517.18	508.44	497.47	489.63	534.24	553.52
Bank % of Establishment	7%	7.24%	6.33%	6.29%	6.47%	6.83%	6.35%	5.80%	5.72%	5.60%	5.53%	6.03%	6.25%

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 slightly higher

Areas of concern

- Increase in absence rate driven by Add Prof., Add 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 trusts.
- 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	7462.16	4.3%	4.5%	0.2%		3.9%	4.3%	4.4%	4.4%	5.2%	25.3%	18.1%	15.5%	10.5%	4.6%
ESR Staff Group	Add Prof Scientific & Tech	232.52	2.9%	4.5%	1.6%		*	3.5%	4.3%	3.2%	*	34.4%	7.9%	15.1%	8.9%	3.8%
	Additional Clinical Services	1287.08	6.0%	6.7%	0.7%		5.8%	6.1%	6.0%	7.0%	5.7%	24.2%	22.4%	14.7%	12.9%	4.8%
	Administrative and Clerical	1562.40	4.3%	4.5%	0.2%		3.9%	4.6%	4.3%	5.3%	5.9%	28.1%	17.4%	14.3%	8.2%	3.5%
	Allied Health Professionals	465.31	3.2%	3.3%	0.1%		*	3.0%	*	4.1%	*	33.7%	14.2%	21.6%	10.1%	4.3%
	Estates and Ancilliary	32.33	5.6%	6.5%	0.8%		*	6.8%	*	*	*	38.3%	22.3%	7.9%	8.0%	2.3%
	Healthcare Scientists	263.21	2.7%	4.0%	1.2%		*	3.4%	3.9%	2.5%	*	23.4%	15.4%	19.8%	8.8%	4.7%
	Medical and Dental	1097.50	2.0%	2.0%	0.0%		1.0%	1.6%	2.4%	1.8%	1.8%	13.8%	9.2%	14.2%	6.4%	0.4%
	Nursing & Midwifery	2521.81	4.9%	4.8%	-0.1%		4.0%	5.4%	4.6%	4.4%	5.9%	24.7%	18.5%	16.0%	11.3%	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

- Monitoring of absence KPIs on Medical e-rostering is under development as part of the rollout.
- 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.

Workforce - Appraisal

Highlights

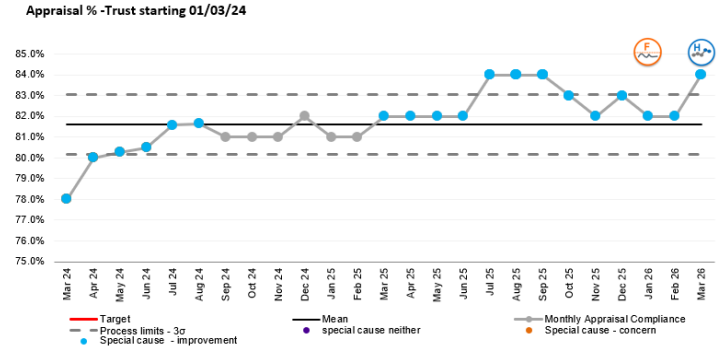
- A matrix has been developed to pair ESR and staff survey data to identify required interventions and bespoke support at service line level.
- Accountability and escalation framework developed and shared at TLT February 2026

Areas of Concern

- Where compliance is the primary focus, quality indicators for appraisal in Staff Survey show deterioration against our national position.

Looking forward

- ToR for internal audit of appraisals approved, field work scheduled.
- Appraisal outreach programme commenced April 2026



Staff Group / Date	31-Mar-26
Add Prof Scientific and Technic	89%
Additional Clinical Services	84%
Administrative and Clerical	77%
Allied Health Professionals	90%
Estates and Ancillary	82%
Healthcare Scientists	84%
Medical Staff - Consultants	90%
Medical Staff - SAS	86%
All Medical Staff	89%
Nursing and Midwifery Registered	84%
GHT Total	84%

Division / Date	31-Mar-26
Corporate Division	76%
Diagnostic & Specialty Division	87%
Medicine Division	83%
Non-Division	67%
Surgery Division	86%
Women & Children Division	82%
GHT Total	84%

Technical Analysis

Appraisal compliance is currently 84%, remaining below the trust target of 90%. Overall performance across most divisions and staff groups is stable, with some evidencing improvement including non-division (a workforce of 19 staff) which still are a divisional outlier but have improved from 39% to 67%, retaining a Red RAG rating.

Within each service there are specific cost codes which are lowering service averages and being approached in our Appraisal April Outreach

Planned Actions

- Bespoke support from the People Development team launched 'Appraisal April' Initiative.
- ESR self-service team commitment to develop more accessible and user-friendly guidance to support accurate recording
- Compliance reports are soon to be accessed by a named representatives in each cost code since reporting has moved to workforce reporting and so will be a key deliverable required of services in our engagement month.

Workforce - Bank

Highlights

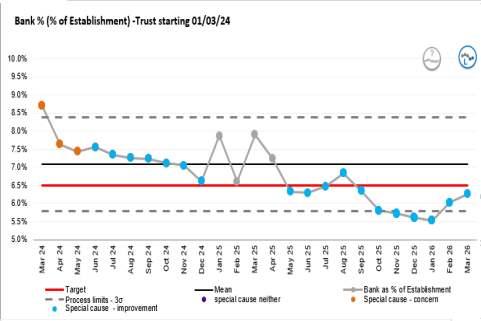
- The Trust target of 6.5% has been achieved in month 12.
- Increase of RN/HCSW (78 WTE) in M12 compared with M11.
- M12 is 15 WTE higher than M12 for 24/25.
- M12 has seen an increase of 12 WTE Locum use for medics

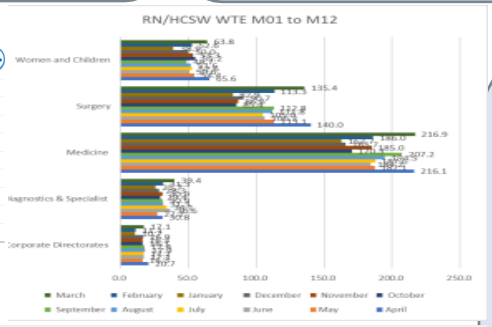
Areas of concern

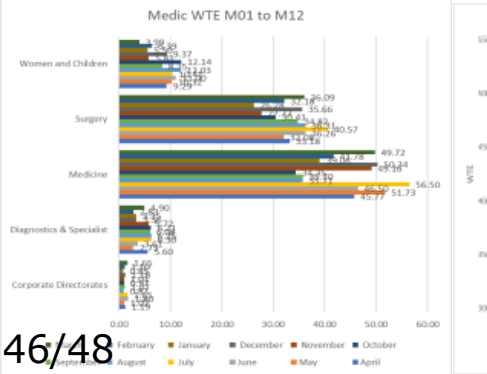
- Overall WTE and £ use of bank is not yet at the trust reduction target of 15% in M11 for the FY.
- M12 for RN/HCSW bank use is higher in 25/26 than 24/25

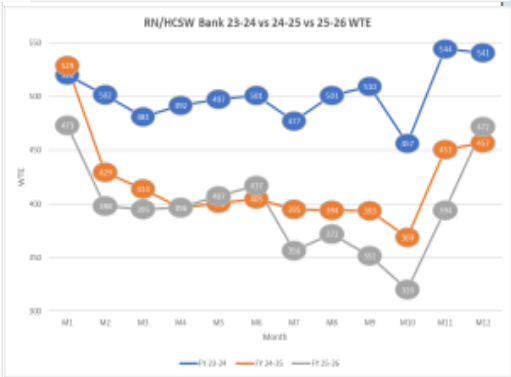
Looking forward

- As the trend for FY23-24, 24-25 and 25-26 WTE use is broadly similar, it is reasonable to assume that M1 FY26-27 will also see a similar WTE use.
- If future IA is taken, the trust can expect increases in Medic and RN/HCSW WTE as displayed in the data in this slide









Technical Analysis

- The trust has seen a increase in temporary RN/HCSW Staffing of 78 WTE (M12 394 to M11 472 WTE).
- This follows previous years M12 increase in temporary staffing use.
- In comparison with M12 of 24/25 FY, there has been an increase of 15 WTE RN/HCSW
- **Medicine** is the highest user of Bank & Locum staff.
- Top 3 users in M12 are ED, COTE and Acute. All 3 areas have increased temporary staffing use compared to M11
- **ED** (69 to 84 WTE), **COTE** (35 to 39 WTE) Acute (29 to 32 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

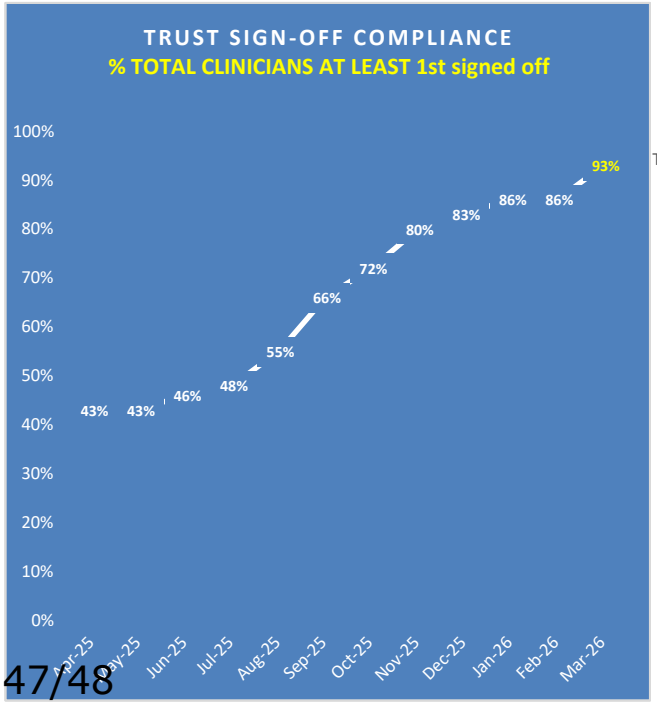
- Job Planning has this year been included in PWR reporting and is also an NHS England Improvement Programme
- The medical e.rostering work is providing a helpful lever as up to date job plans are required for e.rostering
- The October 2025 target of over 60% of job plans signed off by 1st October was met.
- The NHSE target of March 31st, 2026 (for the new financial year) was nearly met at 93% - just 2% shy of the expected 95% margin.

