



Gloucestershire Hospitals
NHS Foundation Trust

Quality Account

2025 – 2026

The background features a grid of squares in various shades of yellow and orange. Some squares contain faint geometric patterns: a star in the top right, a dotted pattern in the middle right, and a triangle in the bottom right. A white rectangular box is positioned in the lower-left quadrant, containing the main text.

Our Quality Account 2025–2026

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements.

Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

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Part ONE: Foreword by the Chief Executive

This Quality Account is published at an important point in Gloucestershire Hospitals NHS Foundation Trust's journey, as we move into the early delivery phase of our new **Trust Strategy 2025–2030**. Our strategy sets a clear and ambitious direction for the organisation: to provide care that is safe, effective, inclusive and responsive, while strengthening our foundations for the future and working in partnership to meet the needs of our communities. This Quality Account reflects how that strategic intent is being translated into practical, measurable priorities during the first year of delivery.

The context in which we are operating remains challenging. National recovery expectations across urgent and emergency care, elective services, cancer and maternity are set alongside a constrained financial environment, workforce pressures and continued regulatory scrutiny. Despite this, our focus remains unwavering: continuous improvement in the quality of care and experience for our patients, every day.

The priorities set out in this Quality Account are deliberately aligned to our strategy and to what matters most to patients and staff, ensuring that quality improvement is grounded in outcomes, experience and safety. The sections that follow describe how these strategic commitments are being translated into focused improvement priorities and assurance statements for the Board, our patients and our partners.

A central theme of our Trust Strategy is improving the timeliness and reliability of care. Long waits and delays have a profound impact on patient experience, outcomes and equity. During 2026/27, we will continue to prioritise recovery across planned, urgent, cancer and maternity services, improving flow through our hospitals and pathways so that patients receive the right care, in the right place, at the right time.

The Trust Strategy also makes clear that tackling health inequalities is a golden thread running through everything we do. Reducing unwarranted variation in access, experience and outcomes is both a moral imperative and a marker of high-quality care. Our year one quality priorities therefore place strong emphasis on

understanding where inequalities exist and embedding equity into the design and delivery of services.

Listening to patients, families and carers, and acting on what we hear, is fundamental to our vision for quality. Strengthening patient experience, voice and learning is a core pillar of this Quality Account, ensuring that feedback and concerns lead to visible improvement and that care is increasingly co-designed with those who use our services.

We are also committed to embedding a robust, Trust-wide quality management system, giving greater clarity and consistency in how we plan for quality, improve services, manage risks and assure ourselves at Board level. This is essential to delivering our strategy with discipline, transparency and accountability.

Finally, our ability to deliver high-quality care depends on our people. Improving patient safety through staffing, culture and speaking up reflects our strategic commitment to compassionate leadership, psychological safety and doing the brilliant basics well. Creating environments where staff feel supported, valued and able to raise concerns is critical to preventing harm and sustaining improvement.

I am deeply proud of the dedication, care and compassion shown by colleagues across the Trust every day. This Quality Account is both an assurance to our patients and partners, and a statement of intent: that quality is at the heart of our strategy, and that we will continue to learn, improve and work together to deliver the care our communities deserve.

I can confirm that, to the best of my knowledge, the information included in this report has been subject to appropriate scrutiny and validation and represents a true and fair account of the Trust's activities and achievements in relation to quality during 2025/26.

Kevin McNamara

Chief Executive



Part TWO: Priorities for Improvement and Statements of Assurance from the Board

The Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to publish an annual Quality Account. This report provides patients, staff, governors, partners and the public with information about the quality of services delivered by Gloucestershire Hospitals NHS Foundation Trust during 2025/26, including where improvement has been made, where further improvement is required, and the priorities that will guide quality improvement in 2026/27.

Quality Accounts are both retrospective and forward-looking. This report reviews progress against the Trust's 2025/26 quality priorities and sets out the priorities for improvement in 2026/27, together with the measures and governance arrangements that will support delivery and Board assurance.

The Trust has prepared this Quality Account to support public transparency, external review and Board assurance. In line with statutory requirements, the report will be shared with NHS Gloucestershire Integrated Care Board, Healthwatch Gloucestershire and the Gloucestershire Health Overview and Scrutiny Committee for review and comment.

The 2026/27 priorities have been developed in the context of the Trust Strategy 2025–2030 and informed by performance in 2025/26, patient and staff feedback, regulatory expectations, quality intelligence and areas where focused action is expected to have the greatest impact on patient safety, clinical effectiveness and patient experience.

Delivery will be overseen through the Trust's quality governance framework and strengthened by the Quality Governance Transformation programme, which brings together patient experience, patient safety and clinical effectiveness within a single ward-to-Board approach. This will support clearer triangulation of quality intelligence, stronger action tracking and more consistent assurance on progress and impact.

Looking forward to our priorities for 2026/27

The Trust's 2026/27 quality priorities reflect the areas where focused improvement is expected to have the greatest impact on patient safety, clinical effectiveness and experience of care. They are aligned to the Trust Strategy 2025–2030 and represent the first year of quality delivery under the new strategy. Each priority has defined measures of success and a clear governance route for monitoring delivery, escalation and Board assurance.

Priority	Aim	What will be measured	Assurance route
Patient experience, voice and learning	To ensure patient, carer and family feedback is routinely used to improve services and demonstrate visible learning. A specific focus will be the learning from the National Maternity and Neonatal Taskforce, the Ockenden Review and the Amos Review.	Friends and Family Test intelligence; complaints timeliness and quality; “You said, we did” evidence; patient and carer involvement; co-design activity including Patient Safety Partners and Martha’s Rule learning.	Patient Experience Group; Quality Delivery Group; Maternity Delivery Group and Quality and Performance Committee.
Timeliness and reliability of care	To reduce avoidable delays	Referral to Treatment, cancer and diagnostic	Integrated Performance

Priority	Aim	What will be measured	Assurance route
	and improve reliability across urgent, elective, cancer, diagnostic, outpatient and maternity pathways.	standards; urgent care performance; long waits; ambulance handovers; delay-related harm; pathway flow and same-day emergency care.	Report; improvement boards; Quality and Performance Committee.
Reducing inequalities in access, experience and outcomes	To identify and reduce unwarranted variation for groups at greater risk of poorer access, experience or outcomes.	Data completeness; variation by deprivation, ethnicity, age and sex; targeted improvement actions; equality and health inequalities impact assessment evidence.	Health Inequalities Working Group; divisional governance; Quality and Performance Committee; Board reporting.
Embedding a Quality Management System	To strengthen how the Trust plans, improves, controls and assures quality from ward to Board.	QMS implementation milestones; divisional quality plans; quality triangulation; action tracking; escalation and closure of improvement actions.	Quality Governance Transformation programme; Quality Delivery Group; Quality and Performance Committee; Board.
Improving safety through staffing, culture and speaking up and	To improve patient safety through safe staffing, learning	Staffing risks; rota gaps; staff survey indicators; Freedom to Speak Up themes;	People governance; Freedom to Speak Up reporting;

Priority	Aim	What will be measured	Assurance route
delivery of the Safety Priorities in the Patient Safety Incident Response Framework	culture, psychological safety and effective routes for raising concerns.	Report, Support and Learn intelligence; restorative practice; incident learning and action completion.	patient safety governance; Quality and Performance Committee; Board.

Progress against these priorities will be reviewed routinely through the Trust's quality governance framework and reported to the Board through established assurance routes. The priorities will also provide the basis for public reporting on progress in the 2026/27 Quality Account.

Continuity between 2025/26 and 2026/27 quality priorities

The 2026/27 quality priorities build on the learning, achievements and residual risks identified through the 2025/26 priorities. Some areas are carried forward as explicit Quality Account reporting priorities because they require continued Board-level focus and public reporting. Others continue through established operational, divisional, regulatory or programme governance routes. The fact that a topic is not named as a separate 2026/27 Quality Account priority does not mean work has stopped; rather, it reflects the most appropriate route for oversight based on maturity, risk and delivery phase.

Looking back on our progress against our local quality priorities

2025/26

The table below summarises progress against the Trust's 2025/26 local quality priorities. It provides a high-level view of the areas of focus, key achievements and improvement work that will continue into 2026/27. The detailed narrative that follows provides further evidence of delivery, assurance and ongoing risks for each priority.

2025/26 priority	What we focused on	What we achieved	What remains a focus for 2026/27
Patient Safety Incident Response Framework, including pressure ulcer and falls prevention	Embedding PSIRF governance, proportionate learning responses, safety huddles, learning panels, and targeted improvement in pressure ulcer and falls prevention	PSIRF operating model embedded; strong incident reporting culture maintained; improved visibility of safety themes; maturing pressure ulcer and falls prevention programmes	Improve timeliness and quality of learning responses; strengthen divisional ownership of actions; reduce variation in safety-critical controls
Outpatient transformation	Reducing overdue follow-ups, implementing GIRFT follow-up protocols, improving advice and guidance, and preparing for a single point of access	Early progress in reducing overdue follow-ups; orthopaedics completed GIRFT protocol implementation; good uptake of advice and guidance	Extend standardised follow-up protocols across specialties; embed single point of access; use released capacity to support elective recovery
Clinical Vision of Flow, including urgent and emergency care improvement	Improving urgent care flow, reducing ambulance handover delays, expanding same-day emergency care and strengthening	Improved 12-hour Emergency Department performance; ambulance handover times reduced; expanded same-day emergency care, virtual wards and	Reduce delay-related harm; improve 4-hour performance; strengthen assessment, streaming, discharge and admission

2025/26 priority	What we focused on	What we achieved	What remains a focus for 2026/27
	admission avoidance	discharge lounge use	avoidance pathways
Fire prevention and fire safety	Strengthening regulatory compliance, estate fire safety controls, enforcement action plans, training and emergency preparedness	Fire safety training exceeded 90%; stronger governance and regulator engagement; clearer programme delivery structure; learning from Tower Block exercise and lithium-ion battery incident	Complete remediation milestones; strengthen emergency communication and command arrangements; continue action on legacy estate and lithium-ion battery risks
Maternity service improvements	Responding to CQC Section 31 conditions, strengthening maternal and fetal deterioration pathways, audit, training and governance	Monthly CQC reporting completed; all eight Section 31 conditions self-assessed as fully met and sustainably embedded by March 2026; strengthened maternity safety governance	Sustain improvements; implement national Maternal Early Warning Score; maintain audit, workforce assurance and governance oversight

Quality priority 1 – Continuing our journey to implement the Patient Safety Incident Response Framework and Plan

Why this was a priority

The continuing implementation of the Patient Safety Incident Response Framework (PSIRF) remained a priority in 2025/26 because it provides the Trust's overarching approach to identifying patient safety risks, responding proportionately to incidents, learning from events and translating that learning into improvement. During the year, the Trust continued to embed a more mature patient safety system, supported by a daily executive-led Incident Response Safety Huddle, weekly Patient Safety Review Panel and oversight through the Safety Experience and Review Group. This work was important to ensure that patient safety learning was system-based, improvement-focused and supported by clear governance and accountability.

What we aimed to achieve

Our aim was to further embed PSIRF across the Trust so that patient safety incidents were triaged consistently, the most appropriate learning response was selected, patients and families were engaged compassionately, and improvement actions were identified, monitored and implemented at divisional and Trust-wide level. We also aimed to strengthen organisational learning by improving the consistency, timeliness and quality of learning responses and by ensuring that themes from incidents informed wider safety priorities and improvement programmes.

What we did

During 2025/26, the Trust continued to operate its PSIRF-aligned model, using a range of proportionate learning responses including Patient Safety Incident Investigations, After Event Reviews, Multi-Professional Reviews and Quality Summits. The Trust also responded to findings from an external PSIRF audit, which confirmed strengths in central governance and decision-making arrangements, while identifying areas for further development in timeliness, training compliance, documentation quality and divisional ownership of actions. In response, work progressed to strengthen policies, governance arrangements, training, documentation processes and the capture and sharing of learning through Datix and safety learning communications.

How we measured success

Success was measured through the strength of PSIRF governance arrangements, the volume and breadth of incident reporting, the use of proportionate learning

responses, completion of learning responses within expected timescales, and evidence that learning was being translated into improvement action. In 2025/26, this included monitoring 15,819 reported incidents, an average of seven new PSIRF learning responses per month, and the proportion of learning responses completed within expected timescales, including 50% of Patient Safety Incident Investigations, 63% of After Event Reviews and 71% of Multi-Professional Reviews. The Trust also monitored Duty of Candour compliance, the quality of recorded actions, training compliance, and the extent to which Trust-wide and divisional themes were being identified and acted upon.