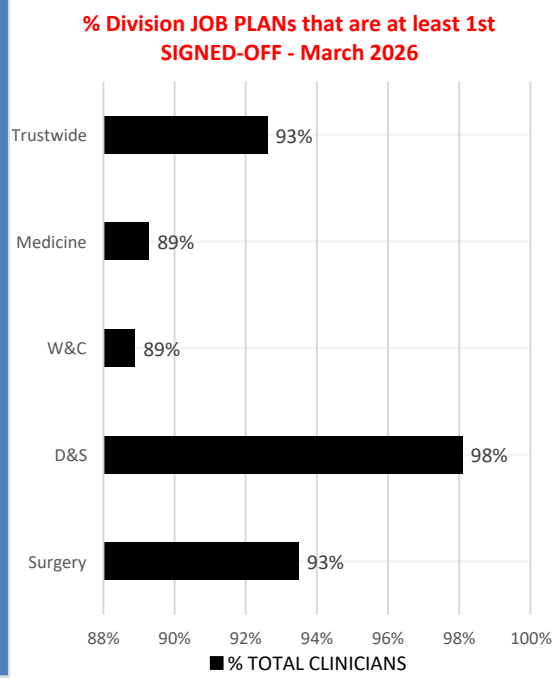
Areas of concern

- 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 reported job plans *now* being in-date (i.e. started within the last 12 months) and at least first signed off (by Clinical Lead CL or Speciality Director SD). Data here is for Trust-wide total of 582 Clinicians (i.e. 480 Consultants and 102 SAS doctors).

Looking forward

- NHS England target for Consultant and SAS job plans was for 95% of Trust job plans to be at least 1st signed off by March 31st, 2026. We managed to finish at 93%. Goal is to leverage on the efforts that got us this close as to hit subsequent milestones and targets in due time.
- 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 review (routine/annual/new change), the Allocate system records it as no longer signed off, even if an in date signed off job plan exists for that clinician. These then have to be manually sorted and sifted out so as to capture those job plans which would have been lost via an automatic report capturing off ALLOCATE.

Planned Actions

- Utilise the lever of e.rostering to improve job planning. This has helped to ensure 100% job plan sign offs in departments where e-rostering has been deployed e.g. Acute Medicine.
- Continue weekly reporting to support SDs and CLs
- The Job Planning department continues to support clinicians and leads with the process

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Thank you

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board of Directors

Date of Meeting	14 May 2026
Report title	Nursing Safer Staffing Report
Sponsoring Director Authors	**Matt Holdaway, Chief Nurse, and Director of Quality** Ana Gleghorn, Associate Chief Nurse for Workforce & Education Divisional Directors of Quality & Nursing Craig Bradley, Deputy Chief Nurse

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

Executive Summary

Executive Summary (AAA+A)
Alert – Where board attention is required

- Persistent, localised safer staffing risks in a small number of services, driven by nurse-to-patient ratios above safe expectations (in particular where ratios exceed 1:7), inconsistent senior (Band 6) nursing cover overnight, and registered nurse (RN) skill mix below national guidance.
- Headroom at 22% does not align with higher national expectations for some high-acuity areas (e.g., Emergency Department and paediatrics), reducing resilience during extraction, sickness, and operational pressure.

Assure – What the board can take assurance from

- A robust, evidence-based safer staffing review process is in place, aligned to Developing Workforce Safeguards (DWS), NICE and National Quality Board (NQB) principles, triangulating Safer Nursing Care Tool (SNCT) audit cycles with nurse-sensitive indicators, benchmarking, and professional judgement.
- Overall organisational performance remains strong against national comparators, with nursing cost per Weighted Activity Unit (WAU) in the lowest quartile and Care Hours per Patient Day above national medians, indicating good productivity and effective deployment at Trust level.

Applaud – What is working well

- Progress since 2022, including improved recruitment in key areas, reduced reliance on agency, and established supervisory Ward Sister/Charge Nurse model in most areas in line with NICE guidance.
- Flexible staffing approaches in some specialist areas (e.g., Lilleybrook) with no deterioration in nurse-sensitive safety metrics, supporting safe care while managing demand variation.

Advise – What action or focus is required

- Strengthen and standardise 24/7 Band 6 senior nurse cover (particularly across surgical wards/departments, theatres/recovery, and services with recurring night-time risk).
- Re-align funded establishments to demand where there is sustained variance, including optimisation of nurse-to-patient ratios in identified older adult and surgical wards, using wards with consistently high Care Hours per Patient Day (CHpPD) above demand as sources for rebalancing.
- Address headroom requirements for high-acuity areas (including paediatrics and ED) and confirm a plan for education/practice development capacity (particularly in Children's/HDU/oncology competence) to sustain the current improvements.
- Improve recording and closure of red-flag actions in HealthRoster to evidence mitigation and strengthen assurance (noting the current level of open red flags).

Previously considered by	Quality Performance Committee, April 2026

Recommendations:

The Trust Board are asked to:

- NOTE the recommendations in the report, especially the following:
  - request Medicine divisional leadership team to optimise nurse-to-patient ratios in older adult wards by re-aligning establishment from wards with consistent Care Hours per Patient Day (CHpPD) above the demand.
  - to request Surgery divisional leadership team, re-align establishments in surgical wards where there has been consistent Care Hours per Patient Day (CHpPD) above the demand.
  - To pause recruitment in the areas identified as having higher Care Hours per Patient Day (CHpPD) than demand whilst plans to develop.
- NOTE the positive progress on nurse staffing since 2022.
- NOTE a commitment to align nursing establishments to demand.

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

Quality, safety and delivery	✓
Digital first	

Impact on any Strategic Risks?

The review identifies localised but persistent patient safety risks arising from nurse-to-patient ratios above recommended levels, inconsistent senior nursing cover overnight, and registered nurse skill mix below national guidance in a small number of services.

Current headroom levels do not fully align with national expectations for high-acuity areas, reducing workforce resilience during times of staff extraction and periods of pressure.

If not mitigated, these risks could impact patient safety, staff wellbeing, and the Trust's ability to sustain safe staffing in line with national standards.

Implications on:	
Equality, Diversity and Inclusion	This report supports equitable access to safe staffing and nursing care for all patients and seeks to ensure staff are deployed fairly and sustainably across services.
Health Inequalities	Safe and effective nurse staffing contributes to reducing health inequalities by supporting timely, consistent and high-quality care for patients with the greatest needs.
Finance and Resource	The report highlights the need to balance patient safety with efficient use of resources and demonstrates improved value through reduced temporary staffing spend over time. The report highlights areas for re-alignment of establishment.
Regulation/Legal	The report supports the Trust's responsibilities to provide safe care and workforce oversight in line with national safer staffing guidance and Board assurance requirements.
CQC-Key line of enquiry	This report provides evidence of how the Trust assesses, triangulates, and responds to nurse staffing risks, supporting the Safe and Well-Led domains.
Green Plan	There are no direct Green Plan implications arising from this report.

Main Report

Purpose of the paper

This paper provides the Trust Board with assurance on nursing staffing levels at Gloucestershire Hospitals NHS Foundation Trust and compliance with Developing Workforce Safeguards (NHSI,

2018), National Quality Board standards and NICE guidance (2014). It summarises the review methodology, key findings and actions required to ensure safe, sustainable nursing care across inpatient wards and assessment areas. Temporary staffing efficiency, spend and utilisation are out of scope.

This paper provides an account of the process used to review staffing levels, the findings of the review and outlines the actions required by the Trust to ensure the right level of nursing care is provided to our inpatient's wards and assessment areas.

The report does not include a review of temporary staffing efficiency, spend or utilisation.

Safe Staffing principles

Safe staffing reviews (NHSI, 2018) should be evidence-based, using tools and data triangulated with outcomes and professional judgement. The Trust uses the Safe Nursing Care Tool (SNCT) in line with NICE guidance: a 30-day audit assesses patient acuity and dependency, translating this into a recommended establishment including headroom. Findings are interpreted over at least three audit cycles and triangulated with nurse-sensitive indicators and local context (including ward layout), noting SNCT is designed around minimum safe care levels and should not be used to justify reducing establishments.

The Safe Nursing Care Tool (SNCT) is an evidence-based method used to establish appropriate nursing staff levels, as stipulated by NICE guidelines. The process involves conducting a 30-day audit, during which patient acuity and dependency are assessed based on the preceding 24 hours.

These assessments are then translated into a recommended ward establishment, which takes headroom into account.

Consistent with National Quality Board (NQB) standards, the SNCT approach triangulates patient acuity and dependency data with nurse-sensitive indicators and professional judgement. To ensure accuracy and reliability, interpretation of the data should be conducted over a minimum of three audit cycles.

The tool does not consider ward geography and how bays and side room layout affect ratios, patient visibility and managing safety.

SNCT designed around minimum safe care levels and national guidance warns against using the tool to justify reducing establishments.

<u>Registered Nurse to patient ratio</u>
NICE (2014) originally described a minimum RN-to-patient ratio of 1:8 for adult inpatient wards. With increased acuity and dependency, 1:8 is now regarded as the absolute minimum, and ratios above this are associated with increased harm risk; a working expectation of 1:7 is therefore considered more appropriate for safe care in current conditions.

Given these changes in patient needs, the previously recommended 1:8 ratio is now considered to be the absolute minimum required to maintain patient safety. Extending this ratio, meaning increasing the number of patients assigned to a single registered nurse beyond eight has been associated with a greater risk of patient harm. Considering these developments, a revised ratio of one registered nurse to every seven patients (1:7) is now deemed appropriate. This adjustment is intended to ensure staffing levels remain within safe limits and patients continue to receive the quality of care they require.

Establishment composition
RCN (2021) recommends a 65% registered / 35% unregistered skill mix (some Trusts apply 70/30). This review indicates most wards are not achieving 65/35, with an average skill mix closer to 55/45.

Supervisory Senior Sister/Charge Nurse
NICE (2014) states the ward Senior Sister/Charge Nurse should be supervisory; this model is established within the Trust.

Headroom
Headroom is the uplift applied to establishments to cover absences and maintain safe care. The Trust applies 22% (annual leave 14%, sickness 4%, study leave 4%), which is comparable with several organisations, including the Shelford Group. Evidence suggests 22% may be insufficient for some high-acuity areas: for example, Emergency Department guidance recommends 27% and paediatrics 25% to reflect training and education needs. The Trust is not currently compliant with these higher headroom expectations.