PSIRF Implementation

15,819

reported incidents in 2025/26

7

Average of
new PSIRF learning responses
per month

Learning responses completed within expected timescales



Duty of Candour Performance

Approx. **81%** Duty of Candour discharge rate

Rates broadly stable around the median during 2025/26.

Safety Alerts Status



What we achieved in 2025/26

In 2025/26, the Trust achieved further progress in embedding PSIRF, with a full operating model in place and clear governance routes from incident identification through to learning and oversight. The Trust maintained a strong incident reporting culture, used learning responses broadly in line with risk and complexity, and strengthened the visibility of patient safety themes across the organisation. Overall assurance from the annual patient safety report was moderate and strengthening, reflecting that the core systems for learning and improvement are established, although timeliness of learning responses, consistency of documentation, training compliance and the reliability of some safety-critical controls remain areas requiring further improvement.

What we will continue to do in 2026/27

In 2026/27, the Trust will continue to embed PSIRF by improving the timeliness of learning responses, strengthening safety-critical controls, reducing unwarranted variation across divisions and wards, and further developing Trust-wide learning from patient safety events. Work will also continue to strengthen the use of Datix to

support oversight of actions and alerts, and to further embed patient voice and consideration of health inequalities within patient safety learning and improvement.

Patient Safety Incident Response Plan (PSIRP)

The Trust's Patient Safety Incident Response Plan (PSIRP) sets out the safety priorities where focused improvement is most likely to reduce harm, strengthen learning and provide clearer assurance on the effectiveness of safety controls. These priorities are informed by incident data, thematic learning, national guidance and local intelligence, and are kept under review as the Trust's patient safety system matures. For 2025/26, this Quality Account highlights two of those priority areas – pressure ulcer prevention and falls prevention – to demonstrate how the Trust is using PSIRF to translate learning into targeted improvement.

Pressure Ulcer Prevention – Safety Priority within the PSIRF Plan

Why this remains a priority

Pressure ulcer prevention remains a priority within the Trust's PSIRF plan because it continues to represent a material and preventable source of patient harm, while also providing an important test of how effectively the Trust translates learning into safer care. The Patient Safety Annual Report identifies that long-term data for hospital-acquired pressure ulcers shows a pattern of controlled but meaningful variation, with an overall downward trend toward 2026, indicating improving system control but not yet complete reliability. The report also concludes that prevention is supported by stronger governance and better visibility of performance, but that ward-level variation and operational pressures remain ongoing risks. For these reasons, pressure ulcer prevention has been retained as one of the Trust's continuing PSIRF safety priorities for 2026/27.

What we aimed to achieve

Our aim was to strengthen the reliability of pressure ulcer prevention by improving early risk identification, enhancing compliance with prevention processes, increasing ward-level visibility of performance, and supporting more proportionate PSIRF-

aligned learning from events. This included seeking to reduce unwarranted variation in practice, improve the consistency of documentation and preventive care, and ensure that learning from incidents, thematic review and specialist insight informed targeted improvement at ward, divisional and Trust-wide level.

What we did

During 2025/26, pressure ulcer prevention continued to be managed through a Trust-wide framework including the relaunched Pressure Ulcer Prevention Improvement Group, specialist leadership from the Tissue Viability Team, and reporting and escalation through the Quality Delivery Group. The Trust strengthened its use of PSIRF principles by enabling more proportionate responses to incidents, supported by Tissue Viability and Patient Safety teams, and by using debriefs and specialist review to capture immediate learning. A Trust-wide dashboard was introduced to improve ward-level visibility of performance, and improvement activity continued through training, link nurse support and follow-up action from the July 2025 Pressure Ulcer Quality Summit.

How we measured success

Success was measured through long-term trends in hospital-acquired pressure ulcers, compliance with key prevention processes, and evidence that learning was translating into improvement. The Patient Safety Annual Report notes that most monthly rates for hospital-acquired pressure ulcers remained within expected statistical limits, with an overall downward trend toward 2026. The Trust also monitored risk assessment compliance, which remained stable at approximately 68%, improving compliance with the SSKIN bundle, and ward-level performance through the Trust-wide dashboard. In addition, oversight included review of incident patterns, thematic learning from pressure ulcer events, and delivery against actions arising from the July 2025 Pressure Ulcer Quality Summit. In line with the PSIRF plan, success was also assessed through the extent to which incidents were reviewed proportionately and learning was used to support targeted improvement rather than routine retrospective investigation.

Pressure Ulcer Prevention:

PSIRF Safety Priority



Learning also monitored through thematic review and actions from the July 2025 Pressure Ulcer Quality Summit.

What we achieved in 2025/26

In 2025/26, the Trust strengthened its pressure ulcer prevention system through clearer governance, better visibility of ward-level performance and a more proportionate PSIRF-aligned approach to learning. The annual report describes this area as having a maturing and improving prevention system, with stronger governance and better performance visibility, while recognising that documentation burden, variation in practice, workforce pressures and the risk of loss of focus under operational pressure remain ongoing challenges. Overall, this provides improving but not yet complete assurance, and supports the decision within the updated PSIRF plan to retain pressure ulcer prevention as a continuing safety priority for 2026/27.

What we will continue to do in 2026/27

In 2026/27, the Trust will continue to strengthen pressure ulcer prevention through further embedding PSIRF-aligned learning, improving the reliability of early risk assessment and preventive care, simplifying documentation and digital processes where possible, and building stronger local ownership through Tissue Viability link roles and divisional engagement. Executive oversight will continue through the

established governance framework, with sustained focus on reducing variation and ensuring that learning consistently translates into safer care.

Falls Prevention – Safety Priority within the PSIRF Plan

Why this remains a priority

Falls prevention remains a priority within the Trust's PSIRF plan because inpatient falls continue to present a significant and common source of avoidable harm, particularly for frail and older patients. Our analysis identifies falls as a continuing safety priority and the programme as moving from a focus on incident volume to a more learning-led approach under PSIRF, with emphasis on workforce capability, quality of incident reporting, hot debriefs and quality improvement methods. We note that sustainability remains dependent on operational headroom and leadership attention. For these reasons, falls prevention has been retained within the updated PSIRF plan for 2026/27 to support continued reduction in harm and stronger organisational learning.

What we aimed to achieve

Our aim was to strengthen the Trust's falls prevention system by improving staff capability, enhancing the quality of incident reporting and immediate learning, and using PSIRF-aligned methods to shift the emphasis from retrospective investigation to real-time improvement. This included reducing harm from inpatient falls, supporting more consistent multidisciplinary prevention practice, and ensuring that learning from falls informed targeted quality improvement at ward, divisional and Trust-wide level.

What we did

During 2025/26, the Trust continued to deliver its falls prevention programme through a combination of workforce development, PSIRF-aligned learning and targeted quality improvement. A full-day falls prevention training programme was provided for nursing and therapy staff, with 199 staff trained during the year, and Falls Link Education Days were reinstated and expanded, with four sessions delivered. The Trust piloted structured hot debriefs on three wards to improve real-time learning from falls, and this learning informed improvements to the Datix investigation

process. Quality improvement work also progressed through Falls Quality Summits and related workstreams, including action on lying and standing blood pressure assessment, continence-related falls risk, bed rail documentation in EPR and access to appropriate footwear.

How we measured success

Success was measured through the rate of inpatient falls per 1,000 bed days, the number and pattern of injurious falls, and evidence that learning from falls was being translated into improvement. In 2025/26, this included routine monitoring of falls per 1,000 bed days, surveillance of injurious falls and serious outcomes such as fractured neck of femur, Duty of Candour cases and RIDDOR-reportable incidents, and review of learning themes through governance routes. The Trust also monitored delivery of workforce and improvement measures, including 199 staff completing the full-day falls prevention programme, four Falls Link Education Days delivered, and a hot debrief pilot implemented across three wards. In line with the PSIRF plan, success was also assessed through the extent to which all inpatient falls were being used as opportunities for proportionate learning and targeted quality improvement rather than relying solely on retrospective review of higher-harm events.

Key metrics – 2025/26

Chart 1: Falls per 1,000 bed days

This chart shows the monthly rate of inpatient falls per 1,000 bed days across 2025/26. While natural month-to-month variation is evident, the overall pattern reinforces the importance of focusing on harm reduction and learning rather than number of falls alone.

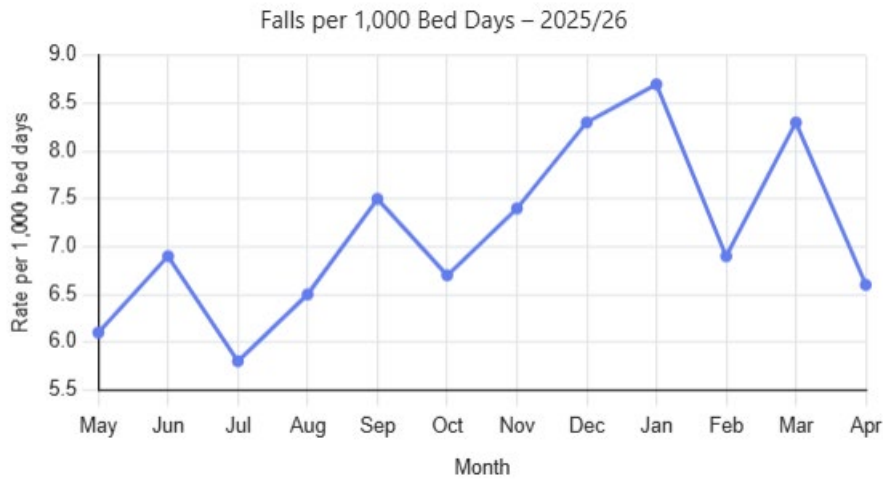


Chart 2: Injurious falls by month

This chart illustrates the number of inpatient falls resulting in harm each month. Ongoing review through governance structures supports timely learning and targeted improvement activity.

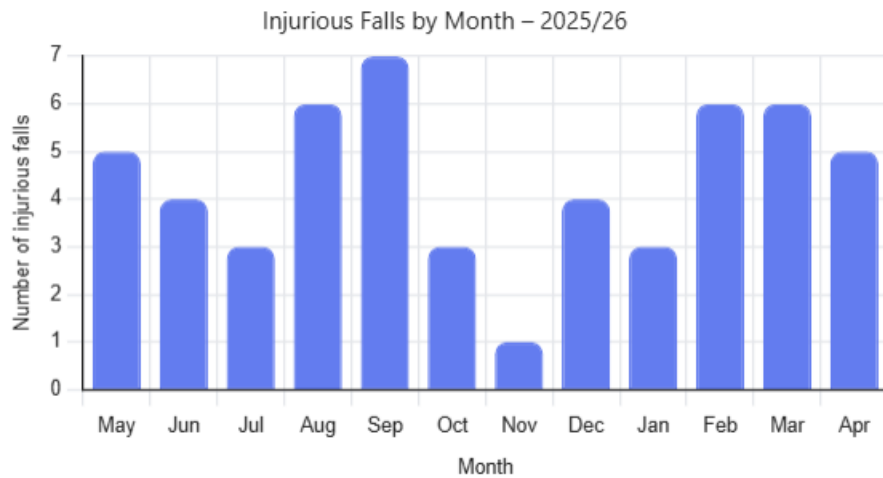
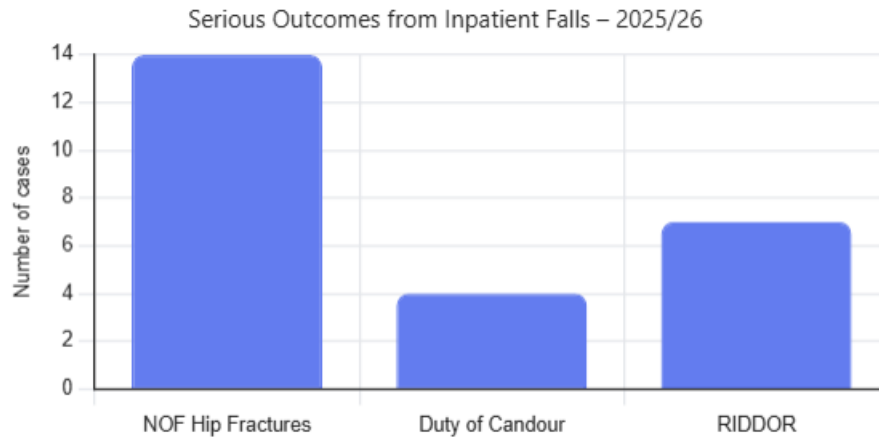


Chart 3: Serious outcomes from inpatient falls (2025/26)

This chart summarises the most serious outcomes associated with inpatient falls during the year, including fractured neck of femur (hip fractures), Duty of Candour cases and RIDDOR-reportable incidents.

3. Serious outcomes from inpatient falls – 2025/26 (bar chart) (NOF hip fractures, Duty of Candour, RIDDOR)



Falls monitoring

Routine monitoring of falls per 1,000 bed days and injurious falls.

199

staff completed
full-day falls
prevention training

4

Falls Link Education
Days delivered

Hot debrief pilot
implemented across

3 wards

Additional oversight included fractured neck of femur, Duty of Candour and RIDDOR-reportable incidents, with learning reviewed through governance routes.

What we achieved in 2025/26

In 2025/26, the Trust made meaningful progress in strengthening a more learning-led falls prevention system. The annual report identifies clear progress in methods, capability and learning systems, including strengthened staff training, structured hot debriefs and improvements to Datix reporting. This reflects a shift towards real-time

learning and harm reduction rather than retrospective root cause analysis alone. However, the report also notes that sustainability remains vulnerable to operational pressures, variable multidisciplinary engagement and the availability of leadership capacity. Overall, this supports an assurance position of progress and maturing capability, while justifying the retention of falls prevention as a continuing PSIRF safety priority for 2026/27.

What we will continue to do in 2026/27

In 2026/27, the Trust will continue to embed PSIRF-aligned falls prevention by fully implementing and evaluating the new inpatient falls Datix reporting form, extending learning from hot debriefs, and progressing quality improvement work arising from the Falls Quality Summits. Further work will continue on the reliability of lying and standing blood pressure assessment, continence-related falls risk, appropriate bed rail use and ward-level feedback on learning. Oversight will continue through the established governance framework, with sustained focus on reducing harm, strengthening consistency of practice and ensuring that learning is translated into safer care.

Quality Priority 2 - Outpatient Transformation

Why this was a priority

Outpatient transformation was a priority during 2025/26 because timely access to planned care is fundamental to quality, patient experience and recovery of constitutional standards. National policy continues to expect NHS organisations to redesign outpatient services so that care is more personalised, efficient and digitally enabled. For the Trust, this work is also important in reducing unnecessary follow-up activity, improving flow through elective pathways, making best use of clinical capacity and helping patients receive the right care at the right time.

This priority supports wider strategic objectives within the Trust's elective recovery programme and medium-term plan. By improving the way referrals and follow-up appointments are managed, the Trust is seeking to reduce unwarranted variation, improve patient experience and release capacity for patients waiting for treatment.

What we aimed to achieve

Our aim was to improve the effectiveness, efficiency and responsiveness of outpatient care through two main areas of focus:

- reducing unnecessary follow-up activity and improving management of follow-up pathways
- improving the quality and timeliness of referrals through advice and guidance and implementation of a single point of access

Together, these changes were intended to support elective recovery, improve patient experience and make better use of clinical capacity.

What we did

Follow-up care workstream

Within the follow-up care workstream, the Trust focused on two main areas.

The first was an overdue follow-up reduction project. This targeted patients who were due a follow-up appointment before 2024 but who had not yet been booked or had not contacted the Trust to request an appointment. Using the elective care hub,

patients were contacted to confirm whether they still wished to be seen. This enabled specialties to gather the information needed to support clinical validation and make decisions about whether patients could be discharged from follow-up or required an appointment.

The second area of work was implementation of Get It Right First Time (GIRFT) standardised follow-up protocols. These are designed to support more consistent decision-making about when follow-up appointments are genuinely needed and when they add value for the patient.

Orthopaedics was the first specialty to complete implementation. This has enabled the team to begin reviewing patients already placed on follow-up lists and to advise those who do not need a further appointment unless they have ongoing concerns. The capacity released is now being used to support patients currently waiting for treatment.

Referral optimisation workstream

The Trust also continued work to improve the way referrals are managed.

This included supporting NHS England's requirement for elective advice and guidance requests to be submitted through the NHS e-Referral Service. This system allows GPs to seek specialist advice before making a formal referral and also supports patients to book their first consultant-led outpatient appointment online. Work has taken place with primary care colleagues to support communication, engagement and consistent use of the system across the county.

Alongside this, preparatory work began for the introduction of a single point of access model for both referrals and advice and guidance. This will require all specialties to move to a more standardised approach, supported by a new digital platform. Work is underway with specialties, primary care and system partners to ensure there is sufficient capacity and clear implementation planning in advance of rollout.

How we measured success

Success was measured through a combination of operational and quality indicators, including:

- reduction in the number of patients waiting for overdue follow-up appointments
- implementation of GIRFT standardised follow-up pathways
- uptake of advice and guidance through the NHS e-Referral Service
- feedback from hospital and primary care colleagues on the referral process
- evidence that released capacity could be used to support waiting list recovery and a return towards constitutional standards

What we achieved in 2025/26

During 2025/26, the Trust made early progress across both workstreams.

The overdue follow-up reduction project enabled specialties to begin reviewing large numbers of patients on follow-up waiting lists and to make more appropriate decisions about whether further appointments were needed. This has supported better use of outpatient capacity and reduced the risk of patients remaining on waiting lists without clear clinical benefit.

The Trust also began implementing GIRFT standardised follow-up protocols, with orthopaedics leading early adoption. This has created a strong foundation for more consistent and value-based follow-up practice across other specialties.

Within the referral optimisation workstream, use of advice and guidance through the NHS e-Referral Service showed good uptake, with positive feedback from both hospital and primary care colleagues. This provides early assurance that referral pathways are becoming more streamlined and that clinicians are increasingly able to access specialist advice without the need for unnecessary formal referral.

Taken together, this work has started to improve the way outpatient pathways are managed and has created additional capacity to support elective recovery. However, the full benefit will depend on consistent implementation across specialties and sustained clinical engagement.

What we will continue to do in 2026/27

During 2026/27, the Trust will continue to:

- expand implementation of GIRFT standardised follow-up protocols across specialties
- embed and evaluate the overdue follow-up reduction programme
- increase consistent use of advice and guidance through the NHS e-Referral Service
- implement the elective single point of access model across all specialties
- use released outpatient capacity to reduce waiting times and improve access for patients awaiting treatment

The next phase of this work will focus on reducing variation between specialties, embedding change more consistently and ensuring that the benefits of transformation translate into measurable improvements in access, flow and patient experience.

Quality Priority 3 and 6 - Clinical Vision of Flow (including emergency care service improvements)

Why this was a priority

Clinical Vision of Flow remained a priority during 2025/26 because delays across urgent and emergency care pathways increase the risk of harm, reduce patient experience and place sustained pressure on hospital capacity. Improving flow is central to the Trust's strategic ambition to provide care that is timely, safe and responsive, and to reduce the impact of crowding, prolonged waits and delayed admission or discharge.

This priority reflects the need to strengthen patient flow across the whole urgent care pathway, from arrival and assessment through to discharge and transfer into community care. For the Trust, this work is about more than improving performance standards; it is about reducing delay-related harm, ensuring patients are cared for in the right place first time, and making best use of available bed capacity and same-day emergency care pathways.

What we aimed to achieve

Our aims for the Clinical Vision of Flow programme during 2025/26 were to:

- improve patient flow across urgent, emergency and assessment pathways
- reduce delay-related harm, particularly for patients experiencing prolonged waits in the Emergency Department and assessment areas
- ensure patients are cared for in the right place first time, with the minimum number of unnecessary moves
- support admission avoidance and timely discharge through effective use of same-day emergency care, short-stay services and virtual wards

Taken together, these aims were intended to improve the timeliness and reliability of care, reduce pressure on inpatient capacity, and deliver better outcomes and experience for patients using urgent and emergency services.

What we did

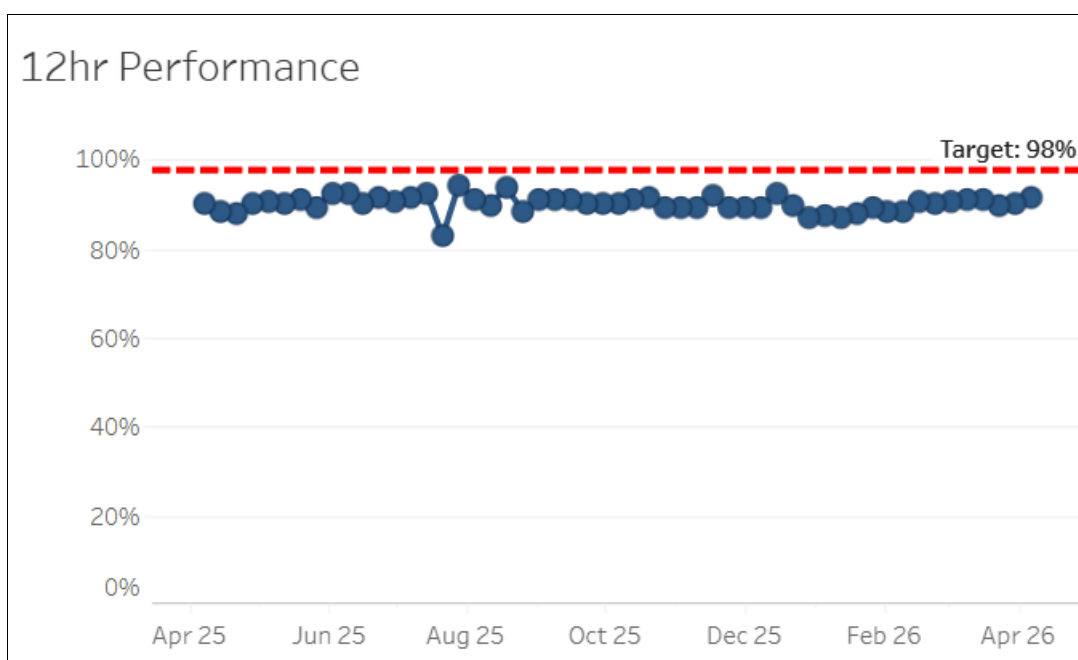
The programme continued as a clinically led quality improvement approach spanning the whole patient journey, supported by the Urgent Care & Flow Improvement Board and the Urgent and Emergency Care Improvement Board. Work focused particularly on Emergency Department service improvement, reducing ambulance handover delays, improving assessment and streaming, expanding same-day emergency care models and supporting timely discharge.

Alongside improvement in Emergency Department flow, the Trust expanded the use of same-day emergency care across medical, surgical and frailty pathways, strengthened use of virtual wards, and increased use of the discharge lounge to free inpatient capacity for patients waiting for admission. This work was supported through defined workstreams, senior responsible officers and programme management support.