This headroom percentage aligns with practices at several other organisations as well as the Shelford Group. However, there is increasing evidence indicating a 22% headroom may not be sufficient to fully meet the needs of staffing and ensure continuous high-quality patient care.

Certain specialties require higher headroom allocations to account for the unique demands placed on their staff. For example, guidance for the Emergency Department recommends a headroom of 27%, while for paediatrics, a headroom of 25% is advised. These increased percentages reflect the considerable levels of training and education necessary in these areas, ensuring staff possess the appropriate knowledge and skills to provide safe and effective care.

The higher headroom allowances are intended to cover the additional time required for ongoing professional development, which goes beyond what is typically included in the standard 22% headroom allocation. The Trust is not currently compliant with this.

Areas excluded from the review:

- Outpatient settings
- Day Case settings.

National Benchmarking
Weighted Activity Unit (WAU) and Care Hours per Patient Day (CHpPD) remain the primary external benchmarking measures in the NHS Model Health System. While there is data lag and limitations, these metrics provide useful context when triangulated with other intelligence and professional judgement.

There is a lag in the Model Health system and the data not always directly comparable with other Trusts so whilst helpful, this data should be triangulated against other sources, intelligence, and professional judgment.

Weighted Activity Unit (WAU)
WAU is a productivity measure comparing cost to output; lower cost per WAU indicates greater efficiency but does not directly reflect care quality. The Trust's nursing cost per WAU is in quartile 1 (about £850), improved from quartile 2 in March 2025 (about £865), and compares favourably with peer and regional medians.

WAU is a measure of efficiency; more productive Trusts will have a lower cost per WAU and

less productive Trusts will have a higher cost per WAU. The WAU metric does not directly correlate to the quality of care.

The cost per WAU detailed below (chart 1) shows the Trust in quartile 1 with a nursing staff cost per WAU of £850, which is significantly lower than regional peer median of £979 and higher than best Decile of £808. In March 2025 the trust was in quartile 2 with a cost per WAU of £865 indicating an improved position in the last 12 months.

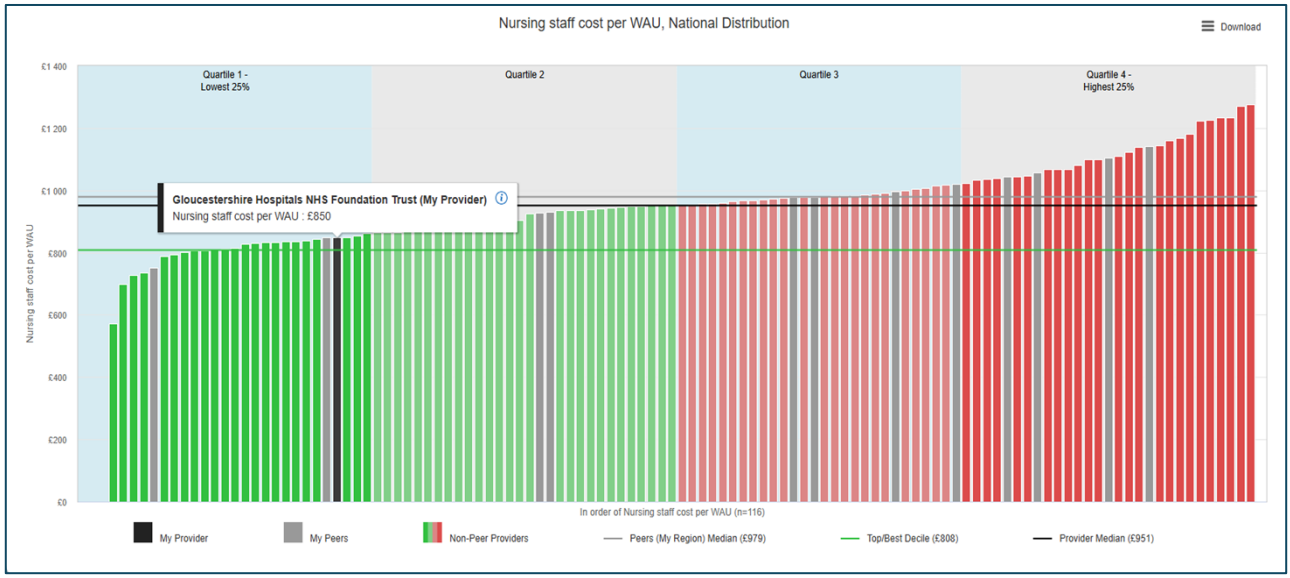


Chart 1: Nursing staff costs per WAU.

Care Hours per Patient Day (CHpPD)

CHpPD reflects actual daily nursing and midwifery care hours relative to patient bed days; very low values may indicate patient safety risk, while very high values may suggest inefficient rostering. In November 2025, the Trust remained above the provider and national medians (about 9.9 vs peers 9.0 and national median 8.7).

CHpPD provided in the Model Health System as a standardised model for Trusts to benchmark and is calculated by taking the total care hours worked by Nursing and Midwifery staff divided by the total patient bed days. Very low rates indicate a potential risk to patient safety with very high rates being suggestive of inefficient rostering.

The information presented below relates to November 2025 (chart 2), detailing the Trust remains in the upper third quartile and above the provider median. The Trust CHpPD is at 9.9, peers at 9.0 and national median at 8.7.

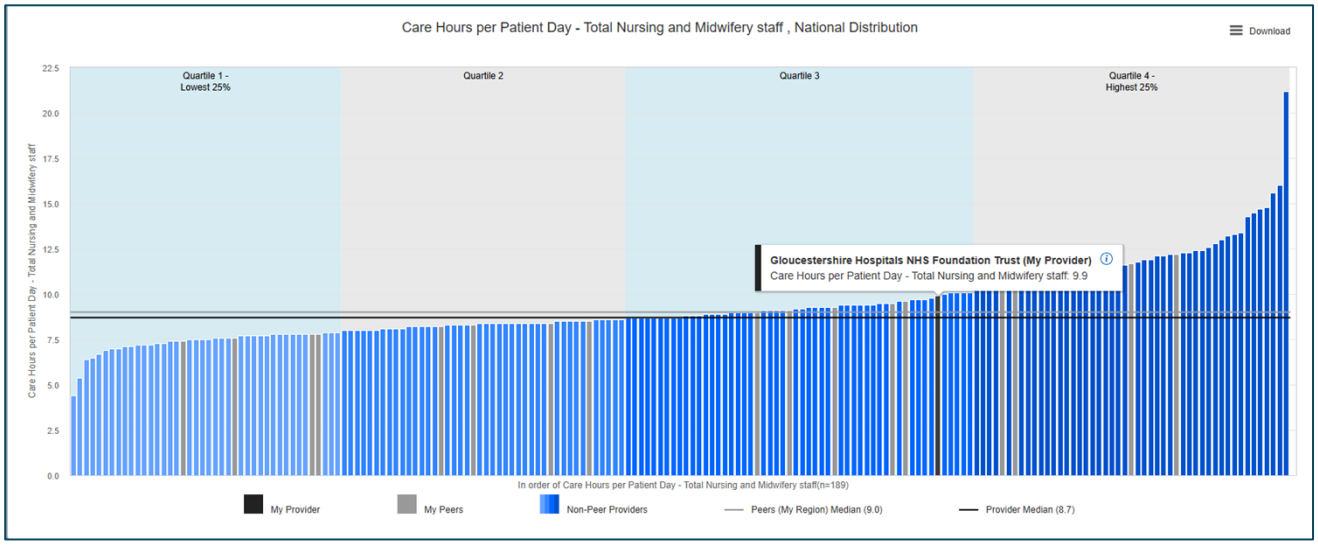


Chart 2: CHPPD benchmark at a national level.

Safer Staffing Triangulation

Departmental risk assessments align to Developing Workforce Safeguards (DWS) (2018) and use triangulation of safe staffing principles, nurse-sensitive indicators and professional judgement. Consistent with DWS, the Trust considers harm data alongside nursing fill rates, skill mix, and use of temporary staffing; this report places particular emphasis on nurse-to-patient ratios and harm, given the strength of evidence linking these to patient outcomes.

This analysis has considered the DWS (2018) requirements, placing particular emphasis on nurse-to-patient ratio and level of harm due to strong evidence linking these factors. Healthcare-related harm is a serious patient safety issue, as it is associated with increased morbidity, longer hospital stays, preventable deaths, and significant financial costs to the NHS.

Although the significance of skill mix is acknowledged, the shift towards a lower skill mix is primarily influenced by the need to support patients, with particular focus on minimising falls due to ward configurations that limit visibility. This is demonstrated by the fact many of the wards comply with the nurse-to-patient ratio principle.

The data for each division is presented in separate tables with a corresponding narrative which surfaces the areas to monitor and those presenting as a concern.

SNCT variance is the difference between the recommended establishment (based on acuity/dependency) and the staffing funded. Negative variance suggests staffing below requirement; positive variance suggests staffing above. Variance must be interpreted alongside harm data, nurse-to-patient ratios, ward layout and professional judgement. Divisional tables and narratives summarise areas to monitor and areas of concern, with supporting detail in the appendices.
A negative SNCT variance indicates staffing levels are below those required to safely meet patient acuity and dependency, while a positive variance indicates staffing above the SNCT requirement. Variance must be interpreted alongside harm data, nurse to patient ratios, ward layout, and professional judgement.

Further information and detail relating to hospital acquired harm can be seen in the appendices.

Medical Division

Within the Medical division, the areas requiring monitoring includes Hatherley, FAU, Respiratory, and Woodmancote. Whereas those areas identified as presenting concerns are Gallery Ward 1, Gallery Ward 2, Guiting, Ryeworth, Ward 7A, and Ward 7B.