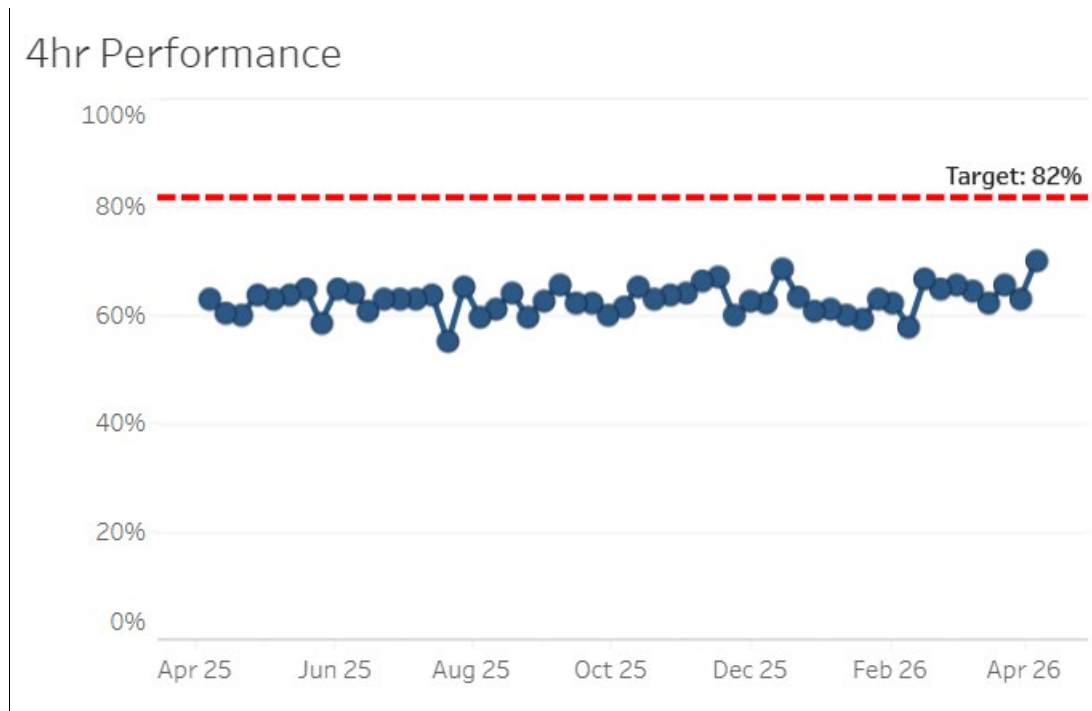
How we measured success

The following metrics are used consistently to track progress and impact:

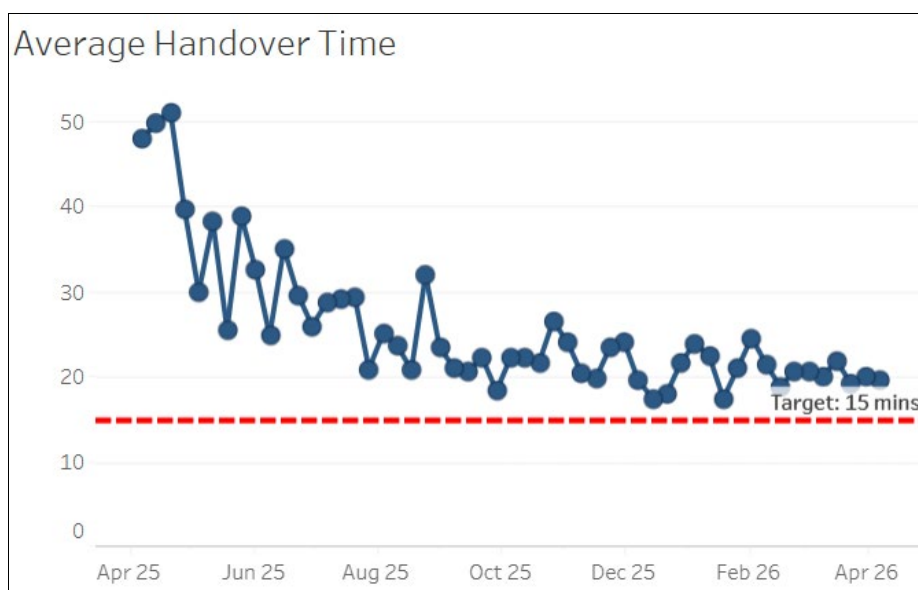
Graph: 12-hour Emergency Department performance, tracks the percentage of patients who spend more than 12 hours in the Emergency Department before being admitted, transferred or discharged. The graph demonstrates near achievement of our 98% target.



Graph: 4-hour Emergency Department performance (overall and non-admitted) means all patients will be seen and have an admission or discharge plan within 4 hours. We are not yet meeting the 4-hour target, but performance appears to stabilise and improve slightly towards the end of the year.



Graph: Ambulance handover times are the time the ambulance must wait at the emergency department to provide a safe patient handover. This time has consistently decreased over the year.



What we achieved in 2025/26

During 2025/26, the Trust made progress across a number of key flow measures. Twelve-hour Emergency Department performance improved and came close to the Trust's target. Although the 4-hour standard has not yet been achieved, performance began to stabilise and showed some improvement towards the end of the year. Ambulance handover times also reduced over the course of the year, providing early evidence of more reliable front-door flow.

The Trust also expanded alternatives to inpatient admission. More patients were managed through medical, surgical and frailty same-day emergency care pathways, and the virtual wards model continued to support selected patients at home with remote monitoring and intervention. The discharge lounge supported an average of up to 31 patients each day, helping to free bed capacity for patients waiting for admission from the Emergency Department.

Taken together, these developments show that the Clinical Vision of Flow programme is beginning to improve pathway reliability and reduce operational pressure. However, performance remains fragile and continued progress will depend on sustained clinical leadership, consistent implementation and strong partnership working across the urgent care system.

What we will continue to do in 2026/27

During 2026/27, the Trust will continue to focus on reducing delay-related harm and improving patient flow across urgent and emergency care. This will include further work to improve ambulance handovers, reduce long waits in the Emergency Department, embed standard approaches to assessment and streaming, expand same-day emergency care models, and strengthen the use of discharge and admission avoidance pathways.

- continue to improve 12-hour and 4-hour Emergency Department performance
- build on reductions in ambulance handover times
- expand use of medical, surgical and frailty same-day emergency care pathways

- strengthen admission avoidance and timely discharge through virtual wards and discharge lounge capacity
- maintain clear governance and oversight through the established improvement boards.

Quality Priority 4 - Fire Prevention and Fire Safety

Why this was a priority

Fire prevention and fire safety was a quality priority because the Trust is operating within a highly regulated fire safety environment and continues to manage material risks associated with legacy estate, enforcement action and emerging hazards. During 2025/26, the Trust continued to respond to strengthened national expectations following the Fire Safety Act, the Fire Safety (England) Regulations and post-Grenfell requirements, while also addressing significant local risks relating to the Tower Block, fire doors and compartmentation, alarm and evacuation arrangements, lithium-ion battery fire risk, and emergency communication and command arrangements. This priority has therefore remained important to ensure patient, staff and visitor safety, maintain regulatory compliance and provide assurance that identified risks are being actively mitigated through a structured improvement programme.

What we aimed to achieve

Our aim was to strengthen the Trust's fire safety system by improving regulatory compliance, reducing life safety risk, and embedding a more structured and transparent approach to governance, assurance and improvement. This included delivering enforcement-driven remediation programmes, improving the quality and coverage of fire risk assessments, strengthening fire safety infrastructure and emergency arrangements, enhancing staff capability through training and exercising, and ensuring that learning from incidents and external feedback was translated into sustained risk reduction.

What we did

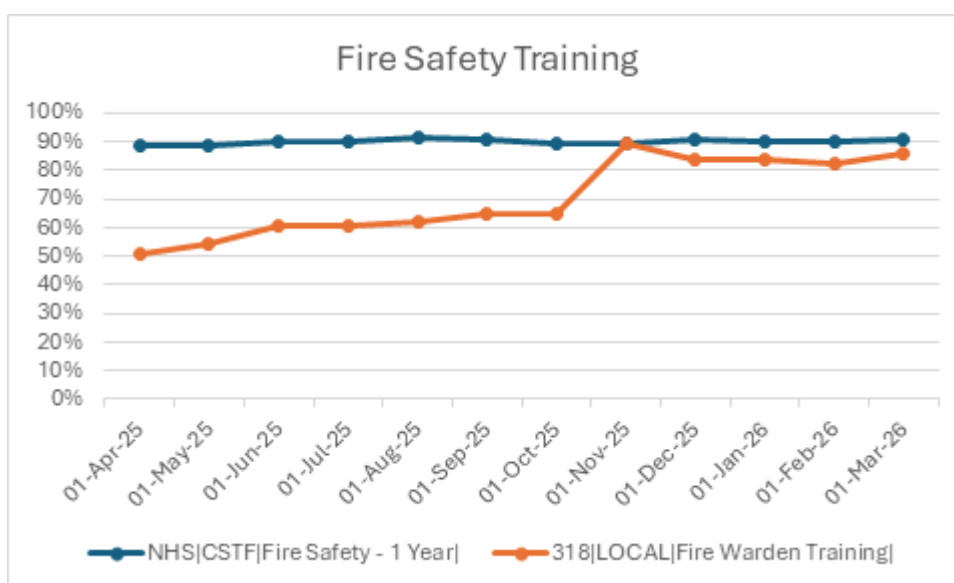
During 2025/26, the Trust strengthened its fire safety arrangements through a structured compliance and governance framework, supported by the Fire Safety Sub-Committee, Trust leadership oversight and ongoing engagement with Gloucestershire Fire and Rescue Service. Work progressed on enforcement-related action plans for the Tower Block, including fire alarm coverage, compartmentation and fire safety management arrangements. The Trust also undertook fire door and

passive fire protection surveys, strengthened its approach to fire risk assessments, increased practical and table-top evacuation training, and completed a full Tower Block fire evacuation exercise. Following a significant lithium-ion battery fire on Ward 8A, a multi-disciplinary debrief was undertaken and actions were progressed to strengthen risk assessment, battery audits, staff training, equipment guidance and external learning.

How we measured success

Success was measured through delivery against enforcement and remediation milestones, training compliance, completion of fire risk assessments and evidence that learning from incidents and exercises was translated into improvement. In 2025/26, this included trust-wide fire safety eLearning compliance of 91%, exceeding the 90% target, monitoring delivery against statutory deadlines extending from 2026 to 2028, and oversight of action plans arising from three key sources: enforcement notices and Tower Block remediation requirements, fire door and compartmentation surveys, and learning from the Tower Block evacuation exercise and the Ward 8A lithium-ion battery fire. The Trust also measured success through the strength of governance and assurance arrangements, including regular review through the Fire Safety Sub-Committee, action tracking, and regulator engagement with Gloucestershire Fire and Rescue Service.

Graph: Fire Safety Training Compliance



What we achieved in 2025/26

In 2025/26, the Trust demonstrated progress in moving from a reactive compliance approach to a more structured, programme-based model of fire safety improvement. Key achievements included establishment of a formal fire compliance delivery framework, clearer separation between capital fire remediation and business-as-usual statutory functions, named accountable leads, milestone tracking, high training compliance, strengthened regulator engagement and learning from both live incidents and exercises. However, significant residual risks remain, particularly in relation to legacy estate issues, the Tower Block environment, lithium-ion battery hazards and emergency communication and command arrangements. Overall, this provides evidence of improving control and stronger governance, while indicating that continued delivery against the fire safety programme remains essential.

What we will continue to do in 2026/27

In 2026/27, the Trust will continue to deliver its fire safety improvement programme through sustained oversight of enforcement and remediation milestones, completion of outstanding infrastructure and compartmentation work, strengthening of fire risk assessments, continued regulator engagement and further development of emergency communication and command arrangements. Work will also continue to address emerging risks such as lithium-ion battery fire safety, while maintaining training compliance and embedding learning from incidents, debriefs and exercises into ongoing operational and strategic fire safety planning.

Quality Priority 5 - Maternity Service Improvements

Why this was a priority

Maternity safety remained a priority during 2025/26 because the Trust continued to respond to the risks and regulatory requirements arising from the Care Quality Commission Section 31 conditions imposed in May 2024. A sustained programme of improvement has been required to strengthen the early recognition, escalation and management of maternal and fetal deterioration and to ensure that improvements are embedded within routine maternity governance and clinical practice.

The programme addressed key risks relating to intrapartum safety, postpartum haemorrhage, fetal monitoring, maternal deterioration, venous thromboembolism risk, workforce assurance and governance. By March 2026, the Trust had self-assessed all eight Section 31 conditions as fully met and sustainably embedded, supported by clinical, governance and performance evidence. This priority therefore remained important both to improve safety and to provide assurance that recovery had moved into a more sustainable phase of control.

What we aimed to achieve

- embed reliable systems for recognising and escalating maternal deterioration across intrapartum and postnatal care
- strengthen fetal monitoring, interpretation and escalation so that deterioration is identified and acted upon promptly
- ensure that improvements were supported by workforce assurance, routine audit, clear governance and sustained organisational learning

What we did

Maternal early warning systems were embedded across intrapartum and postnatal care, with clear escalation thresholds, defined response times, routine audit and dashboard oversight. The Trust also prepared to manage the transition to the new national Maternal Early Warning Score through an agreed implementation plan, staff training and governance oversight.

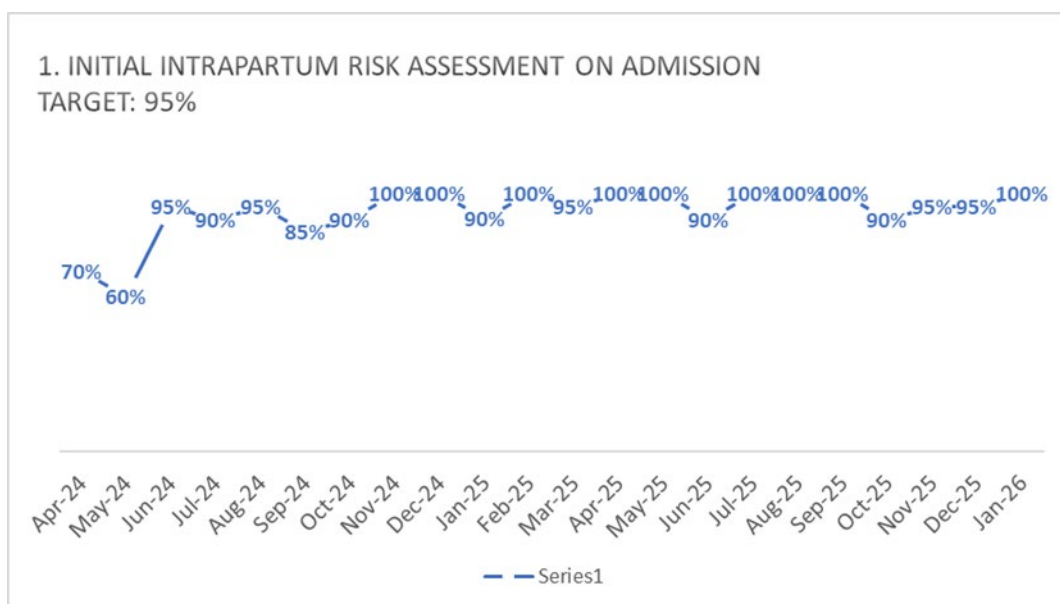
Systems to support safe fetal monitoring and timely escalation were strengthened and aligned to Saving Babies' Lives Care Bundle Version 3, NICE guidance and Maternity Incentive Scheme requirements. This included competency-based training, structured escalation pathways, senior clinical oversight and retention of peer review ('fresh eyes') as a local safety control.

Learning from maternal compromise and fetal deterioration continued through PSIRF-aligned multidisciplinary review, with themes translated into local improvement actions and fed back through established perinatal governance forums. Key outcome and process measures were routinely reviewed through the Intrapartum Forum, Postnatal Forum and the Perinatal Oversight and Assurance Meeting.

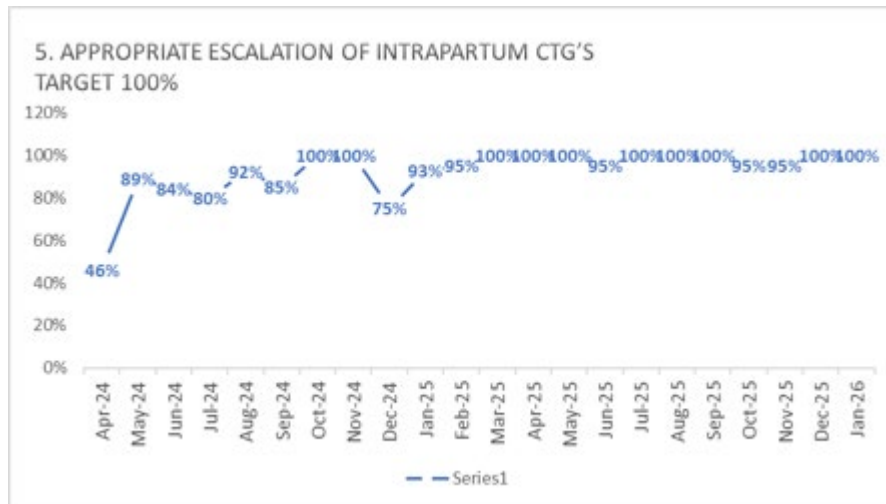
How we measured success

Success was measured through a combination of audit, compliance and assurance indicators, including intrapartum risk assessment on admission, compliance with escalation standards for maternal deterioration, fetal monitoring audits, postpartum haemorrhage surveillance, venous thromboembolism risk assessment, workforce assurance and routine review through maternity governance forums. In addition, monthly reporting to the Care Quality Commission under Conditions 7 and 8 provided external assurance during the recovery period.

Graph: Initial intrapartum risk assessment on admission compliance



Graph: Appropriate escalation of intrapartum cardiotocograph issues



What we achieved in 2025/26

- The Trust made demonstrable progress in strengthening systems for maternal and fetal safety, with evidence of sustained improvement in key process and assurance measures and reliable governance from frontline forums through to executive and Board-level oversight.
- Monthly regulatory reporting to the Care Quality Commission under Conditions 7 and 8 was delivered in full and on time, and enhanced oversight arrangements have now transitioned into business-as-usual governance as improvements have matured.
- Taken together, the data and governance evidence indicate that the Trust has moved from immediate risk mitigation towards more sustainable control, with maternal and fetal deterioration now managed through more reliable systems, continuous learning and embedded assurance mechanisms.

What we will continue to do in 2026/27

In 2026/27, the Trust will continue to embed and sustain the improvements made in maternity safety, with a particular focus on maintaining reliability in maternal and fetal deterioration pathways, supporting safe implementation of the national Maternal Early Warning Score, and ensuring that audit, governance and workforce assurance

continue to provide clear oversight. The emphasis will be on sustaining improvement, reducing variation and ensuring that learning continues to translate into safer care over time, while we implement the recommendations from the National Maternity and Neonatal Taskforce, Ockenden Review and the Amos Review

Part 2.2 Statements of Assurance from the Board

Health Services

Gloucestershire Hospitals NHS Foundation Trust provides acute, elective and specialist healthcare services for a population of more than 650,000 people across Gloucestershire and surrounding areas. The Trust delivers services primarily from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital, with maternity services also provided at Stroud Maternity Hospital. In addition, outpatient clinics and some planned surgical services are delivered by Trust staff in community hospital settings across Gloucestershire, and the Trust provides services at the satellite oncology centre at Hereford County Hospital.

The Trust's services include emergency care, planned care, maternity services, diagnostics, cancer services and a range of specialist pathways. Both main hospital sites have an Emergency Department, minor injury provision and same-day emergency care facilities. The Trust also operates direct admission pathways in a number of specialties, including frailty and gynaecology, to improve patient safety, flow and experience. Some specialist services are concentrated on one site to ensure appropriate use of clinical expertise, equipment and estate capacity.

During 2025/26, the Trust employed around 8,000 staff. Patients were cared for by more than 2,581 registered nurses, 389 midwives, 912 healthcare assistants, 1,227 medical staff, 298 healthcare scientists and 556 allied health professionals. Estates and facilities services were also supported by 880 Gloucestershire Managed Services staff. Together, this workforce provides the clinical, operational and support functions required to deliver safe and effective care across the Trust's range of services.

Health Inequalities

Reducing Health Inequalities

Health inequalities are preventable, unfair and unjust differences in health outcomes, access to services and experiences of care across different population groups.

These inequalities are shaped by wider determinants of health, including deprivation, education, employment and housing. Under the Health and Care Act 2022, NHS trusts have a statutory duty to identify, monitor and act on healthcare inequalities.

Reducing health inequalities is both a statutory requirement and a core commitment within the Trust Strategy 2025–2030. As an acute provider, Gloucestershire Hospitals NHS Foundation Trust has an important role in improving equitable access to hospital services, identifying where unwarranted variation exists and targeting action to those most at risk. This section sets out how the Trust has met that duty during 2025/26 and how health inequalities are being addressed through delivery of the Trust's Quality Priorities and wider improvement programmes.

Local Population Context

Gloucestershire is often described as a relatively affluent county; however, significant inequalities persist. Twelve neighbourhoods fall within the 10% most deprived areas nationally. Residents in these communities experience poorer health outcomes, shorter life expectancy and higher prevalence of long-term conditions. Males born in the most deprived areas of the county can expect to live more than seven years fewer than those in the least deprived areas, while the gap for females exceeds five years.

The population of Gloucestershire is also ageing. Evidence shows that people living in more deprived areas spend a greater proportion of their lives in ill health and develop multiple long-term conditions at younger ages. Although the county has lower ethnic diversity than the national average, the population is becoming increasingly diverse, reinforcing the importance of high-quality demographic data and culturally responsive services.

Statutory Reporting and National Alignment

In line with NHS England's *Statement on Information on Health Inequalities*, the Trust has analysed and published information on health inequalities across nationally specified indicators relevant to acute hospital services. Analysis is undertaken by deprivation, age, sex and ethnicity and aligned to the Core20PLUS5 framework.

Across all indicators reported for 2025/26, deprivation remains the most significant driver of inequality. No statistically significant differences were identified by sex or

ethnicity for elective recovery, urgent and emergency care, smoking cessation or children's oral health. The Trust recognises that improving the completeness and accuracy of ethnicity recording remains essential to strengthening future assurance and insight.

Taken together, this analysis provides assurance that the Trust has a clear understanding of where the most significant inequalities currently sit, with deprivation remaining the most consistent driver of variation. It also highlights an important area for further improvement, namely the completeness and quality of demographic data, particularly ethnicity recording, to strengthen future insight and assurance.

Health Inequalities and Quality Priorities

Action to reduce health inequalities is embedded within the Trust's Quality Priorities and wider improvement programmes, ensuring that quality improvement activity is targeted to those most at risk and supports measurable benefit. This reflects the Trust's strategic commitment to inclusive care and to reducing unwarranted variation in access, experience and outcomes.

Improving Access and Outcomes Through Elective Recovery

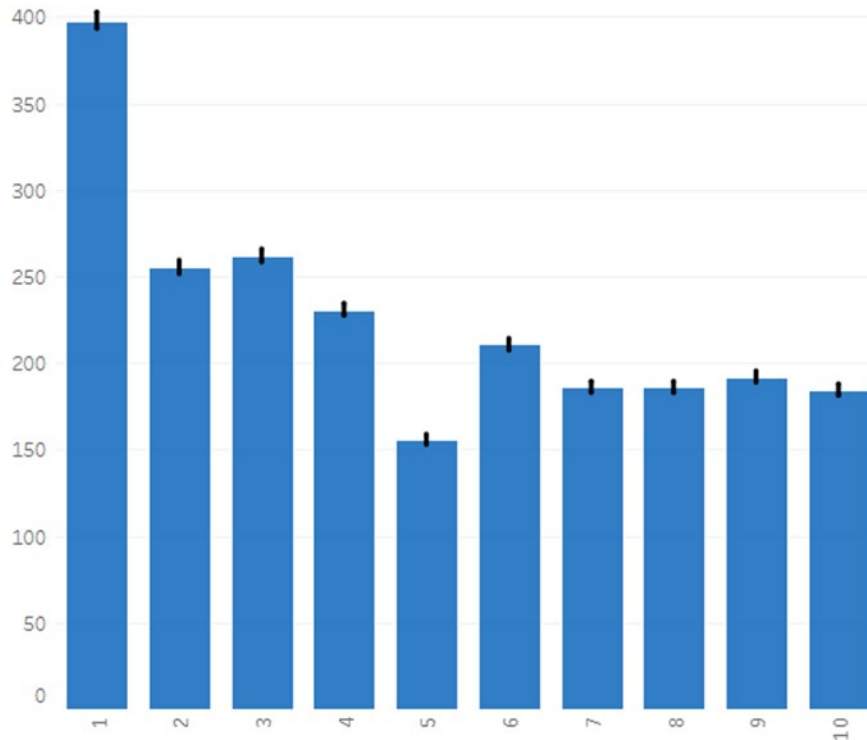
Restoring and improving elective access is a core quality priority. During 2025/26, elective activity for children's services returned to pre-pandemic levels. Adult elective activity remains below pre-pandemic levels overall; however, encouragingly, patients living in the most deprived parts of Gloucestershire are now receiving elective care at rates exceeding pre-pandemic levels. This demonstrates progress in addressing inequitable access to planned care and reflects targeted recovery efforts aligned to the Trust's quality objectives.

Addressing Inequalities in Urgent and Emergency Care

Reducing harm and improving flow through urgent and emergency care pathways is another Trust quality priority. Analysis continues to show a strong deprivation gradient in emergency department attendance. Patients living in the 10% most deprived neighbourhoods attend emergency departments at more than twice the rate of those living in the least deprived areas, as illustrated in the graph below. A similar pattern is observed for children and young people.

ED Attendances - rate per 1,000 (age-standardised)

Rolling 52 weeks; split by Deprivation within Gloucestershire



These findings reinforce the importance of system-wide prevention, early intervention and integrated pathways, and inform the Trust's work with partners to reduce avoidable demand and improve outcomes for vulnerable populations.