The table below details the full assessment of the Medical Division

	SNCT Variance %	Occupancy	Avr RN Fill Rate	Harm Hot spots	Skill Mix	RN:Patient Ratio - D	RN:Patient Ratio - N	Overall Risk
Hatherley	32%	78%	89%	0	80:20	3.0	3.0	
Cardiology	-23%	111%	106%	0	82:18	4.5	5.0	
FAU	-5%	112%	94%	1	66:44	4.8	4.8	
Gallery 1	5%	100%	96%	0	54:46	8.0	8.0	
Gallery 2	-28%	100%	98%	0	54:46	6.0	8.0	
Guiting	-7%	97%	98%	1	56:44	6.0	7.5	
Knightsbridge	-12%	100%	100%	2	64:36	4.0	5.3	
Ryeworth	-15%	97%	98%	0	56:44	5.3	8.0	
Ward 6a	10%	99%	99%	1	53:47	4.6	5.8	
Ward 7a	4%	99%	100%	1	59:41	5.0	7.5	
Ward 7b	-6%	95%	110%	2	63:47	4.6	7.7	
8th Floor	27%	98%	92%	0	62:38	4.3	4.3	
Ward 9b	12%	99%	93%	1	64:36	5.6	5.6	
Woodmancote	-6%	99%	99%	0	56:44	5.3	6.4	

Table 1: Triangulation Data for the Medical Division

Hatherley

Hatherley has completed its first full year in its current location and bed base, including the hyperacute stroke unit. Staffing is aligned to national stroke guidelines, but variable stroke demand remains challenging. Occupancy should be monitored over the next six months to inform future modelling. The Medicine Division are committed to reviewing the establishment to ensure it is matching demand. Recruitment is currently paused and the daily staffing template is operating at a reduced level.

Frailty Assessment Unit (FAU)

FAU has occasionally used Same Day Emergency Care (SDEC) beds overnight for an additional two to three patients during periods of pressure, without requesting extra staffing. This is not intended as routine practice, given the impact on next-day SDEC capacity. Planned SDEC expansion may improve flow and reduce length of stay. Occupancy and harm data should continue to be monitored, with any increase in avoidable harm prompting review.

Knightsbridge Ward

Although SNCT suggests possible investment when considered alongside harm data, current skill mix and nurse-to-patient ratios indicate the workforce is presently sufficient. Closure of the escalation bed is expected to reduce pressure. Harm data should continue to be monitored.

Respiratory Ward

Staffing is based on British Thoracic Society guidance for high dependency and non-invasive ventilation care. Daily staffing is adjusted to acuity and cannot safely rely on temporary staffing. Planned changes to the tracheostomy pathway may affect the current model. The Medicine Division are committed to reviewing the establishment to ensure it is matching demand. Recruitment is currently paused and the daily staffing template is operating at a reduced level.

Woodmancote Ward
Audit cycles have shown significant variation in establishment recommendations. While some findings suggest workforce growth, current harm data and nurse-to-patient ratios support ongoing monitoring rather than immediate action. Increased length of stay, linked to reduced community stroke rehabilitation capacity, is affecting flow and case mix.

Ryeworth Ward
Ryeworth has increasingly received stroke step-down patients from Woodmancote, changing its patient profile. A growing gap between establishment and requirement, alongside one of the highest night nurse-to-patient ratios in the division, requires close monitoring of outcomes and patient experience in the first quarter of 2026.

Cardiology Wards (1 and 2)
Cardiology has expanded from 45 to 51 beds, with escalation beds and increased procedure room use, without a staffing increase. Staffing incidents have risen. The model should therefore be sufficient if escalation beds are not used in the winter.

Gallery Ward 1
Gallery Ward 1 continues to indicate a need for investment. Nurse-to-patient ratios remain above 1:7 by day and night, increasing risk of harm, although enhanced care support may be helping.

Gallery Ward 2
Gallery Ward 2 has a similar profile, with night staffing remaining a recognised risk. Further review is needed to understand the widening gap between establishment and requirement, and any variation in practice.

Guiting Ward
Guiting continues to indicate investment need, although this has reduced following closure of three escalation beds. The ward layout increases risk, so staffing and harm should continue to be monitored closely.

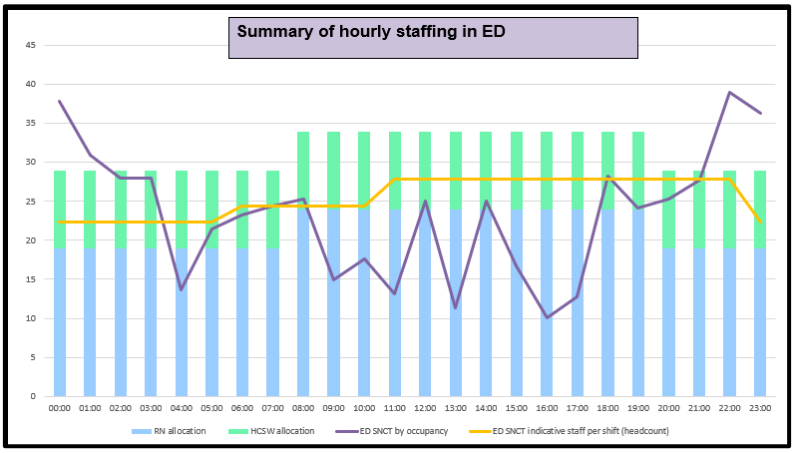
Ward 7A and Ward 7B
Both wards remain areas of concern in relation to staffing ratios and harm data. Improvement in staffing ratios is expected to reduce risk.

Ward 9b
Following reconfiguration in December 2025, Ward 9b now cares solely for general medical patients. The staffing model has been adjusted, but a further SNCT review is needed before establishment is finalised.

Emergency Department

Gloucester only: Patient numbers remained stable across both the 12-day audit and annual attendance period. Most patients were walk-ins, acutely unwell and at risk of deterioration, or stable patients requiring psychological support or assistance with essential needs.

The graph below shows RN (blue) and Healthcare Support Worker (HCSW) (green) staffing by hour, with the purple line showing patient numbers against average and the orange line showing recommended hourly staffing based on 12 days of acuity data.



Graph 1: Hourly Summary of the Emergency Department Staffing - GRH

Following the March 2025 audit and Emergency Care Intensive Support Team ECIST recommendations, the staffing deployment model was comprehensively revised and implemented in September 2025. The intention was to better align nursing and HCSW deployment to patient need and acuity, improve skill mix, support patient safety, and care quality, and respond more effectively to fluctuations in demand.

Despite these changes, the most recent audit shows ongoing congestion between 22:00 and 01:00, suggesting further refinement of staffing and operational arrangements is required. Additional enhancements are planned and, by early summer, all remaining nursing posts are expected to have been advertised and filled through internal and external recruitment. This should reduce reliance on temporary staffing as the department becomes fully established.

The initial SNCT review for Cheltenham Emergency Department remains in progress and is therefore not included in this report.

A further review will be undertaken following the next SNCT audit in summer, using updated data from both Gloucester and Cheltenham. This will inform any further changes to the staffing model and support safe, efficient care across both departments.

Surgical Division

Continuous monitoring is required in all surgical departments, which is primarily driven by the nurse-to-patient ratios observed throughout these departments and the lack of senior nurse cover 24/7. Most wards, excluding Ward 2b, maintain a nurse-to-patient ratio of 1:7 or higher during night shifts. These ratios pose a risk to patient safety and therefore require careful and consistent monitoring.

Surgical Assessment Unit (SAU)

SAU relocated to Ward 5B at Gloucestershire Royal Hospital in December 2023, having originally opened in 2018 with 10 chairs before expanding in response to rising demand. The move significantly increased capacity to 18 trolleys, 3 assessment rooms and 30 chairs, improving the patient environment and supporting assessment and treatment flow. Investment in the nursing workforce, including an Advanced Nurse Practitioner role, supported this expansion.

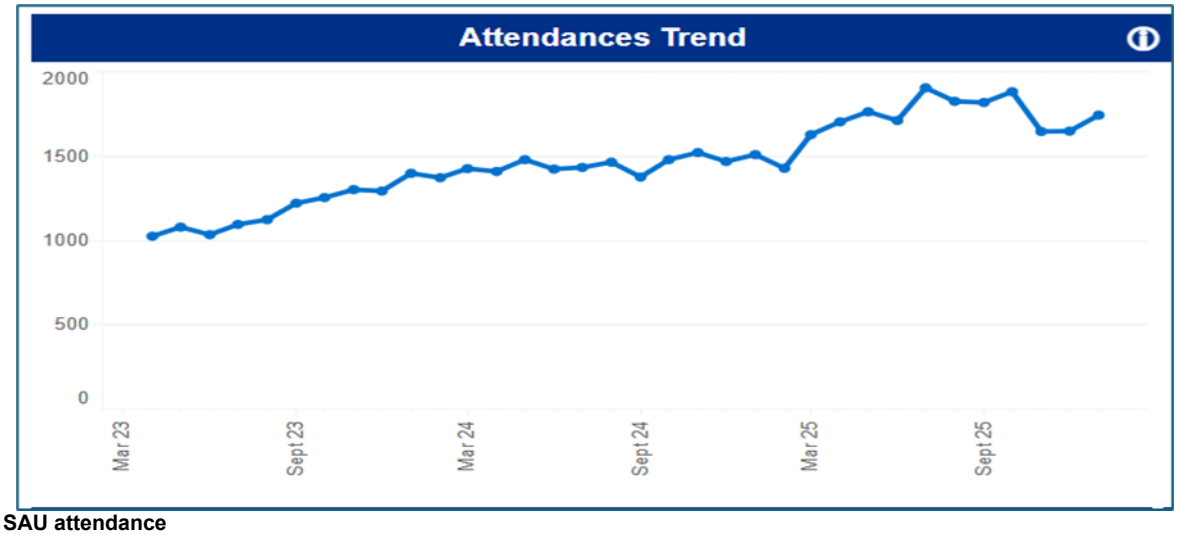


Chart 3: SAU attendance

Over the past two years, attendances have increased by 46.6%, with activity rising from a peak of 1,298 in November 2023 to 1,903 in July 2025. SNCT data has consistently shown a shortfall in assessment area nursing staffing. However, further service transformation opportunities should be explored to reduce pathway demand and overall time in the service before concluding that workforce investment alone is required. The increasing deficit across the last four audits should be considered as part of wider workforce and service redesign.

3rd Floor Trauma and Orthopaedics
In July 2025, registered nurse staffing on Wards 3A and 3B increased by one RN per shift, 24 hours a day, following divisional review of SNCT data showing a sustained deficit. Ward 3A, which cares predominantly for patients with neck of femur fractures, was also showing deterioration in key quality indicators, particularly falls and pressure ulcers. Further audits are required to assess whether the deficit remains following this investment.