Targeting Modifiable Risk Factors: Smoking Cessation

Smoking remains a major modifiable risk factor contributing to health inequalities. As part of its quality priority to reduce preventable harm, the Trust has significantly strengthened tobacco dependency treatment. In 2025/26, 97% of adult inpatients had their smoking status recorded on admission, compared with 74% prior to the introduction of Tobacco Free Team processes. By February 2026, 76% of inpatient smokers were offered specialist support.

This targeted approach improves identification and treatment of smoking dependence, disproportionately benefiting patients from more deprived communities where smoking prevalence is higher.

Preventing Harm in Children: Oral Health Inequalities

Reducing avoidable harm to children forms part of the Trust's wider patient safety and quality agenda. Marked inequalities persist in children's oral health. Rates of inpatient tooth extractions due to decay are substantially higher among children living in the most deprived areas of Gloucestershire, with concentration in parts of Gloucester such as Kingsway, Hardwicke, Quedgeley and Painswick.

These findings support continued collaboration with system partners on place-based prevention and early intervention to address the root causes of avoidable oral health harm.

Governance, Assurance and Improvement

During 2025/26, the Trust established a Health Inequalities Working Group, with executive leadership provided by the Executive Director for Improvement and Delivery. The group provides oversight of analysis, supports delivery of improvement actions and ensures alignment with Trust Quality Priorities and wider Integrated Care System objectives.

Through robust analysis, transparent reporting and clear executive accountability, the Trust demonstrates how it is meeting its statutory duty on health inequalities while strengthening delivery of its Quality Priorities and readiness to respond to future population health needs and regulatory expectations.

During 2026/27, Gloucestershire Hospitals NHS Foundation Trust will continue to strengthen its approach to reducing health inequalities by embedding equity within delivery of its Quality Priorities, the Trust Strategy 2025–2030 and core operational improvement programmes.

Key areas of focus will include:

- **Targeting elective and urgent care recovery to those most at risk**
Building on progress made in restoring access for patients living in the most deprived communities, the Trust will continue to use deprivation-based analysis to inform elective recovery, urgent care redesign and flow

improvement, working with system partners to reduce avoidable emergency demand.

- **Reducing preventable harm through early intervention and risk reduction**

The Trust will further embed Tobacco Dependency Treatment across inpatient and outpatient pathways and strengthen referral to specialist support, focusing on groups with higher smoking prevalence and poorest outcomes.

- **Addressing childhood inequalities and preventable harm**

In partnership with system colleagues, the Trust will support place-based approaches to reducing avoidable tooth extractions in children, using locality-level data to inform targeted prevention and early intervention activity.

- **Improving data quality to strengthen insight and assurance**

Improving the completeness and accuracy of ethnicity and demographic data will remain a priority to enhance understanding of inequalities, strengthen assurance and support more targeted quality improvement.

- **Strengthening leadership, governance and accountability**

The Health Inequalities Working Group will continue to provide executive oversight, ensuring that analysis of inequalities informs quality improvement, operational delivery and reporting to Trust committees and the Board.

Through these actions, the Trust will continue to meet its statutory duties, align with national expectations on reducing health inequalities, and strengthen the delivery of care that is safe, effective, inclusive and responsive for all patients during 2026/27.

Information on Participation in Clinical Audit

During 2025/26, Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in 60 national clinical audits and 4 national confidential enquiries. The Trust participated in 57 national clinical audits (95%) and all 4 national confidential enquiries (100%).

The Trust did not participate in three eligible national audit areas during 2025/26, all within Emergency Medicine Quality Improvement Programmes.

Reports from national clinical audits and national confidential enquiries were reviewed through specialty and divisional governance processes, and actions were taken where improvement was required.

Actions arising from national clinical audit during 2025/26 were reviewed through specialty and divisional governance processes and informed local action planning where improvement was required. Common themes included compliance with national standards, pathway improvement, data quality, specialist review and reduction of unwarranted variation. Priority action areas included cancer, maternity, diabetes, stroke, end of life care, falls prevention and respiratory care.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2025/26 are as follows:

Audit Title	Eligible	Participated	Status
BAUS Data & Audit Programme a) British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Y	Y	Ongoing
BAUS Data & Audit Programme b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Y	Y	Ongoing
Breast and Cosmetic Implant Registry	Y	Y	Ongoing
British Spine Registry	Y	Y	Ongoing
Case Mix Programme (CMP)	Y	Y	Ongoing
Child Health Clinical Outcome Review Programme	Y	Y	Ongoing
Cleft Registry and Audit Network (CRANE) Database	Y *	Y	Ongoing
Emergency Medicine QIPs: a) Adolescent Mental Health	Y	N	N/A
Emergency Medicine QIPs: b) Care of Older People	Y	N	N/A
Emergency Medicine QIPs: c) Mental Health Self Harm	Y	N	N/A
Emergency Medicine QIPs: d) Time Critical Medications	Y	Y	Ongoing
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Ongoing

Audit Title	Eligible	Participated	Status
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	N	N	N/A
Falls and Fragility Fracture Audit Programme (FFFAP) b) National Audit of Inpatient Falls (NAIF)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP) c) National Hip Fracture Database (NHFD)	Y	Y	Ongoing
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Y	Y	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Ongoing
Mental Health Clinical Outcome Review Programme	N	N	N/A
National Adult Diabetes Audit (NDA) a) National Diabetes Core Audit.	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) b) Diabetes Prevention Programme (DPP) Audit	N	N	N/A
National Adult Diabetes Audit (NDA) c) National Diabetes Footcare Audit (NDFCA)	N	N	N/A
National Adult Diabetes Audit (NDA) d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) e) National Pregnancy in Diabetes Audit (NPID)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	N	N	N/A
National Adult Diabetes Audit (NDA) g) Gestational Diabetes Audit	Y	Y	Ongoing
National Audit of Cardiac Rehabilitation	N	N	N/A
National Audit of Care at the End of Life (NACEL)	Y	Y	Ongoing
National Audit of Dementia (NAD)	Y	Y	Ongoing
National Audit of Eating Disorders (NAED)	N	N	N/A
National Bariatric Surgery Registry	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NaoMe)	Y	Y	Ongoing

Audit Title	Eligible	Participated	Status
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Primary Breast Cancer (NAoPri)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Bowel Cancer Audit (NBOCA)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA) ¹	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Ovarian Cancer Audit (NOCA)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Pancreatic Cancer Audit (NPaCA)	Y	Y	Ongoing
National Cancer Audit Collaborating Centre (NATCAN): National Prostate Cancer Audit (NPCA)	Y	Y	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): a) National Adult Cardiac Surgery Audit (NACSA)	N	N	N/A
National Cardiac Audit Programme (NCAP): b) National Congenital Heart Disease Audit (NCHDA)	N	N	N/A
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (NACRM)	Y	Y	Ongoing

Audit Title	Eligible	Participated	Status
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y	Ongoing
National Child Mortality Database (NCMD)	Y	Y	Ongoing
National Clinical Audit of Psychosis (NCAP)	N	N	N/A
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	Ongoing
National Joint Registry	Y	Y	Ongoing
National Major Trauma Registry	N	N	N/A
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing
National Neonatal Audit Programme (NNAP)	Y	Y	Ongoing
National Obesity Audit (NOA) ¹	N	N	N/A
National Ophthalmology Database (NOD): a) Age-related Macular Degeneration Audit	Y	Y	Ongoing
National Ophthalmology Database (NOD): b) Cataract Audit	Y	Y	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	Ongoing
National Perinatal Mortality Review Tool (PMRT)	Y	Y	Ongoing
National Pulmonary Hypertension Audit	N	N	N/A
National Respiratory Audit Programme (NRAP): a) COPD Secondary Care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP): b) Pulmonary Rehabilitation	N	N	N/A
National Respiratory Audit Programme (NRAP): c) Adult Asthma Secondary Care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP): d) Children and Young People's Asthma Secondary Care	Y	Y	Ongoing
National Vascular Registry (NVR)	Y	Y	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N	N	N/A
Paediatric Intensive Care Audit Network (PICANet) ¹	N	N	N/A
Perioperative Quality Improvement Programme (PQIP)	Y	Y	Ongoing
Prescribing Observatory for Mental Health (POMH)	N	N	N/A

Audit Title	Eligible	Participated	Status
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Y	Y	Ongoing
UK Cystic Fibrosis Registry: a) Cystic Fibrosis – Adults	N	N	N/A
UK Cystic Fibrosis Registry: b) Cystic Fibrosis – Children	N	N	N/A
UK Interstitial Lung Disease (ILD) Registry	Y	Y	Registry closed from April 26
UK Parkinson's Audit	Y	Y	Ongoing
UK Renal Registry Chronic Kidney Disease Audit	Y	Y	Ongoing
UK Renal Registry National Acute Kidney Injury Audit	Y	Y	Ongoing

Taken together, this provides assurance that the Trust maintained strong participation in national clinical audit and confidential enquiry during 2025/26, that findings were reviewed through established governance routes, and that action was taken where improvement was required. Areas of non-participation are understood and will inform the clinical effectiveness work programme for 2026/27.

*Cleft Registry data is submitted regionally via Bristol (BRI)

Information on Participation in Clinical Research

During 2025/26, Gloucestershire Hospitals NHS Foundation Trust continued to support patient participation in clinical research, maintaining a broad portfolio of open studies and research recruitment across the year.

The Research, Innovation and Genomics Delivery Team recruited to 69 open National Institute for Health and Care Research portfolio studies in 2025/26, compared with 80 open studies in 2024/25.

Of these studies, 13 (19%) were commercially sponsored and 56 (81%) were non-commercially sponsored. A total of 1,916 participants were recruited to these open studies during the reporting period, compared with 2,057 participants in 2024/25.

While the number of open studies and recruited participants reduced compared with the previous year, the Trust maintained a broad research portfolio and continued to provide patients with access to research opportunities. This provides reasonable assurance that research participation remains established within the Trust, although continued attention to research infrastructure and capacity will be required to sustain and grow activity in future years.

Regulatory Report – Care Quality Commission

Care Quality Commission Registration and Regulatory Position

Gloucestershire Hospitals NHS Foundation Trust remained fully registered with the Care Quality Commission throughout 2025/26. During the reporting period, no new enforcement action was taken against the Trust.

An inspection of Medicine and Oncology services at Cheltenham General Hospital was published in May 2025, confirming a rating of **Good** with no must-do actions.

During 2025/26, the Trust was also subject to further Care Quality Commission inspection activity, including a maternity core service inspection in September 2025, unannounced urgent and emergency care and medicine inspections in December 2025, and a well-led inspection in February 2026. Draft reports for these inspections were still awaited at the year end.

Section 31 Enforcement Notice – Maternity Services

The most significant regulatory activity during the year related to the ongoing management and recovery from a Care Quality Commission Section 31 Enforcement Notice issued in May 2024 for maternity services at Gloucestershire Royal Hospital. The notice required the Trust to demonstrate effective systems across eight conditions relating to intrapartum safety, clinical risk assessment, escalation, workforce assurance and governance.

Throughout 2025/26, the Trust submitted monthly Section 31 progress reports to the Care Quality Commission and Trust Board. By October 2025, the Trust self-assessed that seven of the eight conditions were fully met and sustained. By March 2026, the Trust self-assessed that all eight conditions were fully met and sustainably

embedded, supported by clinical, governance and performance evidence. The Trust also notes that the previous Section 29A warning notice relating to maternity services was withdrawn during 2025/26, reflecting progress in the service's recovery and improvement trajectory.

Wider External Scrutiny and Assurance

In addition to Care Quality Commission oversight, the Trust responded to two Healthwatch Enter and View visits during the year. Management responses and action plans were completed, and the published findings were used to support local improvement.

The Trust also responded during the year to three Fire Enforcement Notices relating to the Gloucestershire Royal Hospital estate, with delivery overseen through established executive and committee governance arrangements. These notices remain subject to monitored action plans extending into 2026/27 and beyond.

Assurance and Improvement

During 2025/26, the Trust maintained regular engagement with the Care Quality Commission and wider system regulators, supported by established governance routes through executive and Board committees. Improvement activity arising from regulatory oversight was managed through routine governance, audit and quality improvement processes.

Information Governance Incidents

During 2025/26, the Trust maintained established arrangements for reporting, reviewing and learning from information governance incidents. During the reporting period, one incident was reported to the Information Commissioner's Office, while the wider profile of incidents remained below the threshold for external notification.

Date reported to ICO	Incident	ICO action

Mar 2026	Complaint of Trust's response to an historic (early 2025) subject access request.	Open
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The Information Commissioner's Office is reviewing the Trust's response before making a decision.

Summary of information governance incidents below the notification threshold during 2025/26

The incidents below were reported through the Trust's Data Security and Protection arrangements between April 2025 and March 2026 and were assessed as below the threshold for notification to the Information Commissioner's Office.

Classification	Number
Confidentiality	146
Integrity	26
Availability	8
Open (investigating)	6

During the year, 186 information governance incidents were reported in line with the Trust's incident reporting policy. The majority related to confidentiality, with smaller numbers affecting data integrity or availability. Incidents were reviewed through established governance routes, and learning was used to inform local action, staff awareness and improvements to information handling processes where required.

Information governance incidents were reviewed through the Trust's established digital and information governance structures, and oversight of these arrangements supports the Trust's annual Data Security and Protection Toolkit submission and compliance with national data security standards.

Learning from Deaths in the NHS

The Trust has established arrangements for Learning from Deaths, supported by the Medical Examiner and Bereavement service, Structured Judgement Review, specialty mortality review and oversight through divisional and Trust-wide governance structures. During 2025/26, these arrangements continued to support identification of learning, monitoring of improvement actions and integration with wider patient safety and mortality governance.

Across the reporting period, all deaths were independently reviewed by the Medical Examiner service and the Trust continued to exceed the national requirement to review at least 10% of deaths through Structured Judgement Review. Mortality indicators improved to within the expected range for both hospital sites, while learning themes remained centred on system pressures, communication and data quality rather than widespread failures in clinical care.

Oversight is provided through the Hospital Mortality Group, with quarterly reporting to the Quality & Performance Committee and onward reporting to Trust Board. Review mechanisms include Medical Examiner scrutiny of all deaths, Bereavement Team feedback, Structured Judgement Reviews and linkage to PSIRF learning responses and national review processes, including LeDeR, child death reviews, perinatal mortality review and MBRRACE.

During 2025/26, the Trust consistently exceeded the national Structured Judgement Review standard, with adult review rates typically between 17% and 22% per quarter. Timeliness improved over the year and most cases reviewed identified good or excellent care, with few concerns requiring escalation. A quality improvement review of the SJR process is underway to strengthen the consistency of learning capture and improve translation of themes into Trust-wide action.

Feedback from families remained positive overall, with recurring themes of compassionate care and staff professionalism. Where concerns were raised, these most commonly related to communication, particularly around updates and expectations. The Trust is therefore exploring more proactive approaches to sharing review outcomes with families to improve experience and reduce the risk of avoidable complaint.

The Trust's 12-month rolling Summary Hospital-level Mortality Indicator fell steadily during 2025/26 and is now consistently within the expected range for both Gloucestershire Royal Hospital and Cheltenham General Hospital. This has been supported by improved clinical documentation and coding, better capture of co-morbidity, and changes to acute medical pathways and direct admission routes. Continued attention to data quality, remedial coding and electronic patient record development remains important to sustaining this position.

Key learning themes during the year included delay-related harm, communication, over-medicalisation and treatment burden, together with specific learning from deaths of people with a learning disability or autism through LeDeR. The most significant ongoing Trust-wide risk remains delay-related harm associated with prolonged Emergency Department waits, particularly for older patients. This learning continues to inform wider work on flow, frailty pathways, admission avoidance and end of life care.

Specific areas of focus during 2025/26 included stillbirths and perinatal deaths, where increased incidence in late 2024 was subject to cluster review, immediate learning and continued monitoring through maternity safety governance. The Trust also maintained strong bereavement and Medical Examiner arrangements and sustained clinical engagement in specialty mortality review and PSIRF-aligned learning.

Key Risks and Mitigations

Risk	Mitigation
Delay-related harm from ED waits	Clinical Vision of Flow, frailty pathways, direct admissions
Sustainability of SHMI improvements	EPR enhancements, continued coding and clinical education
Variability in SJR learning capture	QI review of SJR process and divisional accountability

Communication concerns from families	Proactive feedback pilots and bereavement improvements
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In summary, the Trust's Learning from Deaths arrangements remained compliant and continued to mature. Mortality indicators were within the expected range, learning was identified through established review processes, and key system-wide risks were clearly recognised. Continued focus is required on Emergency Department delays, the sustainability of data quality improvements and the reliable translation of learning into improvement, but the overall position reflects a well-governed and clinically engaged approach to learning from deaths.

Statement on Doctors in Training Rota Gaps

Rota gaps remain a significant and persistent challenge across Gloucestershire Hospitals NHS Foundation Trust, with the greatest impact seen in medical and urgent care specialties. These gaps increase workload intensity, extend working hours and create continued reliance on temporary staffing solutions. They also affect the training experience for NHS doctors in training and locally employed doctors, particularly where service pressures reduce opportunities for supervision, learning and protected development time.

The impact of rota gaps is material for trainee wellbeing, service delivery, patient safety and the Trust's ability to maintain high-quality training environments. Persistent vacancies can increase fatigue, reduce resilience within teams and heighten operational risk, particularly during periods of escalation or industrial action. This also creates financial and workforce sustainability pressures through increased use of bank, locum and agency cover.

The Trust has established governance routes to oversee rota gaps and related risks. The Guardian of Safe Working provides quarterly reports to the Trust Board, supported by exception reporting, working hours compliance data, NHSE Quality Panel feedback and National Training Survey intelligence. These mechanisms help triangulate the lived experience of doctors in training with workforce, safety and

education data, enabling the Trust to identify trends, target interventions and strengthen assurance.

For 2026/27, the Trust will continue to implement a coordinated and sustainable approach to rota gap mitigation. This will include progressing business cases for permanent backfill of persistent gaps through international and locally employed doctors; expanding multi-professional roles such as Advanced Care Practitioners, Physician Associates and Advanced Nurse Practitioners; and strengthening flexible workforce models, including staff bank arrangements, to reduce reliance on agency staffing.

Full implementation of Health Roster will be a key enabler, improving visibility of rota gaps, supporting real-time workforce planning and strengthening compliance oversight. The Trust will also strengthen collaboration between medical staffing, finance, rota coordination and postgraduate medical education teams to improve data accuracy, escalation routes and shared ownership of solutions. Continued engagement with NHSE will remain important to support alignment between trainee numbers, service demand and training pathway flexibility.

Veterans Covenant Healthcare Alliance (VCHA) Veteran Aware Accreditation

Gloucestershire Hospitals NHS Foundation Trust continued to meet the requirements of the Veterans Covenant Healthcare Alliance (VHCA) Veteran Aware framework during 2025/26 and maintained its commitment under the Armed Forces Covenant. The Trust remained focused on ensuring that veterans, reservists, serving personnel and their families were not disadvantaged in accessing healthcare, and that special consideration was given where health needs related to service.

The Trust retained Veteran Aware accreditation throughout the year and continued an active programme of work to support compliance and prepare for re-accreditation in 2026. This included strengthening routine identification of veterans and Armed Forces families within clinical services, improving the recording of Armed Forces status within electronic patient systems, and supporting this through staff awareness activity and patient-facing information.

Where patients were identified as members of the Armed Forces community, the Trust supported timely referral and signposting to relevant NHS veteran pathways and wider support services. The Patient Advice and Liaison Service also provided advice and signposting where required. No formal complaints relating specifically to veterans were received during the reporting period, indicating a positive patient experience.

The Trust also continued to support veterans, reservists and serving personnel within its workforce, including support for reservist commitments, Defence Medical Services placements and Armed Forces awareness activity. Partnership working with Integrated Care System Armed Forces leads, veteran organisations and military welfare services remained in place to support continuity of care and local engagement.

In 2026/27, the Trust will continue to focus on successful Veteran Aware re-accreditation, improved data quality and electronic identification of Armed Forces status, strengthened staff awareness, and continued collaboration with local and regional veteran support partners.

Freedom to Speak Up Guardian Service

The Trust maintained an active Freedom to Speak Up service during 2025/26, supporting staff to raise concerns where barriers existed to speaking up through local routes. The service continues to provide an important source of insight into organisational culture, staff experience and the responsiveness of leaders to concerns raised.

Staff continued to use the Freedom to Speak Up service during the year for support with barriers to speaking up. Since the introduction of Report, Support and Learn, overall Freedom to Speak Up case numbers reduced by 26%, while 423 reports were received through Report, Support and Learn, suggesting that staff are increasingly using the most appropriate routes to raise concerns.

Concerns were raised across a wide range of staff groups, roles and services. Inappropriate attitudes and behaviours remained the most common reason for

contact, and themes relating to racism, discrimination and responsiveness to speaking up were identified and escalated through governance routes for action.

Anonymous reporting remained low. In quarter 4 of 2025/26, 7.1% of Freedom to Speak Up cases were raised anonymously, indicating improving confidence among staff to raise concerns openly.

The Lead Freedom to Speak Up Guardian also continued to support Gloucestershire Managed Services staff to access the service, and work is underway to establish a dedicated Gloucestershire Managed Services Guardian to strengthen that support further.

Overall, this indicates that the Trust continues to maintain an accessible Freedom to Speak Up service, that staff are using appropriate routes to raise concerns, and that learning from those concerns is informing action to strengthen speaking-up culture and organisational responsiveness.

Data Quality

Good quality information underpins the safe and effective delivery of care, service improvement and performance reporting within Gloucestershire Hospitals NHS Foundation Trust. Data quality remains an important enabler of patient safety, operational reliability and regulatory reporting, and the Trust has established arrangements to monitor and improve the quality of data recorded within its core clinical and administrative systems.

During 2025/26, the Trust continued to strengthen data quality through routine identification and resolution of duplicate records, monitoring of day case activity and regular attenders, user feedback, revision of data quality reports, and action in response to Secondary Uses Service data quality reports. Automated reports available through the Trust's BI Hub support identification, escalation and correction of issues within core systems.

For the period April 2025 to March 2026, the percentage of records containing a valid patient NHS number was 99.9% for admitted patient care (national average 99.7%), 100% for outpatient care (national average 99.8%) and 99.4% for accident and emergency care (national average 99.0%). The percentage of records containing a

valid GP practice code was 100% for admitted patient care (national average 99.8%), 100% for outpatient care (national average 99.6%) and 100% for accident and emergency care (national average 99.7%).

A comprehensive suite of daily, weekly and monthly reports supports monitoring of core activity, including outpatient attendances and outcomes, inpatient episodes, critical care data, accident and emergency data and waiting list information. These reports support local correction, escalation and learning, and data quality responsibilities are reflected in system management arrangements and staff training.

Reporting Against Core Indicators

Domain	Indicator	Years	Trust
Domain 1 – Preventing people from dying prematurely	Most recent value of the Summary Hospital Level Indicator SHMI for trust	2025/26	0.927
Domain 3 – Helping people to recover from episodes of ill health or following injury.	Percentage of Patients 0-15 Readmitted to hospital within 30 days of being discharged	2025/26	12.48%
Domain 4 – Ensuring people have a positive experience of care.	Staff who would recommend the trust to their family or friends	2025/26	49%
	Patients who rate the quality of their care as positive or extremely positive	2025/26	92.36%
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	Patients admitted to hospital who were risk assessed for venous thromboembolism	2025/26	89.10%
	Rate of Clostridium difficile infection	2025/26	31.2
	Patient safety incidents and the percentage that resulted in severe harm or death	2025/26	63

Patient Reported Outcomes

Below is from the national website for the period April 2024 to March 2025 (most up-to-date finalised data).

	EQ-5D		EQ VAS		Oxford Score	
	<i>Trust %</i>	<i>England %</i>	<i>Trust %</i>	<i>England %</i>	<i>Trust %</i>	<i>England %</i>
Total Hip	91.60%	89.10%	73.90%	70.90%	99.00%	97.10%
Total Knee	83.90%	81.50%	68.10%	62.30%	96.10%	94.10%

Patient Experience

Patient experience remained a core quality priority for Gloucestershire Hospitals NHS Foundation Trust during 2025/26. The Trust continued to use patient, carer and family feedback from a range of sources to understand experience of care, identify areas of good practice and target improvement where concerns were most persistent. Overall feedback remained positive, particularly in relation to staff kindness, compassion and professionalism, while known risks relating to waiting, communication and discharge continued to require focused attention.

Patient experience is monitored through a triangulated range of local and national intelligence, including the Friends and Family Test, Patient Advice and Liaison Service contacts, formal complaints, national patient surveys and external insight such as Healthwatch Enter and View visits and Patient Led Assessments of the Care Environment (PLACE) Lite assessments. Together, these sources provide a broad and consistent picture of how patients experience care across the Trust and where improvement action is required.