Bibury – Elective Orthopaedics
In December 2025, Snowshill and Bibury Wards were reconfigured to improve patient experience, patient flow, and bed utilisation. Snowshill became a day surgery unit, while Bibury now functions as a 22-bed inpatient ward. Staffing models were revised accordingly, including a planned reduction in registered nurse posts. As this model is newly implemented, it is too early to draw conclusions from SNCT data.

Ward 4b
Ward 4B has been reconfigured as a joint medical and surgical ward, with staffing increased to reflect greater acuity and operational complexity. This is the first audit since reconfiguration, and it is too early to draw firm conclusions. Although current data suggests staffing is slightly above requirement, further audit cycles are needed. Quality metrics remain under close review, with early indications of reduced falls.

Senior Cover on Inpatient Wards and Departments Out of Hours
There remains inconsistency in 24/7 Band 6 senior nurse cover across the organisation. Most surgical wards and departments do not have this level of support, unlike medical inpatient areas. Addressing this remains an important objective.

Department of Critical Care
Critical Care is not included in SNCT benchmarking. Given increasing acuity and demand, the workforce plan should be reviewed alongside divisional risks, future layout changes, revenue implications, and GPICS standards.

Theatres

There is an urgent need to review theatre recovery staffing, particularly within obstetric recovery, where concerns remain regarding skill mix, capacity, and inconsistent senior support. Recovery provision at both GRH and CGH requires evaluation, as demand is rising and out-of-hours recovery continues to rely heavily on Band 5 staff.

Tivoli

The establishment on Tivoli is currently being reviewed by the Division, there is an opportunity to reduce the bed base at weekends and align the establishment accordingly. Recruitment is currently paused whilst these plans are prepared.

	SNCT Variance %	Occupancy	Avr RN Fill Rate	Harm Hot spots	Skill Mix	RN:Patient Ratio - D	RN:Patient Ratio - N	Overall Risk
Bibury	17%	66%	90%	0	67:33	5.8	7.9	
Tivoli	25%	96%	99%	0	58:42	5.3	7.0	
Ward 2a / Annexe	10%	93%	99%	0	51:49	7.3	7.3	
Ward 2b	12%	101%	74%	0	58:42	5.5	5.5	
Ward 3a	-6%	97%	100%	0	55:45	6.0	7.5	
Ward 3b	-12%	100%	99%	0	58:42	5.0	7.3	
Ward 4a	9%	102%	95%	1	57:43	5.8	7.3	
Ward 4b	7%		114%	0	57:43	5.2	7.3	
Ward 5a	6%	102%	99%	0	57:43	5.8	7.3	
5b/SAU	-26%	120%	96%	0	67:33	6.8	10.3	

Table 2: Triangulation Data for the Surgical Division

Diagnostic and Specialist Services

This section provides an update on staffing and operational matters affecting Lilleybrook, Rendcomb, the Acute Haematology and Oncology Unit (AHOU), Avening, and the Edward Jenner Unit. The commentary remains consistent with previous reports, with additional detail on recent developments and ongoing challenges.

	SNCT Variance %	Occupancy	Avr RN Fill Rate	Harm Hot spots	Skill Mix	RN:Patient Ratio - D	RN:Patient Ratio - N	Overall Risk
Lillybrook	-22%	75%	98%	0	63:37	6.0	9.0	
Rendcomb	9%	96%	100%	1	76:24	4.4	5.5	

Table 3: Triangulation Data for the Diagnostic and Specialist Services

Rendcomb

Stem cell activity at Rendcomb remains paused due to the closure of the pharmacy manufacturing unit and is unlikely to resume before July or August 2026. This has affected audit findings and staffing requirements since March 2026. The ward layout also requires at least two registered nurses to be present in the side room area at all times, regardless of patient numbers, due to distance from the main ward and the high acuity of patients treated there.

Lilleybrook and Acute oncology Haematology Unit (AHOU)

Lilleybrook and AHOU have implemented flexible staffing across both areas, with no deterioration in nurse-sensitive safety metrics and minimal reliance on temporary staffing. A new oncological risk linked to AHOU activity may reduce flexibility, particularly during evening and twilight shifts. In addition, rising oncology and haematology activity is creating pressure in Avening and the Edward Jenner Unit. A business case is being developed, informed by a time and motion study showing a 6 WTE shortfall against optimal staffing levels.

Women's and children's

Ward 9A – Gynaecology

Ward 9A continues to experience staffing and operational pressure due to high elective activity, increased acuity associated with outlier admissions, and limited senior nursing cover overnight. Audits consistently indicate staffing below patient need, particularly where trauma, orthopaedic and surgical outliers require more complex care than the core gynaecology cohort. Occupancy also frequently exceeds the funded staffing model for 13 patients. Pressure is greatest from Monday to Wednesday because of high elective theatre activity and rapid turnover. A review of staffing levels and the introduction of overnight Band 6 cover should be considered to improve patient safety, flow, and clinical oversight.

Children's Ward (including High Dependency Unit (HDU) and Emily Kent)

Children's nursing staffing has improved significantly following successful recruitment, with thirteen newly registered children's nurses joining in September 2025 and the ward now fully staffed. Although the audit took place during a period of lower occupancy, it still identified a gap between funded and recommended staffing, reducing flexibility when acuity or specialist need increases. A temporary practice development post has supported induction, supervision and staff confidence, and there is a strong case for this support to continue on a substantive basis, particularly for HDU and oncology competence. Agency spend has reduced significantly, reflecting improved recruitment, leadership oversight and more flexible deployment.

	SNCT Variance %	Occupancy	Avr RN Fill Rate	Harm Hot spots	Skill Mix	RN:Patient Ratio - D	RN:Patient Ratio - N	Overall Risk
Ward 9a	-12%	91%	99%	1	67:33	6.5	6.5	
Paediatrics	-12%	57%	79%	1	75:25	3.4	3.4	

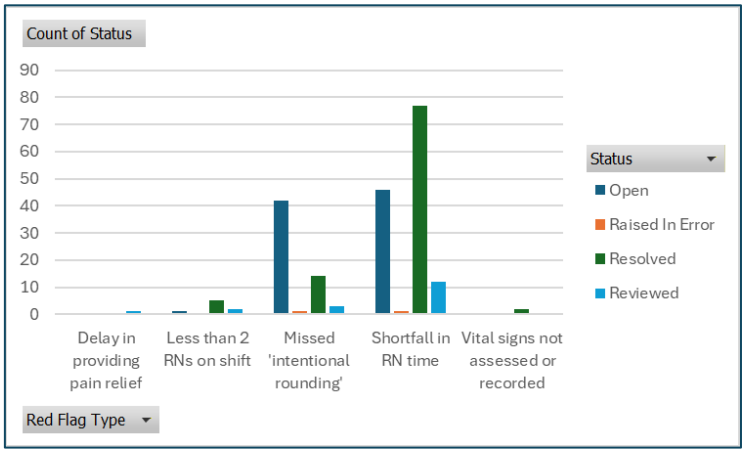
Table 4: Triangulation Data for the Women's and Children's Division

Red flags

A red flag incident signals inadequate staffing, skill mix, or deployment for patient needs, posing risks that require escalation. As per NICE (2014), red flags act as early warnings; they must be identified to the lead nurse and prompt immediate action to resolve risk, such as redeploying staff or seeking support.

Both the incident and response must be documented and reviewed regularly to improve workforce planning, ensuring red flags are used proactively for patient safety.

Red flags are recorded within Health Roster and over the past six months, a total of 207 red flags have been reported, with two identified as erroneous entries. The table below outlines the categories of red flags raised, highlighting RN time shortfall and missed intentional rounding as the most frequent incidents. AMU, Gallery Ward 2, Ward 9b, and Guiting are currently the top reporting areas.



Graph 2: Red flags Data

One area needing improvement is documenting the actions taken to address risks. Although there is confidence that steps are taken during the relevant shifts, these actions are not reflected in the health roster. As of this report, 107 red flags are still open in the system. Resolving this issue will be a key focus over the next six months.

Safer Staffing Recommendations

The following recommendations are made

- request Medicine divisional leadership team to optimise nurse-to-patient ratios in older adult wards by re-aligning establishment from wards with consistent CHpPD above the demand.
- to request Surgery divisional leadership team, re-align establishments in surgical wards where there has been consistent CHpPD above the demand.
- To pause recruitment in the areas identified as having higher CHpPD than demand to allow plans to develop.

These recommendations reflect the audit findings and are aligned with national safer staffing guidance, with a focus on leadership, establishment alignment to demand, development/education capacity, and targeted service review.

References

National Institute for Health and Care Excellence (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals. London National Institute for Health and care Excellence.

National Quality Board (2016) Supporting NHS provider to deliver the right people, with the right skills, are in the right place at the right time – Safe sustainable and productive staffing. London National Quality Board

NHS England & Improvement (2018) Developing workforce Safeguards. London: NHS England & Improvement.

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Appendices

Appendix 1: Nursing sensitive indicators

Infection Prevent and Control

Healthcare associated infections (HCAIs) are infections picked up during healthcare delivery. This evaluation uses case numbers of MRSA and MSSA bacteraemia and *C. difficile* infections, as they are tracked nationally and help benchmark NHS performance.

Local MRSA acquisition data, indicating new hospital transmissions, is also included, as it is a sensitive measure of staffing safety. The following figures display infection rates by ward across the Divisions from April 2025 to January 2026, using a traffic light heat map to highlight areas with higher infection rates.