Overall patient feedback remained positive during 2025/26. Friends and Family Test positivity remained above 90%, with high response volumes across services, and patients frequently described staff as caring, professional and reassuring. This positive feedback was echoed through other local experience routes and reinforces the importance of compassionate staff behaviours as a consistent strength within the Trust's patient experience profile.

Feedback also continued to highlight recurring pressure points, particularly in relation to access and waiting, communication during delays, and aspects of discharge planning and aftercare. These themes were reflected across complaints, PALS contacts and national survey findings, indicating that the Trust has a clear

understanding of the main issues affecting experience of care. Services with higher volumes of concerns have been identified, and patient experience data is increasingly being used alongside safety, operational and performance information to target improvement and monitor impact.

During 2025/26, the Trust used patient feedback to inform a range of improvement actions. These included strengthening co-designed work in maternity triage, improving support for carers, increasing compliance with the Accessible Information Standard, expanding volunteer support roles, and using feedback to shape improvements in discharge, communication and outpatient pathways. Patient experience improvement has also been linked more explicitly to wider transformation work, including outpatient transformation, Clinical Vision of Flow and digital development, helping to ensure that experience is considered alongside safety, effectiveness and access.

Taken together, these findings indicate that patient experience remained positive overall during 2025/26, with clear strengths in compassionate care and a consistent understanding of the main issues affecting patients and carers. The Trust continues to use this intelligence to inform service improvement and to strengthen how patient voice is reflected within quality governance and improvement planning.

In 2026/27, the Trust will continue to focus on improving communication and expectation-setting during waits, strengthening discharge experience and carer involvement, targeting services where concerns are most persistent, and embedding patient experience more fully within delivery of the Trust Strategy 2025–2030 and the Quality Governance Transformation programme.

National Cancer Patient Experience Survey

The National Cancer Patient Experience Survey provides an important source of assurance on how patients experience cancer care and enables comparison with other NHS trusts nationally. It complements local patient experience feedback and informs improvement across cancer pathways.

The most recently published results relate to the 2024 survey, with 264 responses from 412 eligible patients. Overall, results were positive and showed strengths in

compassionate care, staff support and professionalism, with the Trust continuing to score above the national average for key driver questions relating to administration of care, team working and wellbeing support.

The survey also identified areas for improvement, particularly around communication, timely access to support and aspects of the overall coordination of care. These themes have informed local improvement work within cancer services during 2025/26. This provides assurance that cancer patient experience remains positive overall, while giving the Trust a clear basis for targeted improvement in the areas of communication, coordination and access to support.

Recognition and Escalation for Patient Deterioration and Martha's Rule

Recognition and escalation of patient deterioration remained a core patient safety priority for the Trust during 2025/26. Established arrangements were in place to support timely recognition, escalation, treatment and learning, with oversight informed by NEWS2 audit, Martha's Rule implementation, sepsis exception reporting, Deteriorating Patient Exception Reports, committee review and Internal Audit.

The Trust has strong arrangements for escalation once deterioration is recognised, supported by the Acute Care Response Team, high staff engagement in escalation for clinical concern, and timely treatment once pathways are activated, particularly for sepsis. However, assurance work during the year continued to identify variation in early recognition, especially within the first hour of admission, the reliability of observations, and the quality of documentation supporting escalation decisions.

Governance and performance

Oversight is provided through the Deteriorating Patient and Resuscitation Committee, divisional governance structures and the Acute Care Response Team, with alignment to national requirements including NEWS2, Martha's Rule and NICE sepsis guidance. During 2025/26, ward-level audits demonstrated strong escalation reliability for patients with NEWS2 scores of 5 or more, often at 80–100% compliance, indicating that staff generally acted appropriately once deterioration was

identified. In contrast, first-hour NEWS2 completion following admission remained low, typically 40–65%, representing an area for focused improvement.

Martha's Rule was implemented across adult, paediatric and maternity inpatient areas, including emergency care. Data demonstrated a strong staff culture of escalation for clinical concern, with more escalations triggered by clinical judgement than by NEWS2 score alone. Patient and family escalations remained relatively low but provided useful insight, particularly in relation to communication, pain and changes in cognition or mobility. Documentation showing that patients or families had been asked how the patient felt also improved during the year.

Sepsis audits demonstrated strong screening reliability, with NEWS2 used consistently and high-risk features identified appropriately. Once sepsis was recognised, antibiotics were administered within NICE-aligned timeframes, with median treatment times of around 30 minutes. This indicates that the principal sepsis risk remains delayed recognition rather than delayed treatment and improvement work continues to focus in this area.

Improvement and forward look

During 2025/26, the Trust re-established NEWS2 dashboards, strengthened standardised audit tools, expanded Martha's Rule and aligned deterioration and sepsis work more closely. In 2026/27, priorities will include improving first-hour recognition of deterioration, reducing retrospective documentation, strengthening divisional ownership of audit results, and aligning workforce training across NEWS2, sepsis and escalation pathways.

The Trust has effective escalation and treatment processes once deterioration is recognised, supported by strong governance and implementation of Martha's Rule. Further improvement is required, however, in the reliability of early identification and documentation, particularly within the first hour of admission. This remains an important area of quality and patient safety focus for 2026/27.

Local Indicators within the Trust's Integrated Performance Report

The Trust maintains an established Integrated Performance Report which is reviewed routinely through Trust Board, Trust Leadership Team and the Quality and

Performance Committee. This provides regular oversight of local quality indicators across safety, effectiveness, access and patient experience, supporting timely identification of risk, escalation of concerns and monitoring of improvement action. These local indicators complement the nationally mandated Quality Account indicators by providing more frequent and operationally relevant oversight through the Trust's routine governance structure.

As at March 2026, the Integrated Performance Report showed a mixed but improving position, with progress in urgent care flow, planned care recovery, mortality, infection prevention and patient safety indicators, while continued pressure remained in urgent and emergency care standards, cancer performance, diagnostic capacity, delayed discharge and complaints responsiveness.

The principal unresolved risks identified through the integrated report remain timely access and flow across urgent, cancer and diagnostic pathways, together with the impact of delayed discharge and complaints responsiveness on patient experience. These areas continue to be managed through targeted recovery plans, integrated governance routes and routine escalation to executive and Board oversight.

The Trust's local indicators provide a routinely reviewed and triangulated picture of quality and performance. They show where performance is improving, where risks remain, and where recovery and improvement actions continue to require focused oversight. This supports transparent monitoring of delivery against the Trust's Quality Priorities and the Trust Strategy 2025–2030.

Part THREE: Other Information

Annex 1: Statements from Healthwatch, Integrated Care Board and Overview Scrutiny Committee

Statement from Healthwatch Gloucestershire

Thank you for sharing the Quality Account for Gloucestershire Hospitals NHS Foundation Trust for 2025–2026. Healthwatch Gloucestershire would like to congratulate the Trust on its continued progress over the past year, and we recognise the scale of challenge the Trust continues to face.

Healthwatch Gloucestershire welcomes the strong emphasis on strengthening patient experience, access to care and reducing health inequalities in the Trust's Strategy 2025-2030. The focus on learning, improving feedback systems, co-designing services with patients and carers, and demonstrating "You said, we did" outcomes is particularly important. From our engagement with local people, we know that clear communication, involvement in decisions and being listened to remain key priorities for patients.

We are also pleased to see the continued focus on improving timeliness and reliability of care, particularly through work on patient flow, outpatient transformation and reducing waiting times. Delays in accessing services and communication during waiting continue to be areas of concern for patients, and we support the Trust's prioritisation of improvements in these areas.

Healthwatch Gloucestershire values the strong and collaborative relationship we have with the Trust and the openness to patient feedback as evidenced through our work this year to understand inpatient experiences at Gloucestershire Royal Hospital. Having one of our volunteers on the Council of Governors further enables us to share public feedback and provide insight. Our volunteers have also valued the opportunity to support the Trust with their PLACE Lite visits this year.

We remain committed to working alongside the Trust to ensure that patient and public voices are at the heart of service delivery and improvement.

Statement from NHS Gloucestershire Integrated Care Board (written by Chief Nursing Officer)

NHS Gloucestershire Integrated Care Board welcomes the opportunity to review Gloucestershire Hospitals NHS Foundation Trust's Quality Account for 2025/26. The Trust has built on its previous quality priorities during 2025/26 and has demonstrated continued commitment to all three pillars of quality: patient experience, patient safety and clinical effectiveness. The Quality Account reflects a more integrated and improvement-focused approach to quality, with evidence of strengthened governance, clearer prioritisation and increased emphasis on learning and delivery.

The Integrated Care Board particularly recognises the progress made in embedding thematic learning from incidents, moving beyond individual case review towards approaches that are more likely to support sustained organisational improvement. It is encouraging to see that completion rates for learning responses have improved, although further progress in timeliness will remain important. The use of Quality Summits, including work to reduce falls, provides a positive example of how the Trust is bringing services together to identify learning and drive cross-organisational improvement.

The Board also acknowledges the significant work undertaken to reduce the number of patients on follow-up waiting lists and improve outpatient pathway management. This programme has delivered demonstrable progress and supports the Trust's wider aim of improving timeliness and reliability of care. Similarly, the Clinical Vision of Flow programme has been clinically led and appropriately focused on patient safety, with measurable improvement in ambulance handover times and a clearer emphasis on reducing delay-related harm across urgent and emergency care pathways.

The quality improvement work within maternity services has been substantial and has contributed to a sustained position of improvement across the areas identified through Care Quality Commission enforcement action. The Board also notes the importance of the fire prevention and safety programme, which is supported by a clear governance structure and reflects the Trust's attention to environmental and regulatory risk.

The Integrated Care Board supports the priorities identified for 2026/27 and notes that they are aligned to the Trust Strategy 2025–2030 and reflect the core domains of quality. In particular, the focus on culture, speaking up and restorative practice is welcome, recognising the importance of staff experience, psychological safety and compassionate leadership in delivering safe care.

Overall, NHS Gloucestershire Integrated Care Board considers this to be a strategically aligned Quality Account, demonstrating meaningful progress during 2025/26 and a clear focus on the areas that will be most important in the year ahead.

Statement from Gloucestershire Health Overview and Scrutiny Committee (HOSC)

The role of the Gloucestershire Health Overview and Scrutiny Committee (HOSC) is to challenge and support local health service providers in making better decisions on behalf of the people who live in our county and who use NHS services. Comprising local councillors from across Gloucestershire, the committee is often described as the NHS's 'critical friend'.

As Chair of HOSC, I have confidence in Kevin McNamara and his team when called upon to attend scrutiny committee meetings, report on performance and respond to councillor questions. I am reassured by the Trust's continued commitment to improving the care of its patients, who are also our residents. In addition to attendance at six public in-person committee meetings each year, the Trust remains in regular communication with me and committee members on current and emerging issues. Kevin and his team listen carefully to what matters most to the committee, including waiting times, safety issues, treatment outcomes and the overall patient experience.

The Trust is open to constructive challenge from HOSC, and Kevin, in his role as Chief Executive of Gloucestershire Hospitals NHS Foundation Trust, engages positively with that scrutiny. This openness contributes to better care for the people of Gloucestershire.

Annex 2: Statement of Directors Responsibility for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare a Quality Account for each financial year. In preparing the Quality Account, the directors have taken steps to satisfy themselves that the content of the Quality Account meets the requirements set.

The content of the Quality Account is consistent with internal and external sources of information including:

- board minutes and papers for the period April 2025 to March 2026
- feedback from NHS Gloucestershire Integrated Care Board dated 28 May 2026
- feedback from Gloucestershire Health Overview and Scrutiny Committee dated 28 May 2026
- feedback from Healthwatch Gloucestershire dated 4 June 2026
- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for 2024/25, with the 2025/26 report due in July 2026
- the 2024 National Patient Surveys published by the Care Quality Commission in 2025/26
- the 2024 National Staff Survey published in January 2025
- current Care Quality Commission inspection reports.

The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered. The quality performance information reported in the Quality Account is reliable and accurate.

The Quality Account has been prepared in accordance with the latest published NHS England requirements and supporting guidance, which incorporate the Quality Accounts regulations, together with the standards to support data quality for the preparation of the Quality Account.

The directors confirm, to the best of their knowledge and belief, that they have complied with the above requirements in preparing the Quality Account.

By order of the board

Deborah Evans.

K. McNamara.

Trust Chair

Deborah Evans

Chief Executive

Kevin McNamara