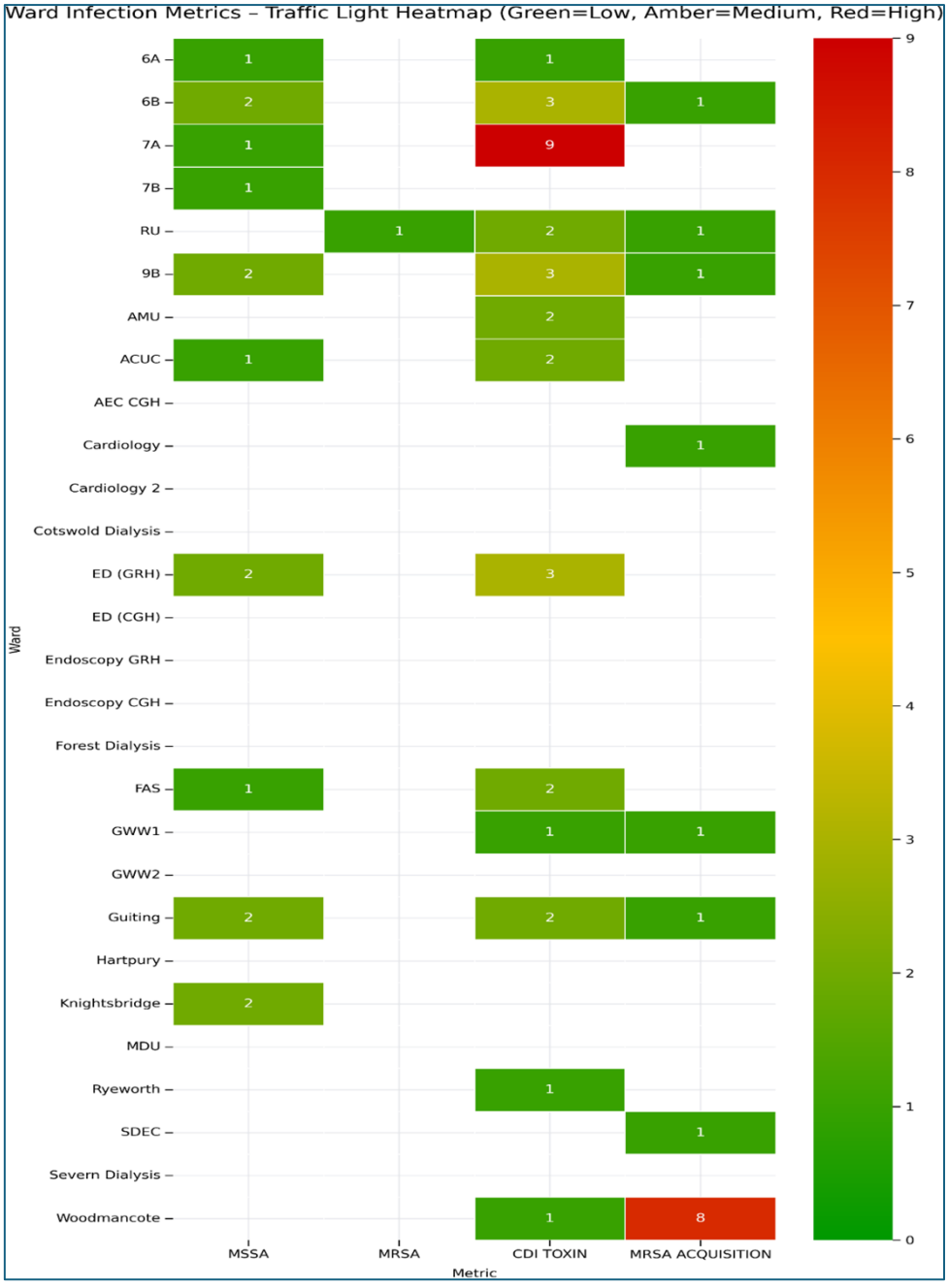


Figure 1: Heat map of the Medicine division HCAI data from April 2025-January 2026

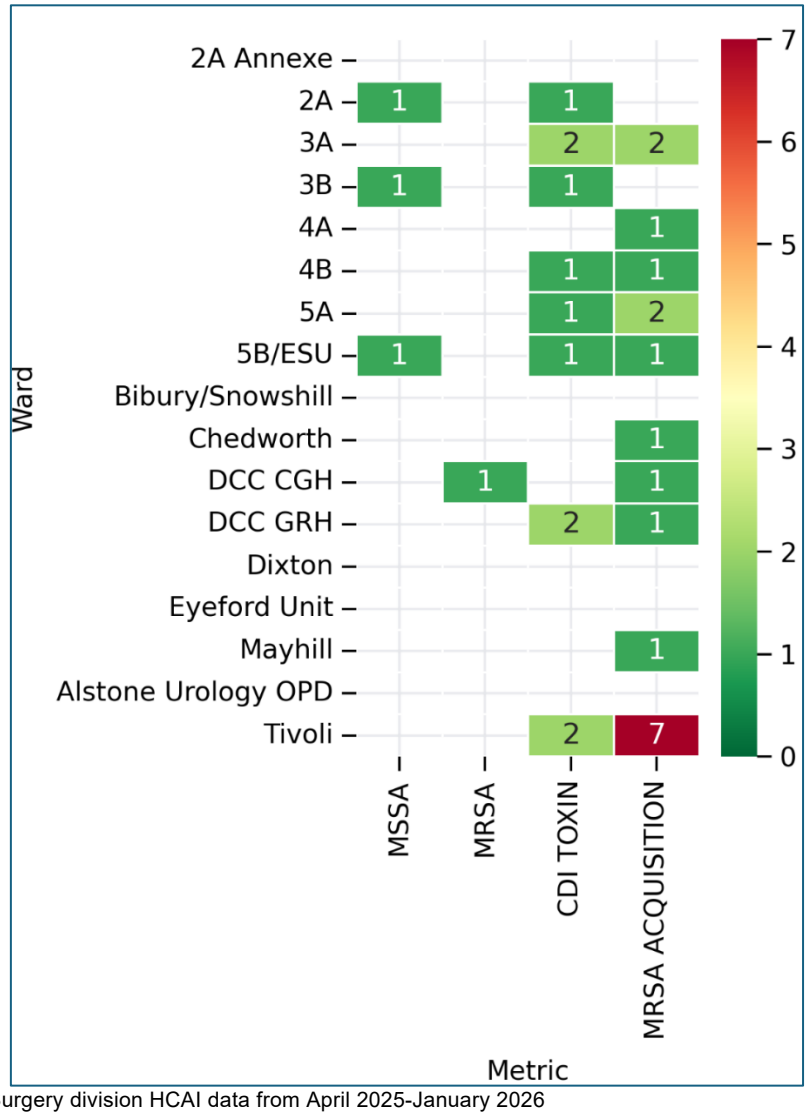


Figure 2: Heat map of the Surgery division HCAI data from April 2025-January 2026

Both Diagnostic and Specialist Services and Women and Children divisions have had no Methicillin-Sensitive *Staphylococcus aureus* (MSSA) and Methicillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia apportioned to their wards and units during April 2025-January 2026 and only one *C. difficile* infection was apportioned to Rendcomb side rooms.

Outbreak data can also be used as a meaningful metric to assess nursing staffing because they are more likely to occur when staffing capacity and/or skill mix is insufficient to consistently deliver infection prevention and control standards. Trends in the frequency, duration, or scale of outbreaks can therefore provide an early indicator of workforce pressure.
At present the Trust is below the nationally set annual threshold for *C. difficile* infections; with fewer cases and a lower-case rate per 100,000 bed days when compared to 2024-25.

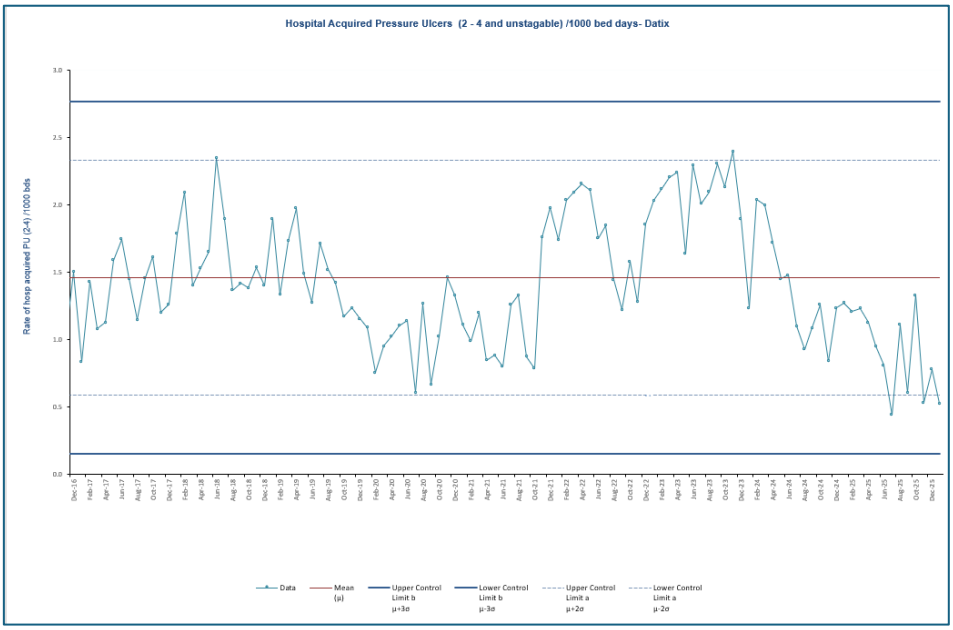
Gloucestershire ICB are within the lowest 25% quartile across all ICBs in England *for C. difficile* and the lowest across the seven systems within the South-West (according to NHS Model health data).

The annual CDI reduction plan continues to be implemented and engaged in the system and regional CDI improvement groups. Gloucestershire ICB also have the lowest reported infection rates per 100,000 population rolling 12-month rate, across Southwest ICBs for all reported Gram-negative blood stream infections and MSSA bacteraemia.

The Infection Prevention and Control (IPC) team also continue to deliver a comprehensive infection prevention and management annual programme which supports local and system wide quality improvement.

Pressure Ulcers

Over the reporting period, the number of pressure injuries demonstrated a downward trend, indicating sustained improvement in prevention and management practices.



Graph 3: Hospital Acquired Pressure Ulcers

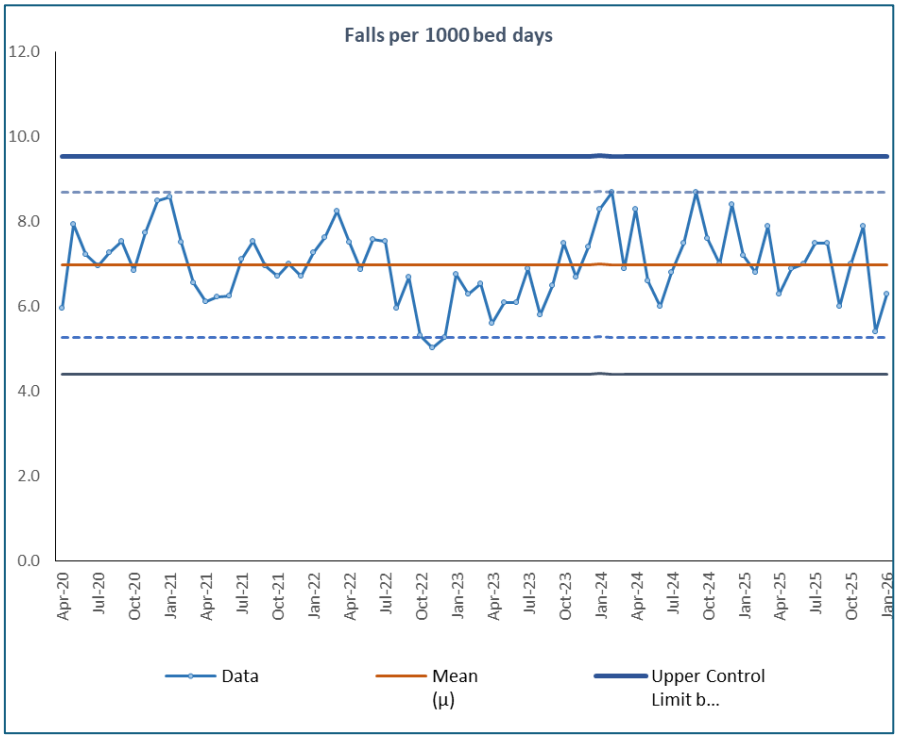
At the outset of the review period, the total number of reported pressure injuries ranged from two to three, indicating initial challenges in risk identification, repositioning compliance, documentation accuracy, and staffing levels within inpatient wards.

Subsequent data collections revealed a measurable decline in these numbers, aligning with the reduction in nursing vacancies and the introduction of targeted interventions These interventions include enhanced skin risk assessments upon admission, increased frequency of repositioning schedules, improved staff education on pressure injury prevention particularly following a TVN-led silver quality improvement project and increased utilisation of pressure-relieving equipment.

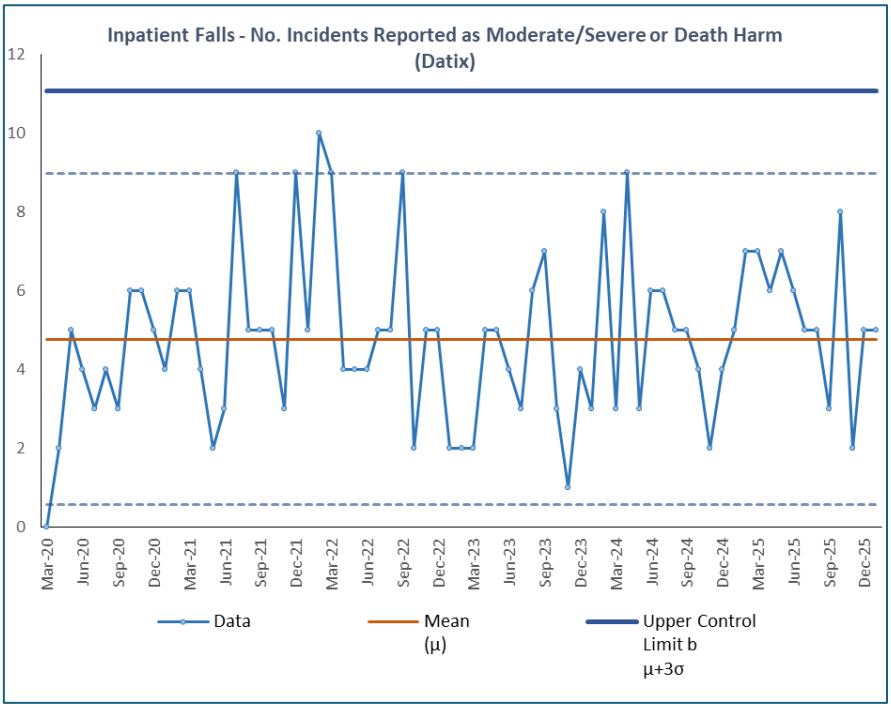
The occurrence of category 4 pressure ulcers during this period highlighted the need for additional support in specific wards, particularly regarding education and documentation practices.

Falls

The graphs below illustrate both the rate of falls per 1000 bed days and the corresponding number of falls resulting in moderate or greater harm. Since June 2024, there has been a steady improvement, particularly in the reduction of falls causing moderate or above harm, which can be attributed to ensuring adequate staffing levels and appropriate skill sets.



Graph 4: Falls per 1000 bed days



Graph 5: Incidents reported as moderate or above harm

The team continues to provide ongoing training and education, and, following the falls summit, has implemented two key initiatives. Firstly, revisions have been made to the falls section of the nursing admission documentation which will make the documentation more patient focused around the inventions, following the assessment of the patients' risk of falls.

Secondly, a 'hot debrief' section has been incorporated into the Datix form to capture pertinent information that may otherwise be overlooked, ensuring instant learning is captured as soon as possible after the event.

FOI: Public

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Safer Staffing Review

Putting the latest SNCT results in context

Matt Holdaway, Director of Quality and Chief Nurse

the Best Care for Everyone
care / listen / excel

Our progress

What's happened since 2022 to nurse staffing?

2022-Foundation for Improvement

In 2022, the Trust began a significant transformation in nurse staffing, focussed on data driven decision making and stronger operational grip

- Shift to a more robust, data led approach to setting establishments, rota design and deployment of staff
- Creation of Associated Chief Nurse for Workforce and Education to provide dedicated senior leadership
- Roll out of a refreshed Safer Nursing Care Tool (SNCT)training programme and annual cycle of business
- Strengthening of day to day staffing oversight and escalation
- Tighter controls of temporary workforce reducing unnecessary variation and cost
- Delivery of an ambitious domestic and international recruitment and retention programme

Overview of 2022

RN

Vacancies
359

Establishment
2428

HCSW

Vacancies
117

Establishment
827

CHpPD
9.05

National average
9.21

Overview of 2023

RN

Vacancies
349

Establishment
2483

HCSW

Vacancies
4

Establishment
820

CHpPD
8.09

National average
9.62

Overview of 2024

RN

Vacancies
212

Establishment
2603

HCSW

Vacancies
35

Establishment
828

CHpPD
8.93

National average
9.44

Overview of 2025

RN

Vacancies
121

Establishment
2661

HCSW

Vacancies
111

Establishment
890

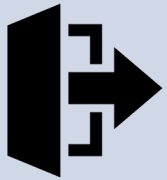
CHpPD
9.65

National average
11.41

Our improvement journey

RN vacancy from **14.8%** to **4.5%**

Inpatient ward vacancy for Band 5s close to zero



RN turnover rate **5.2%** compared to **8%** nationally

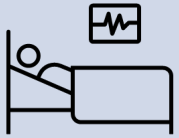
WAU is in quartile 1 and compares favourably with medians, indicating a productive workforce.

Our improvement journey

RN sickness is 5.3% putting us in 2nd quartile nationally

CQC inpatient survey we were in top 5 Trusts in region on "nursing" questions for first time (joint 2nd)

22% increase in 4 years of staff answering positively to *"I am able to meet all the conflicting demands on my time at work"*



Positive FFT has gone from 88% in 2022 to 94% now, putting us in 1st quartile

Our improvement journey

Falls per month causing harm currently averaging (12-month) at 5.4, lowest we have had for a rolling 12-month period

Infection rates are the lowest in the South West

Hospital acquired pressure ulcers have gone from an average of 52 per month in 2022 to 24 this year (to Nov)

Finance overview

Investment in nursing over time

- In November 2023 executives approved re-baselining costs for pay enhancements and establishing Courtyard to 15.71WTE, increasing ED establishment by 20.1WTE and making minor adjustments to HCSW for enhanced care. **Cost pressure of £2.336m.** This was an accounting adjustment, not based on the SNCT report.

- Prior to this the previous investment based on SNCT was in May 2019.

Pay bill for nursing and midwifery

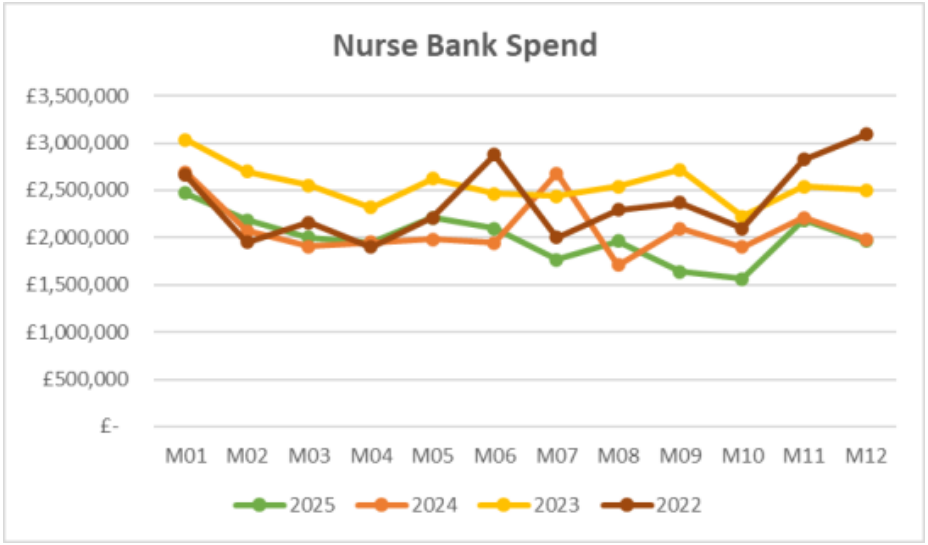
Nominal £000	2022/23 **182,560**	2023/24 **178,778**	2024/25 **186,536**	2025/26 **199,510**
22/23 Real-terms £000	Baseline **182,560**	5% **170,265**	5.5% **168,392**	3% **174,815**

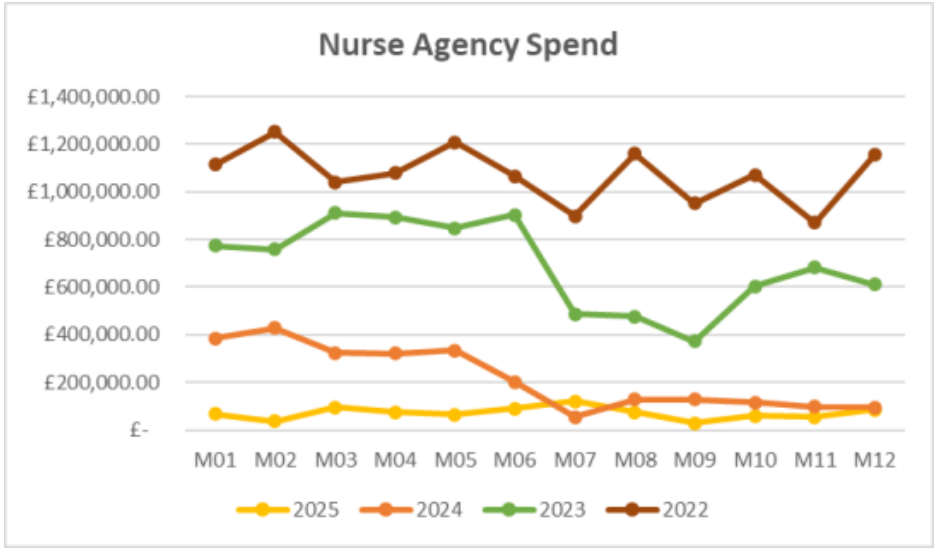
Pay costs improvement

- In real-terms bank and agency has **reduced 47%** since 2022/23

- Total nursing and midwifery pay bill has **decreased 4.2%** in real-terms over the same period whilst nursing and midwifery outcomes have improved

Temporary Workforce Spend





Summary

Summary

Over the past four years, the Trust has delivered sustained improvements in nurse staffing, workforce experience, financial efficiency and patient outcomes.

This progress has been achieved not through recurrent growth in spend, but by:

- Strengthening data-led decision-making in setting nurse establishments and deploying staff
- Developing and supporting local nursing leadership to use workforce data confidently and consistently
- Reducing reliance on temporary workforce while maintaining safety and quality
- Translating improved staffing grip into measurable improvements in patient safety and experience

Overall, the Trust now has a more stable, productive and cost-effective nursing workforce, with clear evidence of benefit for patients, staff and the organisation.

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Thank you

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Alert, Advise and Assure Report to the Board of Directors Meeting held on 14 May 2026

Title		ADVISE, ALERT, ASSURE and APPLAUD Report of the meeting of the People and Organisational Develoment Committee held on 14 April 2026
Board member lead		Marie-Annick Gournet
Written by		Marie-Annick Gournet (Chair)
Confidentiality		None
Requires Tick as appropriate	**Approval**	
	Assurance	x
	Discussion	
	Note	X

Purpose of report

To present an update to the Board of Directors from the meeting of the Peoplr and Organisational Development Committee held on 14th April 2026 (quorate). This committee meets five times a year 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.

Matters posing risk to Well-Led domains requiring Board attention:

- **Inclusive and fair recruitment:** Consultant recruitment processes are not consistently transparent or standardised, with risk of bias in shortlisting, panel practice, and informal pre-interview engagement. This presents a risk to fairness, equality of opportunity, and reputational integrity.
- **Persistent workforce wellbeing challenges** : High levels of musculoskeletal issues and work-related stress continue to drive sickness absence with no evidence of natural reduction.
- **Inequality in workforce outcomes: T**he disability pay gap remains significant and structural. Headline improvements in other pay gaps risk masking underlying inequities in progression, representation, and access to opportunity.

- **Psychological safety and speaking up:** Continued high levels of anonymous reporting indicate partial progress but also signal lack of confidence and trust in speaking up openly.

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

- **Clarity of impact and outcomes:** The reset of the Staff Experience Improvement Programme is strategically aligned but requires clearer success measures, outcome metrics, and demonstrable impact to provide robust assurance.
- **Leadership capability at all levels:** Variability in line manager capability is limiting uptake of wellbeing support and consistent people management. Strengthening leadership development remains critical.
- **Use of data for insight**: Current workforce data lacks sufficient granularity and relies heavily on staff survey data. Improved triangulation and deeper analysis are required to fully understand inequality, wellbeing drivers, and workforce risks.
- **Embedding inclusive practices:** Recruitment, staff experience, and anti-discrimination workstreams require consistent implementation of value-based approaches and accountability across all levels of leadership.
- **Workforce risks emerging externally;** including potential continued issue of visa policy changes and funding risks affecting GP trainee arrangements.

ASSURE: inform the board where positive assurance has been received

- **Strengthened governance and oversight:** Significant progress in audit closure and compliance demonstrates improved control, follow-through, and accountability.
- **Effective workforce management controls:** Vacancy management and temporary staffing controls are effective, with no adverse impact on service delivery indicators to date.
- **Embedding of key cultural programmes**: Leadership development, restorative culture, and communication approaches are now integrated into business-as-usual structures.

APPLAUD: Positive achievements and strength

- **Health and wellbeing initiatives:** successful introduction of staff health checks with high satisfaction and early identification of health issues.
- **Enhanced audit maturity:** Notable improvement in governance, follow-through, and accountability.
- **Collaborative system working (ICS):** Progress in aligning recruitment and workforce processes across partner organisations.

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	

Board assurance framework

BAF reference	**SR03:** Inability to attact and retain a skillful compationate workforce that is representative of the communities we serve.

Risks discussed

The Committee discussed the following risks:

- Recruitment and retention challenges
- Equality, diversity and inclusion risks (including pay gaps and discrimination)
- Workforce wellbeing and sickness absence
- External policy risks (e.g. visa changes)
- Cultural and psychological safety indicators

Recommendations

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

- **Take assurance** from the areas outlined above, particularly in relation to audit, workforce controls and programme embedding.
- **Note the report** and the areas highlighted under Alert and Advise for ongoing scrutiny and action.
- **Support continued focus** on measurable impact, leadership capability, and data-driven insight to strengthen Well-Led performance.

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Alert, Advise and Assure Report to the Board of Directors Meeting held on 14 May 2026

Title		ADVISE, ALERT and ASSURE Report of the meeting of the Finance and Resources Committee held on 24 March 2026
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 24 March 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** – Although the Trust is looking at breakeven the Month 11 position is showing a full year under delivery risk against our savings plan of c£7.3m. This was a deterioration of £0.2m on prior month and remains a concern going into 2026/27. There has been much good learning and reason to be more optimistic for 2026/27 but move towards amber needs achievement of deliverables and a more informed view can be arrived at towards the end of quarter 1.
- **Capital and Estates Programme Delivery** - At the end of Month 11, the Trust had goods delivered, works done or services received totalling £28.6m, against a planned spend of £47m, equating to a variance of £18.4m behind plan. £27M to deliver before year end. This is a significant risk. Current forecast is for an overspend of £4.4m which is considered

extremely unlikely. Mitigations were in place, and the Trust had since agreed to return £700k of funding to NHSE. Committee was keen to see lessons learned exercise on back ended nature of expenditure and to explore if the current approach means that the Trust is not spending on its highest priorities.

- **Finance System update** Committee considered this risk to be red given the nature of significant milestones and undertakings by the supplier which are outside of the Trust's control. Items within our control have been well tested and mitigated. Go/No go decision to be taken later in the calendar year.
- **Strategic Clinical Systems (Electronic Patient Record - EPR) review conclusion –** The Committee noted significant deep-rooted issues with the architecture of clinical systems which is negatively impacting care delivery, patient and clinician experience, financial income and expenditure, and leading to more outages due to the complex nature of the estate. The issues are impacting pace of Transformation and there is a need to review the forward strategy via the endorsed EPR business case process.
- **HIMMS digital maturity assessment –** The committee clearly noted the score has now been reduced to level one (least mature) against a national target of level five (more mature). Whilst the Trust has made overall progress of near 50% the lack of a single clinical data repository through the use of multiple systems creates a glass ceiling to digital maturity and presents risks to the Trust digital first approach.

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

- **Financial Performance Report -** The M10 position was a £0.07m surplus, which was marginally 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 £7m adverse to plan. NHSE £4.9M cash injection received.
- **Digital and Chief Information Officer Assurance report -** The updated noted positive progress on key infrastructure risks and delivery of the Digital programme, however, this month was an important month in coming to a joint understanding of the current state of the Trust's digital maturity and clinical system architecture which will require increased support and focus to ensure strategic Trust plans are enabled.
- **Integrated Digital Report –** Committee were happy to recognise the work undertaken to learn lessons and provide greater assurance. The report was noted as a good, confidence inspiring candid "Warts and all" update which was very welcome**.** It was noted that the EPR programme underdelivered this year and a new approach to delivery was being developed with improved focus.
- **Data Centre project assurance -** The Committee were updated on the ongoing approach to this and were supportive of the progress and assurance over the plan, recognising ongoing risks given the multi-year timeline to completion and that current environmental risks (such as a lack of air conditioning resilience) are still in play although mitigated as much as possible in the short term
- **Back up strategy and assurance report** - The Committee welcomed this work, recognising that previous DSPT submissions on backup had just about been achieved with little leeway. The new approach articulated through the plan detailed in the report was supported as a key component of the Trust's digital security and business continuity recovery and will assist in delivering national data security standards. Helpfully, some back up blind spots had been identified and addressed. The proposal also reduced the risk of significant unnecessary cost in this area.

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

- **Costing submission –** The Committee APPROVED the process in place and was happy to provide assurance to the Board on the plan to successfully completed the mandated costing submission for 2026.
- **Medium Term Planning –** Committee NOTED the minor refinement to the plan and the resubmission to NHSE on 18th March.
- **Strategic Clinical Systems (EPR) review conclusion –** The Committee SUPPORTED this work and ENDORSED the recommendations for development of the business case, capital funding identification and exploring partnership opportunities.
- **Terms of Reference review and Committee effectiveness review –** The Committee SUPPORTED the effectiveness review process, with members agreeing to complete the questionnaire and agreed to review the Committee Terms of Reference and to feed back for discussion at the next meeting. The Committee particularly supported the opportunity to contribute on approach to drafting of papers.
- **GMS Dividend** – The Committee APPROVED a total dividend payment of £2.22M before 31st March 2026.
- **Lithotripter and Urology business case -** The Committee APPROVED an uplift from the originally approved RIBA stage 2 estimate of £1,885,726.88 to RIBA Stage 5 tendered costs £3,692,709,72 including a £500,000 contingency. The significant areas of cost increases were around the contingency levels, services capacity, and infrastructure, locating the AHU and associated structural and service improvements works needed, fire compartmentation measures, detailed design, and market tendered prices.

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 IT estate

Recommendations

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